STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345179	A. BUILDING _____ B. WING _____	C 02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MOORESVILLE	752 E CENTER AVENUE MOORESVILLE, NC 28115

(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
E 000	Initial Comments A recertification and complaint investigation survey was conducted 01/23/23 to 01/26/23. The survey team returned to the facility on 02/08/23 to validate the credible allegations of IJ removal. Therefore, the exit date was changed to 02/08/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # TEQX11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation suvey was conducted from 01/23/23 through 01/26/23. The survey team returned to the facility on 02/08/23 to validate the credible allegations of IJ removal. Therefore, the exit date was changed to 02/08/23. The following intakes were investigated: NC00191499, NC00193540, NC00192848, NC00194035, NC00194395, NC00194403, NC00194471 and NC00197114. Eighteen (18) allegations were investigated and nine (9) resulted in deficiencies. Event ID #TEQX11. Immediate Jeopardy was identified at: CFR 483.60 at tag 802 at a scope and severity (K) CFR 483.60 at tag 805 at a scope and severity (K) CFR 483.60 at tag 835 at a scope and severity (K) Immediate Jeopardy began on 01/22/23 and was removed on 02/07/23.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		3/10/23

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

Electronically Signed | 03/02/2023

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F 584	Continued From page 1	F 584		

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable

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F 584	Continued From page 2 sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to repair exposed damaged dry wall on 1 of 7 units (100 hall) and affected 5 of 12 occupied rooms (Room #103, Room #107, Room #108, Room #109, and Room #111), the facility also failed to label personal care items located in shared bathrooms on 1 of 7 units (400 hall) and affected 3 of 6 shared bathrooms (Rooms #400/402, Rooms #401/403, and Rooms #405/407). The findings included: 1a. An observation of Room #103 was made on 01/23/23 at 12:10 PM. The wall behind the bed had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was missing exposing the dry wall underneath that was damaged from the bed. The bumper board was found in the bathroom with exposed wood and hardware that was used to secure it to the wall. An observation of Room #103 was made on 01/24/23 at 9:01 AM. The wall behind the bed had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was missing exposing the dry wall underneath that was damaged from the bed. The bumper board was found in the bathroom with exposed wood and hardware that was used to secure it to the wall. An observation of Room #103 was made on	F 584	The damaged dry wall on 100 Hall and the occupied rooms #103, #107, #108, #109, and #111 will be repaired by the maintenance department staff by 3/09/2023. The personal care items in the shared bathrooms on 400 hall and the affected shared bathrooms in rooms #400/ 402, #401/403, and #405/407 were replaced and labeled and stored in the residents' room on 2/01/23 by the licensed nurse. All current residents have the potential to affected. An audit was completed on 2/02/23 by the licensed nurse to ensure personal items are labeled and stored in the residents' room. An audit will be completed by 3/9/2023 by the maintenance department to ensure facility damaged dry wall in the halls and in resident rooms have been repaired. The maintenance department staff will be educated by the administrator by 3/9/2023 related to ensuring that facility dry walls to include walls in the hall and in resident rooms are being repaired if damaged. The nursing staff will be educated by 3/9/2023 related to ensuring personal items are labeled and stored in the residents' room and not in shared bathrooms by the Director of Nursing (DON)/ designee.	

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F 584	Continued From page 3 01/25/23 at 9:41 AM. The wall behind the bed had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was missing exposing the dry wall underneath that was damaged from the bed. The bumper board was found in the bathroom with exposed wood and hardware that was used to secure it to the wall. An observation of Room #103 was made on 01/26/23 at 10:38 AM. The wall behind the bed had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was missing exposing the dry wall underneath that was damaged from the bed. The bumper board was found in the bathroom with exposed wood and hardware that was used to secure it to the wall. b. An observation of Room #107 was made on 01/23/23 at 12:11 PM. The wall behind the bed had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was missing exposing the dry wall underneath that was damaged from the bed. An observation of Room #107 was made on 01/25/23 at 9:44 AM. The wall behind the bed had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was missing exposing the dry wall underneath that was damaged from the bed. An observation of Room #107 was made on 01/26/23 at 10:39 AM. The wall behind the bed	F 584	Maintenance staff and nursing staff to include licensed nurses, certified nursing assistances, certified medication aides and agency nursing staff will not be allowed to work until the education is completed. New hires also will be required to complete the education. The Maintenance Director will complete audits of the facility dry walls to include walls in resident rooms and in the halls weekly for 4 weeks and monthly for 2 months to ensure that damaged dry walls continue to be repaired as required. The Director of Nursing/ designee will complete audits of 10 rooms weekly for 4 weeks and monthly for 2 months to ensure personal items continue to be labeled and not stored in shared bathrooms. The Administrator will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review to ensure the facility's continued compliance.	

