STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345270	A. BUILDING _____ B. WING _____	C 09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT SPRUCE PINES	218 LAUREL CREEK COURT SPRUCE PINE, NC 28777

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint investigation was conducted 08/30/22 through 09/07/22. A total of 13 allegations were investigated and 4 were substantiated: NC00192365, NC00192349, NC00192181, and NC00192437. Event ID #30EY11. Intakes NC00192365 and NC00192349 resulted in Immediate Jeopardy. Immediate Jeopardy was identifed at: CFR 483.12 at tag F600 at a scope and severity J. CFR 483.12 at tag F607 at a scope and severity J. The tags F600 and F607 constituted Substandard Quaily of Care. Immediate Jeopardy began on 08/21/22 and was removed on 09/01/22. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		9/9/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/03/2022

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F 600	Continued From page 1 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, family, staff, Psychiatric Nurse Practitioner, and Physician interviews, the facility failed to protect an 81 year old female resident with severe cognitive impairment (Resident #1) from a sexual encounter from a 74 year old male resident with intact cognition (Resident #2) for 1 of 3 residents reviewed for abuse. Resident #2 was observed standing up beside the bed, Resident #1 was lying on the bed and both were completely naked. Immediate Jeopardy began on 08/21/22 when Resident #2, who was cognitively intact, was found by nursing staff in Resident #1's room with the door closed and Resident #2 was observed standing up beside the bed, Resident #1 was lying on the bed and both were completely naked. Immediate Jeopardy was removed on 09/01/22 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective. Findings included: Resident #1 was admitted to the facility on 02/25/22 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) assessment dated 06/04/22 assessed Resident #1 with severe impairment in cognition. She	F 600	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction in s prepared and/or executed solely because it is required by the provisions of federal and state law. F600 Abuse Facility failed to protect an 81-year-old female resident with severe cognitive impairment (resident #1) from a sexual encounter from a 74-year-old male resident with intact cognition (Resident#2) for 1 of 3 residents reviewed for abuse. Resident #2 was observed standing up beside the bed. Resident #1 was lying on the bed and both residents were completely naked. Residents #1 was assessed head-to-toe with no injuries found on on 8/21/22. Family was notified of head-to-toe assessment on 8-21-22 and declined offer for further evaluation at local hospital. Resident #1 was placed on q 15-minute checks until room change to a different hall on the morning of 8/22/22 when family agreed to accept the facility's offer that was made on 8/21/22 to relocate resident to a hallway requiring a code to be entered on keypad which would ensure	

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F 600	Continued From page 2 required limited staff assistance with activities of daily living except for eating and displayed wandering behavior 1 to 3 days during the MDS assessment period. Resident #2 was admitted to the facility on 04/27/22 with diagnoses that included schizophrenia. The quarterly MDS assessment dated 08/04/22 assessed Resident #2 with intact cognition. He was assessed as being independent or needing supervision (cueing, oversight) with activities of daily living. Review of the nurse progress notes revealed an entry written by the Assistant Director of Nursing (ADON) dated 08/21/22 at 6:20 PM that read in part, "Resident #1 was found to have a male visitor in her room privately. Male was redirected by staff to his room." Review of the nurse progress notes revealed an entry written by the ADON dated 08/21/22 at 6:19 PM that read in part, "Resident #2 was found visiting in another resident room and was redirected back to his room." During an observation and attempted interview on 08/30/22 at 9:20 AM, Resident #1 was unable to recall Resident #2 or the incident that occurred on 08/21/22. Resident #1 was sitting in her recliner with her "baby doll" lying on the bed beside her. During the interaction, Resident #1 kept referring to her baby doll as her real child and how good he was being with company. During an interview on 08/30/22 at 9:57 AM and follow-up telephone interview on 09/07/22 at 1:31	F 600	resident #1 was safe from resident #2. Resident #1 was discharged from facility as previously planned on 8/30/22. On 8/21/22 Resident #2 was redirected back to his room and placed on q 15-minute checks. Resident #2 was assessed head-to-toe with no injuries noted on 8/31/22. Resident #2 was discharged on 9/21/22 as previously planned. On 8/31/22, all staff in all departments were interviewed to determine if any other resident may have been affected and if they had observed and not reported any behaviors or verbalizations of a sexual nature. The interview included questioning about Resident #2 and any other residents that could be identified with behaviors, or verbalizations. On 8/31/22, an audit of all residents with a Brief Interview of Mental Status (BIMS) of 10 or above, was completed by the DON, ADON, Unit Manager, Social Worker, and Rehab Manager to determine if they have experienced any unwanted touching or any other interaction of a sexual nature. No concerns were found. On 8/31/22, an audit consisting of thorough skin assessment of all residents with a BIMS of 9 or less was completed by DON, ADON and MDS Nurse to determine if there is evidence that they have experienced any unwanted touching or any other interaction of a sexual nature. No concerns were found.	