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F 584	Continued From page 4	F 584		

had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was missing exposing the dry wall underneath that was damaged from the bed.

c. An observation of Room #108 was made on 01/23/23 at 12:15 PM. The wall behind the bed had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was hanging half on the wall and half off the wall exposing the dry wall underneath that was damaged from the bed.

An observation of Room #108 was made on 01/24/23 at 9:02 AM. The wall behind the bed had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was hanging half on the wall and half off the wall exposing the dry wall underneath that was damaged from the bed.

An observation of Room #108 was made on 01/25/23 at 9:45 AM. The wall behind the bed had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was hanging half on the wall and half off the wall exposing the dry wall underneath that was damaged from the bed.

An observation of Room #108 was made on 01/26/23 at 10:40 AM. The wall behind the bed had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was hanging half on the wall and

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half off the wall exposing the dry wall underneath that was damaged from the bed.

d. An observation of Room #109 was made on 01/23/23 at 12:15 PM. The wall behind the bed had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was hanging half on the wall and half off the wall exposing the dry wall underneath that was damaged from the bed.

An observation of Room #109 was made on 01/24/23 at 9:03 AM. The wall behind the bed had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was hanging half on the wall and half off the wall exposing the dry wall underneath that was damaged from the bed.

An observation of Room #109 was made on 01/25/23 at 9:46 AM. The wall behind the bed had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was hanging half on the wall and half off the wall exposing the dry wall underneath that was damaged from the bed.

An observation of Room #109 was made on 01/26/23 at 10:44 AM. The wall behind the bed had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was hanging half on the wall and half off the wall exposing the dry wall underneath that was damaged from the bed.

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e. An observation of Room #111 was made on 01/23/23 at 12:17 PM. The wall behind the bed had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was missing exposing the dry wall underneath that was damaged from the bed.

An observation of Room #111 was made on 01/24/23 at 9:05 AM. The wall behind the bed had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was missing exposing the dry wall underneath that was damaged from the bed.

An observation of Room #111 was made on 01/25/23 at 9:47 AM. The wall behind the bed had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was missing exposing the dry wall underneath that was damaged from the bed.

An observation of Room #111 was made on 01/26/23 at 10:46 AM. The wall behind the bed had an area approximately 5 inches wide by 5 foot long where a board (bumper board) had been placed to protect the wall from the bed. The bumper board was missing exposing the dry wall underneath that was damaged from the bed.

An interview was conducted with the Maintenance Assistant (MA) on 01/26/23 at 10:55 AM. The MA walked the 100 hall and observed Room #103, Room #107, Room #108, Room #109, and Room #111. He stated that he was unaware that the bumper boards were missing or hanging half off the wall, he added that the facility did not use the

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bumper boards anymore. The MA stated that they were remodeling and updating the facility one room at a time and there was no schedule as to which room was on the list or when. He stated that when a room came open, they would begin remodeling and updating the room, but it just depended on when it came open and how busy they were with other repairs. He added that currently they had one room on the 100 hall that was currently being remodeled. Generally, the staff would make the maintenance department aware of anything that needed to be repaired and at times they would fill out a repair ticket. He added that once the repair was made they would throw the ticket away since the repair had been made. The MA removed the bumper board from Room #103 bathroom and stated that should not be in the bathroom because a resident could get hurt on the splintered wood and indicated he was going to throw the board away. The MA again confirmed he was unaware of the bumper board that were missing or not in place because the rooms that he had visited on his daily rounds were not like that.