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F 600	Continued From page 3 PM, Resident #1's Responsible Party (RP) recalled on 08/21/22 at approximately 5:00 PM she was contacted by facility staff and informed of an incident that had occurred between Resident #1 and Resident #2. The RP could not recall the name of the staff member but stated she was told when a Nurse Aide had gone to Resident #1's room, Resident #1 was found lying on the bed naked and a male resident was standing by her bed also naked. Resident #1 was checked by 2 nurses, there was no semen found on Resident #1 and the male resident was removed from the room. The RP added she was also advised not to come to the facility that night as Resident #1 was "calmed down and sleeping." The RP stated she didn't sleep all night worrying about Resident #1 and arrived at the facility first thing the next morning. She stated Resident #1 did not recall details of the incident and when the RP pushed her through the facility in her wheelchair, she waved at various residents but could not state or point out who the resident was that had been in her room. The RP stated Resident #1 had severe dementia and there was no way she could consent to any type of intimate or sexual relationship with any resident. During interviews on 08/30/22 at 5:05 PM and 08/31/22 at 9:10 AM, Resident #2 could not recall the exact date but stated he had walked to Resident #1's room to visit with her, she invited him into the room, he shut the door and they sat down on the side of the bed. Resident #1 stated he "saw an opening with her, started kissing her, and one thing led to another." Resident #2 stated the interaction with Resident #1 was a "mutual agreement" and at first stated he took off Resident #1's clothes but later stated he assisted her with taking off her clothes. Resident #2 could	F 600	0n 8/31/22, education was provided to the Administrator and DON by the Regional Clinical Director and Regional Director of Operations, regarding the meaning of consensual and how to evaluate and make determinations of a resident's ability/capacity to consent to sexual relations. On 8/31/22 all staff in all departments including as needed and agency staff were re-educated on the facility Abuse and Neglect protocols, which included sexual abuse. The facility orientation packet to include abuse education will be completed with all staff including agency staff prior to starting their first shift for all future new hires. Nursing home Administrator, or designee, shall interview 4 random residents per week, with a BIMS of 10 or higher, to determine if they have experienced any unwanted touching or any other interaction of a sexual nature x 4 weeks then 2 random residents x 4 weeks for a a total of 8 weeks. The Director nursing, or designee, will assess 4 random resident's with a BIMS of 9 or below from head-to-toe and for noted psychosocial changes to monitor non-interviewable residents for signs of abuse x 4 weeks and then 2 random residents x 4 weeks for a total of 8 weeks. These audits will be conducted from 10/9/22 and 12/3/22 and the findings shall be reported to QAPI committee; audits will continue at discretion of QAPI committee.	

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not state at what point Resident #1 laid down on the bed and explained they did not have sexual intercourse but if staff had not come into the room, "it would have led to that." He stated they both cared for one another and he did not do anything to her that she had not wanted. Resident #2 indicated both he and Resident #1 were both consenting to the relationship and what transpired.

During interviews on 08/30/22 at 1:45 PM and 08/31/22 at 9:55 AM, Nurse Aide (NA) #1 recalled at approximately 3:00 PM on 08/21/22 she was completing the last round of her shift and when she got to Resident #1's door, it was closed which was not unusual if her family was visiting. When she knocked and opened the door, she saw Resident #2 standing by the bed in between the bed and door, with his back toward the door and Resident #1 was lying on the bed, both completely naked. NA #1 stated she was unable to open the door completely and stayed in the doorway as she called for Nurse #1 to come to the room. NA #1 stated after Nurse #1 looked into the room and saw Resident #1 and Resident #2, Nurse #1 left the room to go and get Nurse #2 while she remained standing in the doorway of the room and by the time both Nurse #1 and Nurse #2 got back to the room, Resident #2 had started to put his pants back on and Resident #1 had walked to her bed by the window and laid down. NA #1 stated Resident #2 had his back to the door and she did not visualize him from the front and could not state if he was aroused. She explained Resident #1 and Resident #2 did not appear to be in a state of arousal because they were both in a calm state. NA #1 stated Resident #1 had impaired cognition and did not feel she would be able to consent to a sexual encounter.

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For instance, NA #1 explained Resident #1 believed her baby doll was real and even attempted to feed her "baby" from her daily meal trays. NA #1 explained prior to the incident on 08/21/22 she had no inclination of any type of relationship between Resident #1 and Resident #2 nor had she noticed either one visiting the other.

During a telephone interview on 08/30/22 at 1:28 PM, NA #2 stated she was not assigned to Resident #1 and Resident #2's hall but she had heard the commotion and thought maybe Resident #1 had fallen. She could not recall the time it had occurred when she went down to Resident #1's room but stated other staff were already there, and she saw Resident #2 standing by the bed with his back toward the door completely naked and Resident #1 was lying on the bed by the door completely naked except for one sock. NA #2 stated Resident #2 was "still in his right mind" but Resident #1 had impaired cognition and she did not feel Resident #1 would be able to consent to a sexual encounter.

During a telephone interview on 09/01/22 at 10:15 AM, Nurse #1 recalled on 08/21/22 NA #1 called her down to Resident #1's room and when she arrived at the door, Resident #2 was standing by the bed next to the door, with his back toward the door, pulling up his pants and Resident #2 was lying in her bed by the window and "acted as if she was asleep." Nurse #1 left to get Nurse #2 while NA #1 stayed at the doorway of Resident #1's room. When Nurse #1 and Nurse #2 got back to Resident #1's room, Nurse #2 asked Resident #2 to go back to his room. Nurse #1 stated she remained in the room as Nurse #2 assessed Resident #1 who found no visual

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evidence of sexual intercourse. Nurse #1 recalled Resident #1 was lying in her bed, completely naked, and did not appear in any distress. After Resident #1 was assessed, she and Nurse #2 went to Resident #2's room to speak with him about what had occurred. Nurse #1 recalled Resident #2 told her that when he walked down to Resident #1's room, she was standing in the doorway in just her briefs and it "woke something up in him." She added Resident #2 denied having sex with Resident #1. Nurse #1 stated while she was sitting down next to Resident #2 talking with him, she could "smell" Resident #1 on his hands and described it as a "vaginal smell." Nurse #1 recalled during their conversation, Resident #2 had stated he and Resident #1 were in a relationship which she thought was odd and explained Resident #1 thought Resident #2's roommate was her husband and when she wandered into their room, Resident #2 would tell Resident #1 he didn't want her in the room. Nurse #1 stated Resident #1 had impaired cognition and did not feel that she was able to consent to an intimate or sexual relationship with Resident #2.