The Assistant Director of Nursing (ADON) was interviewed on 01/26/23 at 12:02 PM and stated that if the staff noticed something that needed to be repaired, they would fill out a form and give it the maintenance department or put it in their box. Additionally, if other repairs were brought to our attention we would discuss the issue and have the maintenance department repair what ever the issue was.

The Director of Nursing (DON) was interviewed on 01/26/23 at 1:22 PM who stated she had only been at the facility for a few weeks. She stated that all staff were expected to observe rooms and

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common areas for any needed repairs and should be communicating them with the maintenance department.

The Administrator was interviewed on 01/26/23 at 3:23 PM. The Administrator stated that he had only been at the facility for a few weeks but had identified a lot of things in the facility that needed to be repaired. He stated he was actively working to develop a plan to get the required repairs completed.

2 a. An observation of the shared bathroom of rooms 400 and 402 on 01/23/23 at 11:54 AM revealed a brown hairbrush, black comb and a hair spray product sitting on the sink. All the toiletry items were unlabeled.

On 01/24/23 at 10:09 AM a subsequent observation was made of the shared bathroom of rooms 400 and 402 and the unlabeled personal items were in the same position.

An observation was conducted with Nurse Aide (NA) #1 of the shared bathroom of rooms 400 and 402 on 01/26/23 at 10:50 AM. The unlabeled black comb remained on the sink and a soiled brief was hanging off the trash can. There was also a soiled washcloth lying in the floor beside the trash can. The NA removed the items from the bathroom and explained that all residents' personal items should be stored in their rooms and labeled with their names to prevent from being used on other residents.

On 01/26/23 at 1:50 PM an interview was

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conducted with the Director of Nursing who explained that the residents' personal items should be labeled with their names and put in bags and kept in their bedside tables. She indicated their personal items should not be stored in the shared bathrooms.

b. An observation of the shared bathroom of rooms 401 and 403 on 01/23/23 at 11:10 AM revealed a gray bed pan stored in the handrail and 2 open bottles of skin and hair cleanser sitting on the sink. All personal items were unlabeled.

On 01/24/23 at 9:56 AM a subsequent observation was made of the shared bathroom of rooms 401 and 403 and the unlabeled personal items remained in the same position.

On 01/26/23 at 10:50 AM an observation was made with NA #1 of the shared bathroom of rooms 401 and 403. The unlabeled bed pan remained stored in the rail and the 2 open bottles of skin and hair cleanser remained on the sink. There was also an unlabeled black comb sitting on the sink. The NA removed the items from the bathroom and explained that all residents' personal items should be stored in their rooms and labeled with their names to prevent from being used on other residents.

On 01/26/23 at 1:50 PM an interview was conducted with the Director of Nursing who explained that the residents' personal items should be labeled with their names and put in bags and kept in their bedside tables. She indicated their personal items should not be stored in the shared bathrooms.

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F 584	Continued From page 10 c. An observation of the shared bathroom of rooms 405 and 407 on 01/23/23 at 12:09 PM revealed 2 gray wash basins stored on the top of the paper towel rack, a white toothbrush and an open bottle of skin and hair cleanser sitting on the sink and 2 urinals sitting on the back of the commode. All the personal items were unlabeled. On 01/24/23 at 10:12 AM a subsequent observation was made of the shared bathroom of rooms 405 and 407 and the unlabeled personal items remained in the same position. On 01/26/23 at 10:45 AM an observation was made of the shared bathroom of rooms 405 and 407 with NA #1. The unlabeled wash basins, white toothbrush, bottle of skin and hair cleanser and one urinal was in the same position as previous observations. The NA removed the personal items from the bathroom and explained that all residents' personal items should be stored in their rooms and labeled with their names to prevent from being used on other residents. On 01/26/23 at 1:50 PM an interview was conducted with the Director of Nursing who explained that the residents' personal items should be labeled with their names and put in bags and kept in their bedside tables. She indicated their personal items should not be stored in the shared bathrooms.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		3/10/23