During an interview on 08/30/22 at 3:57 PM, Nurse #2 recalled on 08/21/22 she went to Resident #1's room with Nurse #1 to assess the situation and when she arrived, Resident #2 was buckling up his pants and Resident #1 was lying in the bed by the window covered with a blanket. Nurse #2 told Resident #2 he needed to get back to his room and he said he was headed that way. Nurse #2 stated Resident #1 could not tell her what had happened but did state she was washing her pants, which were noticed in the sink wet. She added Resident #1 could probably take her own clothing off but it would take her some

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time and it was not normal for her to undress herself or lie in the bed naked. Nurse #2 recalled Resident #1 was completely naked under the blanket and when she completed a visual body examination, she found no evidence of a sexual encounter such as semen or other bodily fluids on the bed linens or Resident #1's vaginal area. When Resident #2 was questioned, he reported they did not have sexual intercourse. Nurse #1 added due to Resident #1's cognition and confused state she felt Resident #1 would not be able to provide consent. Nurse #1 stated both residents were placed on 15 minute checks but staff had to keep redirecting Resident #2 from trying to go back into Resident #1's room.

During an interview on 08/30/22 at 3:28 PM, the Administrator stated she was informed of the incident on 08/21/22 and came into the facility to start an investigation. She discussed the incident with the Regional Director of Operations (RDO) and based on what was reported to them from staff there was no evidence of a sexual encounter. The Administrator added Resident #2 stated Resident #1 had invited him into her room and neither Resident #1 nor Resident #2 showed any signs of distress. Resident #2 was returned to his room and both residents were placed on 15 minute checks for a period of 72 hours; however, Resident #1's 15 minute checks were discontinued on 08/22/22 when she was moved to a hall with keypad access. The Administrator stated since neither Resident #1 nor Resident #2 displayed any signs of distress, Resident #1 was making logical statements at the time and invited Resident #2 into her room, Resident #1 did not attempt to cover up her nakedness until staff entered the room, and Resident #2 felt Resident #1 was a willing participant, the Administrator and

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RDO both felt the incident between Resident #1 and Resident #2 was mutual and not reportable.

During a joint interview with the Administrator on 08/31/22 at 5:45 PM, the RDO explained when nursing staff discovered Resident #1 and Resident #2 both undressed in Resident #1's room on 08/21/22, Resident #1 was calm, showing no signs of distress or requesting Resident #2 to get out of her room. The RDO confirmed no one asked Resident #1 if she wanted to have sexual contact with Resident #2 and explained the nursing staff were probably caught off guard when they saw both residents undressed in the room and were unsure of what to ask. The RDO restated based on Resident #1's demeanor at the time of the incident, there was every indication she wanted the contact with Resident #2.

During a telephone interview on 08/31/22 at 5:03 PM, the Psychiatric Nurse Practitioner (NP) explained she was new to the facility but had seen Resident #1 on a few occasions. The Psychiatric NP explained during their interactions, Resident #1 hadn't been able to provide a good history or recall. Based on her interactions and conversations with Resident #1, the Psychiatric NP stated she did not feel Resident #1 could give consent for a sexual relationship.

During a telephone interview on 09/01/22 at 11:49 AM, the facility's Medical Doctor (MD) revealed she was informed of the incident that occurred between Resident #1 and Resident #2 on 08/21/22 and upon the nurse's assessment of Resident #1, there was no evidence of semen, other bodily fluids, or trauma. The MD added Resident #1 had no lasting effects as a result of

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the incident. The MD stated it was her medical opinion that Resident #1 did not have the mental capacity to consent to any type of sexual or intimate relationship due to her impaired cognition.

The Administrator was notified of Immediate Jeopardy on 08/31/22 at 4:35 PM. The facility provided the following Credible Allegation of Immediate Jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
On 8/21/22 the facility failed to protect a resident with severe cognitive impairment from sexual advances from a cognitively intact male.

Resident #1 was at risk of suffering from the deficient practice. Resident #1 is no longer a resident as of 8/30/22 as she had a planned discharge on 8/30/22.

All cognitively impaired residents are also at risk from suffering from the deficient practice.

Resident #2 is still in the facility. He will remain on 15 min checks until his planned discharge home.

On 8/31/22, all staff in all departments were interviewed by members of the interdisciplinary team (IDT) that consists of Administrator, Director of Nursing (DON), Assistant Director of Nursing, Unit Managers (ADON), Social Worker, Activities Director, Business Office Manager, Admissions Director, Rehab Manager, and Office Assistant, to determine if any other resident may have been affected and if they had observed and not reported any behaviors or verbalizations of a

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sexual nature. The interview included questioning about Resident #2 and any other residents that could be identified with behaviors, or verbalizations. Behavior is defined in the education as verbalizations, unwanted sexual touching, or any other activity of a sexual nature that could represent intent for sexual misconduct.

On 8/31/22, an audit of all residents with a Brief Interview of Mental Status (BIMS) of 10 or above, was completed by the DON, ADON, Unit Manager, Social Worker, and Rehab Manager to determine if they have experienced any unwanted touching or any other interaction of a sexual nature. No concerns were found.

On 8/31/22, an audit consisting of thorough skin assessment of all residents with a BIMS of 9 or less was completed by DON, ADON and MDS Nurse to determine if there is evidence that they have experienced any unwanted touching or any other interaction of a sexual nature. No concerns were found.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

0n 8/31/22, education was provided to the Administrator and DON by the Corporate Consultant, Regional Clinical Director and Regional Director of Operations, regarding the meaning of consensual (relating to or involving consent or consensus) and how to evaluate and make determinations of a resident's ability/capacity to consent to sexual relations. For evaluation of residents who admit to the facility with a BIMS of 9 or less (which demonstrates

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cognitive impairment) and express a desire to participate in sexual activity on the Sexual History Assessment or make verbalizations, demonstrate inappropriate sexual behavior such as unwanted touching or other advances of a sexual nature, will be evaluated by their physician to determine their capacity to consent to sexual activity. These findings will be discussed with the resident's responsible party by Administrator, DON, ADON, Unit Manager, or Social Worker.

Administrator and Director of nursing were also re-educated on 8/31/22 by the Corporate Consultant, Regional Clinical Director and Regional Director of Operations, of the requirement for facility new hire orientation to include Abuse education for all new hires including agency employees.

On 8/31/22, after being reeducated as outlined above education for all staff was completed by the Administrator and DON. The education consisted of the following:
The definition of abuse (including sexual abuse), and the need to immediately notify their supervisor of all issues related to these infractions. Supervisors must inform the Administrator or DON immediately in person or by phone if not in the facility.
The need to report all resident verbalizations, behaviors, inappropriate or unwanted touching that is sexual in nature. Staff members must notify their supervisor immediately. Supervisors must inform the Administrator or DON immediately and by phone if not in the facility.
The need to be vigilant in observing and protecting all residents from verbalizations, behaviors, and inappropriate or unwanted touching that is sexual in nature

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All staff in all departments including as needed and agency staff were re-educated on the facility Abuse and Neglect protocols, which included sexual abuse, in person or by phone on 8/31/22. No one will be allowed to work prior to receiving this education and it will be included in new hire orientation. The department supervisor is responsible to ensure the orientation packet to include abuse education is completed with all staff including agency staff prior to starting their first shift.

Alleged IJ removal date 9/1/22.

On 09/07/22, the facility's credible allegation for Immediate Jeopardy removal effective 09/01/22 was validated by the following: Resident #2 remained on 15 minute checks with no inappropriate behaviors noted and interviews with alert and oriented residents revealed they felt safe in the facility. Staff interviews revealed they had received education on resident abuse and verbalized if they observed any inappropriate behaviors/abuse, they were to immediately intervene, separate the residents involved, and immediately report what was observed to the Administrator. Review of the facility's documentation revealed staff education was completed on 08/31/22. Skin assessments were conducted on all cognitively impaired residents with no concerns identified and alert and oriented residents were interviewed who all reported they felt safe at the facility and had not experienced any unwanted touching or other interactions of a sexual nature. Staff questionnaires were completed by all facility staff and revealed no one reported knowledge of any resident in the building who had exhibited behaviors or verbalizations

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F 600	Continued From page 13 that would alert them to a possible interaction of a sexual nature.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, family, and staff interviews, the facility failed to implement their abuse policy in the areas of identification, reporting and thoroughly investigating resident to resident sexual abuse for 1 of 3 residents reviewed for abuse (Resident #1). On 08/21/22, Resident #2, a 74 year old male with intact cognition, was observed standing up beside Resident #1's bed while Resident #1, an 81 year old female with severe cognitive impairment, was lying on the bed and both were completely naked. In response to the incident, the facility completed an investigation but the investigation did not include: 1) identifying and assessing other residents, including those with impaired cognition, to determine if they had experienced unwanted touching or behaviors of a sexual nature, 2) report the incident of resident to resident sexual abuse to the State Agency within	F 607	F607 The facility failed to implement their abuse policy in the areas of identification, reporting and thoroughly investigating resident to resident sexual abuse for 1 of 3 residents reviewed for abuse. On 8/31/22, the incident between Resident #1 and Resident #2 that occurred on 8/21/22 was reported to the Department of Health and Human Services, Division of Health Service Regulation, local law enforcement, and Adult Protective Services by facility Administrator. Facility conducted a thorough investigation to include:	9/9/22

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F 607	Continued From page 14 2 hours of being notified and notifying law enforcement and Adult Protective Services, and 3) interview all staff to determine if they had observed and not reported resident behaviors or verbalizations of a sexual nature, assess Resident #2, and have Resident #1 assessed by licensed professionals trained to assess for sexual abuse after being found in a compromising position. The facility also failed to include in their abuse policy the regulatory requirement for reporting abuse to the Adult Protective Services and having a qualified professional assess a resident after a suspected or alleged sexual encounter. Immediate Jeopardy began on 08/21/22 when the facility failed to identify the event as sexual abuse which placed other cognitively impaired residents at risk. Immediate Jeopardy was removed on 09/01/22 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective. Findings included: The facility's "Abuse and Neglect Protocol", with a revised date of 06/13/21, read in part: "It is the responsibility of our employees, facility consultants, attending Physicians, etc. to promptly report any incident or suspected incident of neglect or resident abuse to facility management. All reports of abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management." The "Policy Interpretation and Implementation"	F 607	Resident #1's family and physician were notified of the incident on 8/21/22. Resident #2's physician was also notified on 8/21/22. A skin assessment was completed by DON on 8/31/22. On 8/31/22, an audit was completed by interviewing all residents with a Brief Interview of Mental Status (BIMS) of 10 or above by the Director of Nursing (DON) and designees to determine if they have experienced any unwanted touching or any other interaction of a sexual nature. No concerns were noted. On 8/31/22, an audit consisting of thorough skin assessment of all residents with a BIMS of 9 or less was completed by DON and designees to determine if there is evidence that they have experienced any unwanted touching or any other interaction of a sexual nature. No concerns were noted. On 8/31/222, all staff in all departments were interviewed by members of the interdisciplinary team, (IDT), to determine if any other resident(s) may have been affected and if they had observed and not reported any behaviors or verbalizations of a sexual nature. The interview included questioning about Resident #2 and any other residents that could be identified with behaviors, or verbalizations. On 8/31/22 the Administrator and DON were also reeducated by the Regional Director of Operations and the Regional	

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F 607	Continued From page 15 section specified in part: 2 c. "Sexual abuse is defined as, non-consensual sexual contact or any type with a resident." 10. Upon receiving reports of physical or sexual abuse, a licensed nurse or physician shall immediately examine the resident. Findings of the examination must be recorded in the resident's medical record. Note: If sexual abuse is suspected, DO NOT bathe the resident or wash the resident's clothing or linen. Do not take items from the area in which the incident occurred. Call the police immediately. The policy did not include a trained ro qualified person to assess the victim. 12. If an incident of suspected abuse occurs, facility shall report immediately, but not later than 2 hours after forming the suspicion if the events that cause the suspicion result in serious bodily injury or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury to the designated state agency. 13. The individual conducting the investigation will, at a minimum: ...g) interview the person(s) reporting the incident, h) interview any witnesses to the incident, i) interview the resident (as medically appropriate), k) interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. The policy did not include notification to Adult Protective Services. Resident #1 was admitted to the facility on 02/25/22 with diagnoses that included dementia. The quarterly Minimum Data Set (MDS) assessment dated 06/04/22 assessed Resident #1 with severe impairment in cognition. She required limited staff assistance with activities of daily living except for eating and displayed	F 607	Clinical Director on all components of the facility's abuse policy and how to identify abuse. Education included the definition of abuse, reporting requirements to all required agencies including law enforcement and Adult Protective Services, the need to protect cognitively impaired residents by assessing all cognitive impaired residents for the identification of abuse, the assessment of both victim and perpetrator by qualified individuals in the ER setting, and conducting a thorough investigation when allegations of sexual abuse are present. On 8/31/22 Administrator and DON re-educated all staff in all departments including as needed and agency staff on the facility Abuse and Neglect protocols, including the need to report suspected or witnessed abuse to Administrator immediately and the need for thorough investigation. The facility orientation packet to include abuse education will be completed with all staff including agency staff prior to starting their first shift for all future new hires. The Regional Director of Operations will provide oversight weekly to ensure that facility reporting requirements are met and that all facility investigations are being completed according to policy. The facility Regional Director of Operations, or other corporate designee, will interview both the Administrator and DON weekly and review facility investigation(s) X 4 weeks to ensure reporting requirements were met and investigation(s) were conducted per	

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F 607	Continued From page 16 wandering behavior 1 to 3 days during the MDS assessment period. Resident #2 was admitted to the facility on 04/27/22 with diagnoses that included schizophrenia. The quarterly MDS assessment dated 08/04/22 assessed Resident #2 with intact cognition. He was assessed as being independent or needing supervision (cueing, oversight) with activities of daily living. The facility's investigation documentation of the incident on 08/21/22 involving Resident #1 and Resident #2 was reviewed. There was no documentation that initial or investigative reports were submitted to the State Agency or law enforcement was notified. There was documentation of a skin assessment completed 08/21/22 on Resident #1 but there was no evidence of an assessment completed 08/21/22 on Resident #2 or other residents in the facility. An undated and unsigned timeline of events read in part, "Approximately 3:15 PM Resident #2 was found standing in Resident #1's room nude. Resident #2 was lying in the empty bed nude. Nurse responded to Resident #1's room. Both Resident #1 and Resident #2 were found to be at their baseline and in no distress. Resident #2 dressed himself and was redirected back to his room. Investigation was implemented immediately ..." The investigation documentation included witness statements from NA #1, Nurse #1, Nurse #2, and a summary of events signed by the Administrator but no other staff interviews were included. During an interview on 08/30/22 at 2:58 PM, the	F 607	policy, and will interview either the Administrator, or the DON and will review facility investigation(s) x 4 weeks to ensure that reporting requirements have been met and that facility conducted investigation(s) per policy for a total of 8 weeks. These audits will be conducted from 9/4/22 to 10/29/22 and the findings shall be reported to the facility's QAPI committee by the Regional director of operations in person or via phone/internet conference; audits will continue at the discretion of QAPI committee. Completion Date 9/9/22	

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Assistant Director of Nursing (ADON) revealed she was the manager on call when Nurse #2 had contacted her on 08/21/22 to report a Nurse Aide (NA) (she couldn't recall which NA) had found Resident #2 in Resident #1's room putting on his pants with Resident #1 undressed and lying in bed. The ADON stated she wasn't sure what to do since this was the first time something like that had happened. She immediately contacted the Administrator to inform her of the incident and from that point on, the Administrator pretty much handled the investigation. The ADON stated when she arrived at the facility, she entered progress notes in both Resident #1's and Resident #2's medical record noting Resident #2 was found in Resident #1's room but did not assess or interview either resident or staff involved. The ADON added she was not instructed by the Administrator to submit the initial report to the State Agency, notify law enforcement or Adult Protective Services.

During an observation and attempted interview on 08/30/22 at 9:20 AM, Resident #1 was unable to recall Resident #2 or the incident that occurred on 08/21/22. Resident #1 was sitting in her recliner with her "baby doll" lying on the bed beside her. During the interaction, Resident #1 kept referring to her baby doll as her real child and how good he was being with company.

During an interview on 08/30/22 at 9:57 AM and follow-up telephone interview on 09/07/22 at 1:31 PM, Resident #1's Responsible Party (RP) recalled on 08/21/22 at approximately 5:00 PM she was contacted by facility staff and informed of an incident that had occurred between Resident #1 and Resident #2. The RP could not recall the name of the staff member but stated she was told

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when a Nurse Aide had gone to Resident #1's room, Resident #1 was found lying on the bed naked and a male resident was standing by her bed also naked. Resident #1 was checked by 2 nurses, there was no semen found on Resident #1 and the male resident was removed from the room. The RP added she was also advised not to come to the facility that night as Resident #1 was "calmed down and sleeping." The RP could not remember the date or the name of the staff member she spoke with but stated she was "advised against" having Resident #1 sent to the hospital for an evaluation and tested for Sexually Transmitted Disease (STD) because the examination "was pretty intense" and they were not sure Resident #1 could tolerate it. The RP stated she didn't sleep all night worrying about Resident #1 and arrived at the facility first thing the next morning. She stated Resident #1 did not recall details of the incident and when the RP pushed her through the facility in her wheelchair, she waved at various residents but could not state or point out who the resident was that had been in her room. The RP stated Resident #1 had severe dementia and there was no way she could consent to any type of intimate or sexual relationship with any resident.

During interviews on 08/30/22 at 5:05 PM and 08/31/22 at 9:10 AM, Resident #2 could not recall the exact date but stated he had walked to Resident #1's room to visit with her, she invited him into the room, he shut the door and they sat down on the side of the bed. Resident #1 stated he "saw an opening with her, started kissing her, and one thing led to another." Resident #2 stated the interaction with Resident #1 was a "mutual agreement" and at first stated he took off Resident #1's clothes but later stated he assisted

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her with taking off her clothes. Resident #2 could not state at what point Resident #1 laid down on the bed and explained they did not have sexual intercourse but if staff had not come into the room, "it would have led to that." He stated they both cared for one another and he did not do anything to her that she had not wanted. Resident #2 indicated both he and Resident #1 were both consenting to the relationship and what transpired.

A signed witness statement written by NA #1 on 08/21/22 read in part, "Doing my 3:00 PM round, I knocked on Resident #1's door and promptly entered to check on her and change her. I walked in to find Resident #2 standing in the nude several feet from Resident #1 who was lying nude on bed #1. Residents were not touching or communicating upon entrance. I stopped immediately and looked out into the hall and saw Nurse #1 and alerted her to come to the room. I stayed in the room while Nurse #1 responded. Resident #2 had started to dress himself and Resident #1 got up, left bed #1, went and got into her bed which is bed #2. Residents were at their baseline, with no signs or symptoms of distress or in a state of arousal. There was no indication that a sexual encounter had occurred."

During interviews on 08/30/22 at 1:45 PM and 08/31/22 at 9:55 AM, Nurse Aide (NA) #1 recalled at approximately 3:00 PM on 08/21/22 she was completing the last round of her shift and when she got to Resident #1's door, it was closed which was not unusual if her family was visiting. When she knocked and opened the door, she saw Resident #2 standing by the bed in between the bed and door, with his back toward the door and Resident #1 was lying on the bed, both

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completely naked. NA #1 stated she was unable to open the door completely and stayed in the doorway as she called for Nurse #1 to come to the room. NA #1 stated after Nurse #1 looked into the room and saw Resident #1 and Resident #2, Nurse #1 left the room to go and get Nurse #2 while she remained standing in the doorway of the room and by the time both Nurse #1 and Nurse #2 got back to the room, Resident #2 had started to put his pants back on and Resident #1 had walked to her bed by the window and laid down. NA #1 stated Resident #2 had his back to the door and she did not visualize him from the front and could not state if he was aroused. She explained Resident #1 and Resident #2 did not appear to be in a state of arousal because they were both in a calm state. NA #1 stated Resident #1 had impaired cognition and did not feel she would be able to consent to a sexual encounter. For instance, NA #1 explained Resident #1 believed her baby doll was real and even attempted to feed her "baby" from her daily meal trays. NA #1 explained prior to the incident on 08/21/22 she had no inclination of any type of relationship between Resident #1 and Resident #2 nor had she noticed either one visiting the other.

During a telephone interview on 08/30/22 at 1:28 PM, NA #2 stated she was not assigned to Resident #1 and Resident #2's hall but she had heard the commotion and thought maybe Resident #1 had fallen. She could not recall the time it had occurred when she went down to Resident #1's room but stated other staff were already there, and she saw Resident #2 standing by the bed with his back toward the door completely naked and Resident #1 was lying on the bed by the door completely naked except for

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one sock. NA #2 stated after Resident #1 was assessed by Nurse #2, she was instructed to assist Resident #1 with getting dressed. NA #2 stated Resident #2 was "still in his right mind" but Resident #1 had impaired cognition and she did not feel Resident #1 would be able to consent to a sexual encounter.

A witness statement written by Nurse #1 dated 08/21/22 read in part, "At approximately 3:15 PM, NA #1 alerted me to come to Resident #1's room. Upon entering the room, Resident #2 was standing naked in front of the first bed with his back to the door and was starting to put his pants back on. Resident #1 was laying on the second bed and threw the blanket over herself. Resident #2 was redirected to his room after he was dressed. This Nurse notified Nurse #2 of the incident and waited for next directions. I assisted Nurse #2 conduct a body audit on Resident #1. Residents were interviewed and found to be at their baseline. It was determined that residents did not have sex but Resident #2 reported that "one thing led to another." Resident #2 was educated that he was not allowed to go back into Resident #1's room. Both residents were placed on every 15 minute checks."

During a telephone interview on 09/01/22 at 10:15 AM, Nurse #1 recalled on 08/21/22 NA #1 called her down to Resident #1's room and when she arrived at the door, Resident #2 was standing by the bed next to the door, with his back toward the door, pulling up his pants and Resident #2 was lying in her bed by the window and "acted as if she was asleep." Nurse #1 left to get Nurse #2 while NA #1 stayed at the doorway of Resident #1's room. When Nurse #1 and Nurse #2 got back to Resident #1's room, Nurse #2 asked

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Resident #2 to go back to his room. Nurse #1 stated she remained in the room as Nurse #2 assessed Resident #1 who found no visual evidence of sexual intercourse. Nurse #1 recalled Resident #1 was lying in her bed, completely naked, and did not appear in any distress. After Resident #1 was assessed, she and Nurse #2 went to Resident #2's room to speak with him about what had occurred. Nurse #1 recalled Resident #2 told her that when he walked down to Resident #1's room, she was standing in the doorway in just her briefs and it "woke something up in him." She added Resident #2 denied having sex with Resident #1. Nurse #1 stated while she was sitting down next to Resident #2 talking with him, she could "smell" Resident #1 on his hands and described it as a "vaginal smell." Nurse #1 recalled during their conversation, Resident #2 had stated he and Resident #1 were in a relationship which she thought was odd and explained Resident #1 thought Resident #2's roommate was her husband and when she wandered into their room, Resident #2 would tell Resident #1 he didn't want her in the room. Nurse #1 stated Resident #1 had impaired cognition and did not feel that she was able to consent to an intimate or sexual relationship with Resident #2.

A witness statement dated 08/21/22 by Nurse #2 read in part, "at about 3:20 PM, Nurse #1 notified this Nurse that Resident #2 was naked in Resident #1's room. This Nurse went to Resident #1's room to find Resident #2 standing in the middle of the room pulling his pants up and Resident #1 was lying in her bed covered with a blanket. This nurse redirected Resident #2 back to his room and notified the ADON. With the assistance of Nurse #1, this Nurse conducted a

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head to toe assessment of Resident #1. Resident #1 was found to be at baseline and no injuries were found. Resident #1 had no clothing on and the NA was instructed to assist Resident #1 with getting dressed. This Nurse and Nurse #1 interviewed Resident #2 who reported Resident #1 was in her underwear, he got excited and "one thing led to another." Resident #2 stated, "it was a mutual agreement." This Nurse asked if he had sex with Resident #1 and he stated he did not have sex with her. Resident #2 was educated that he could not go back into Resident #1's room and both residents were placed on every 15 minute checks."

During an interview on 08/30/22 at 3:57 PM, Nurse #2 recalled on 08/21/22 she went to Resident #1's room with Nurse #1 to assess the situation and when she arrived, Resident #2 was buckling up his pants and Resident #1 was lying in the bed by the window covered with a blanket. Nurse #2 told Resident #2 he needed to get back to his room and he said he was headed that way. Nurse #2 stated Resident #1 could not tell her what had happened but did state she was washing her pants, which were noticed in the sink wet. She added Resident #1 could probably take her own clothing off but it would take her some time and it was not normal for her to undress herself or lie in the bed naked. Nurse #2 recalled Resident #1 was completely naked under the blanket and when she completed a visual body examination, she found no evidence of a sexual encounter such as semen or other bodily fluids on the bed linens or Resident #1's vaginal area. When Resident #2 was questioned, he reported they did not have sexual intercourse. Nurse #1 added due to Resident #1's cognition and confused state she felt Resident #1 would not be

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able to provide consent. Nurse #1 stated both residents were placed on 15 minute checks but staff had to keep redirecting Resident #2 from trying to go back into Resident #1's room.

During an interview on 08/30/22 at 3:28 PM, the Administrator stated on 08/21/22 at approximately 3:15 PM, she was notified by the ADON of the incident involving Resident #1 and Resident #2. The Administrator explained staff had already separated the two residents and placed them both on 15 minute checks so she instructed them to conduct a head-to-toe assessment on Resident #1 and get statements from both Resident #1 and Resident #2. The Administrator added she arrived at the facility approximately 4:30 PM and started her investigation which included talking with both Resident #1 and Resident #2 and conducting interviews with staff who had direct knowledge of the incident and residents residing on the same hall as Resident #1 and Resident #2. The Administrator explained when she interviewed additional staff, if they did not actually witness the incident or have direct knowledge of Resident #1 and Resident #2's behaviors, she did not have staff write a statement or include their interviews as part of the investigation. The Administrator also verified other than Resident #2, no other residents were assessed on 08/21/22. She discussed the incident with the Regional Director of Operations (RDO) and based on what was reported from staff they both felt there was no evidence of a sexual encounter. The Administrator explained since neither Resident #1 nor Resident #2 displayed any signs of distress, Resident #1 was making logical statements at the time and invited Resident #2 into her room, Resident #1 did not attempt to cover up her nakedness until staff

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entered the room, and Resident #2 felt Resident #1 was a willing participant, the Administrator and RDO both felt the incident between Resident #1 and Resident #2 was mutual and not reportable. The Administrator verified she did not nor did she instruct staff to notify law enforcement, Adult Protective Services, or submit the initial investigation report to the state agency regarding the incident on 08/21/22 involving Resident #1 and Resident #2. The Administrator stated she felt a thorough investigation was completed, no one alleged abuse and at the end of the day, it was determined what they had were 2 residents unclothed and in the same room with no evidence a sexual encounter had occurred and if she had suspected abuse, she would have reported it immediately.

The Administrator was notified of Immediate Jeopardy on 08/31/22 at 4:35 PM. The facility provided the following Credible Allegation of Immediate Jeopardy removal:

o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

On 8/21/22, the facility failed to follow the abuse policy in the areas of identification, prevention, protection, and reporting to law enforcement, and APS.

*Resident #1 was at risk of suffering from the deficient practice. Resident #1 is no longer a resident as of 8/30/22 as she had a planned discharge on 8/30/22.
*Cognitively impaired residents are also at risk from suffering from the deficient practice. The facility will determine cognitive impairment based

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on Brief Interview for Mental Status (BIMS) scores. A score of 9 or below will represent a cognitively impaired resident who is at risk.

o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

On 8/31/22, the facility reported the incident between Resident #1 and Resident #2 that occurred on 8/21/22 to the law enforcement, and Adult Protective Services by facility Administrator.

Resident #1's family and physician were notified of the incident on 8/21/22.

Resident #2's physician was also notified on 8/21/22. A skin assessment was completed by DON on 8/31/22.

On 8/31/22, an audit was completed by interviewing all residents with a Brief Interview of Mental Status (BIMS) of 10 or above by the Director of Nursing (DON) and designees to determine if they have experienced any unwanted touching or any other interaction of a sexual nature. No concerns were noted.

On 8/31/22, an audit consisting of thorough skin assessment of all residents with a BIMS of 9 or less was completed by DON and designees to determine if there is evidence that they have experienced any unwanted touching or any other interaction of a sexual nature. No concerns were noted.

On 8/31/222, all staff in all departments were interviewed by members of the interdisciplinary

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team (IDT) that consists of Administrator, Director of Nursing (DON), Assistant Director of Nursing, Unit Managers (ADON), Social Worker, Activities Director, Business Office Manager, Admissions Director, Rehab Manager, and Office Assistant, to determine if any other resident may have been affected and if they had observed and not reported any behaviors or verbalizations of a sexual nature. The interview included questioning about Resident #2 and any other residents that could be identified with behaviors, or verbalizations. Behavior is defined in the education as verbalizations, unwanted sexual touching, or any other activity of a sexual nature that could represent intent for sexual misconduct.

On 8/31/22 the Administrator and DON were also re-educated by the Regional Clinical Director and the Regional Director of Operations on all components of the facility's abuse policy and how to identify abuse. Education included the definition of abuse, reporting requirements to all required agencies including law enforcement and Adult Protective Services, the need to protect cognitively impaired residents by assessing all cognitive impaired residents for the identification of abuse, the assessment of both victim and perpetrator by qualified individuals per policy [if family is in agreement, facility will send resident(s) to be evaluated in the Emergency Room setting], and conducting a thorough investigation when allegations of sexual abuse are present. Regional Clinical Director or Regional Director of Operations will provide oversight weekly to ensure that reporting requirements are met and that facility investigations are completed according to policy.

Alleged IJ removal date 9/1/22.

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F 607	Continued From page 28 On 09/07/22, the facility's credible allegation for Immediate Jeopardy removal effective 09/01/22 was validated by the following: Staff interviews revealed they had received education on resident abuse and verbalized if they observed any inappropriate behaviors/abuse, they were to immediately intervene, separate the residents involved, and immediately report what was observed to the Administrator. The Regional Director of Operations educated the Administrator and Director of Nursing on abuse to include reporting requirements and the meaning of consensual. Review of the facility's documentation revealed staff education was completed on 08/31/22 including the Administrator and Director of Nursing. Staff questionnaires were completed by all facility staff and revealed no one reported knowledge of any resident in the building who had exhibited behaviors or verbalizations that would alert them to a possible interaction of a sexual nature. All residents identified as alert and oriented by the facility were interviewed and asked if they had experienced any unwanted touching or other interactions of a sexual nature with no concerns voiced. Skin assessments were completed by Registered Nurses on all cognitively impaired residents with no concerns identified.	F 607		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the	F 808		9/9/22

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F 808	Continued From page 29 task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on record view, observations, and interviews with staff, the facility failed to provide a controlled carbohydrate diet as ordered by the physician for 1 of 1 resident (Resident #3) reviewed for a therapeutic diet. The findings included: Resident #3 was admitted to the facility on 08/12/22 with diagnosis that included diabetes mellitus and dementia. The admission Minimum Data Set (MDS) dated 08/19/22 indicated Resident #3 was cognitively intact and required supervision with setup for eating. Review of Resident #3's care plan revised on 08/19/22 identified his potential for nutritional problems related to dementia and diabetes mellitus with interventions including serve diet as ordered. Review of a physician's order written on 08/28/22 revealed Resident #3 received a controlled carbohydrate diet (CCD). During an observation of meal tray service on 08/30/22 at 12:20 PM Resident #3 was served the dessert listed on the menu that included a single serving of peach cobbler and single serving container of vanilla ice cream. The diet card placed on the lunch tray indicated a CCD diet was to be served and listed the dessert	F 808	F808 Therapeutic Diet Prescribed by Physician Based on record review, observations, and interviews with staff, the facility failed to provide a controlled carbohydrate diet as ordered by the physician for 1-1 resident (Resident #3) reviewed for a therapeutic diet. Resident #3 received peach cobbler and vanilla ice cream on 12:20pm meal tray instead of the half portion of dessert or substitute as indicated on resident's tray card. Resident # 3 consumed the peach cobbler and vanilla ice cream on his tray. On 8-30-22 the Director of Nursing notified resident's physician and the facility monitored resident's blood sugar. During observation of resident's blood sugar levels on 8-30-22, resident's blood sugars were within his normal range. The Food Service Director immediately completed an audit on 8-30-22 of other residents trays served in the facility and did not find any other resident to have been affected by the deficient practice. The Food Service Director will monitor the tray line for one meal a day alternating mealtimes during scheduled work days.	

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F 808	Continued From page 30 choices as peach cobbler and vanilla ice cream and were grayed out with a line through the words. The diet card indicated dessert substitutes of a fruit and grain and another choice were to be served. During an interview on 08/30/22 at 12:33 PM the Food Service Director (FSD) explained residents with a CCD would receive either a half portion of a dessert or a substitute. The FSD confirmed Resident #3 was not supposed to receive peach cobbler or vanilla ice cream for dessert and food items grayed out with a line through the words meant those items were not served and a substitute should be provided. The FSD revealed Dietary Aide (DA) staff were responsible for putting desserts on the meal trays and indicated fruit and other sugar free desserts were available for substitutes. During an interview on 08/30/22 at 1:19 PM DA #1 revealed she was responsible for putting desserts on the meal tray for Resident #3. After review of Resident #3's diet card DA #1 confirmed peach cobbler and vanilla ice cream were grayed out with line through the words. DA #1 revealed she had overlooked and might not have completely read the diet card. DA #1 revealed she typically worked as the Cook and recently started working on the tray line one day a week and wasn't familiar with plating desserts. During an interview on 08/30/22 at 2:01 PM the Director of Nursing revealed she expected the food on the plate matched the diet card before being served to Resident #3. An interview was conducted on 08/31/22 at 3:33 PM with the Administrator. The Administrator	F 808	Food service director completed an audit of all resident tray cards on 9-1-22 to ensure all tray card accurately reflect therapeutic diets prescribed by physician. On 8/30/22 the Food Service Director provided education to all kitchen staff which included following tray cards which includes honoring choice and preferences. The Food Service Director, or designee, will randomly check a minimum of 8 resident trays after they have been served on the hall for accuracy 4 times per week for 4 weeks and then 2 times per week for 4 weeks. Audits will be conducted between September 11, 2022 and November 5, 2022 and the findings shall be reported to the QAPI committee; audits will continue at discretion of QAPI committee. Completion Date 9/9/22	

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F 808	Continued From page 31 revealed she expected the food on meal tray to match the diet card when served to residents.	F 808		