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F 641	Continued From page 11 by: Based on record review and staff interview the facility failed to accurately code the Minimum Data Set (MDS) in the areas of antipsychotic medications and indwelling catheters (Resident #43, Resident #22 and Resident #51) for 3 of 6 sampled residents. The findings included: 1. Resident #43 was admitted to the facility on 01/17/20 with diagnoses that included major depressive disorder, dementia, psychosis, and anxiety. Review of a physician order dated 03/31/22 read, Risperidone (antipsychotic) 0.25 milligrams (mg) by mouth two times a day related to psychosis. Review of the comprehensive annual MDS dated 11/04/22 revealed that Resident #43 was severely cognitively impaired for daily decision making and required extensive to total assistance with activities of daily living. The MDS indicated that Resident #43 received 7 days of an antipsychotic medication during the assessment reference period. The subsequent Antipsychotic Medication Review questions at N0450 that asked if the resident received antipsychotic medications since admission/entry or reentry or the prior assessment whichever is more recent indicated that no antipsychotics were received. No information was provided regarding the Gradual Dose Reduction (GDR)or Date of last attempted, Drug Regiment Review, Medication Follow up, or Medication intervention. The MDS was completed by MDS Nurse #2. MDS Nurse #2 was interviewed via phone on	F 641	Resident #43 and Resident #22 Minimum Data Set (MDS) coding was corrected by the MDS Coordinator on 1/26/23 in the area of antipsychotic medications. Resident #51 MDS coding was corrected by the MDS Coordinator on 1/26/23 in the area of indwelling catheter. All current residents on antipsychotic medications and who have indwelling catheters have the potential to be affected. An Audit was completed on 2/24/2023 by the Regional Clinical Reimbursement Consultant to ensure residents that are prescribed antipsychotic medications and residents who have indwelling catheters MDS are accurately coded. The MDS coordinator was educated on 2/28/23 by the Regional Clinical Reimbursement Consultant to ensure residents that are prescribed antipsychotic medications and residents with indwelling catheters MDS are accurately coded. MDS Coordinators will not be allowed to work until the education is completed. New hires also will be required to complete the education. The MDS Coordinator will complete audits of the facility MDS assessments to ensure MDS assessments continue to be coded accurately in the areas of indwelling catheters and antipsychotic medications weekly for 4 weeks and monthly for 2 months to ensure continued compliance.	

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F 641	Continued From page 12 01/25/23 at 3:39 PM. MDS Nurse #2 acknowledged that Resident #43 had received an antipsychotic during the assessment reference period and that the lack of information at the follow up questions at N0450 was just a "data entry error" on her part. The Director of Nursing (DON) was interviewed on 01/26/23 at 1:03 PM. The DON stated that she expected MDS Nurse #2 to investigate the things that she was documenting and expected the MDS to be completed as accurately as possible with all the required information. The Administrator was interviewed on 01/26/23 at 3:31 PM who stated that in the few weeks he had been at the facility he had identified some concerns with the completion of MDS but had not had time to address them yet. He stated he expected the MDS to be coded accurately with all the required information. 2. Resident #22 was admitted to the facility on 02/27/18 with diagnoses that included major depressive disorder with behavioral disturbances. A review of Resident #22's Psychiatric progress notes dated 11/21/22 revealed [Quetiapine] 25 mg had been received twice daily. "Continue [Quetiapine] as its use is in accordance with current standards of practice and a GDR (gradual dose reduction) attempt at this time is likely to impair this individual's function or cause psychological instability by exacerbating an underlying medical condition or psychiatric disorder". A review of the December 2022 Medication Administration Record indicated Resident #22 had received Quetiapine (an antipsychotic	F 641	The MDS Coordinator will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review to ensure the facility's continued compliance.	

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medication used to help reduce psychosis) 25 milligrams (mg) by mouth twice a day.

The quarterly Minimum Data Set (MDS) assessment dated 12/21/22 revealed Resident #22 received an antipsychotic medication daily during the assessment period. The MDS noted a GDR had not been documented by a physician as clinically contraindicated. The MDS was completed by MDS Nurse #1.

On 01/25/23 3:50 PM an interview was conducted with the Minimum Data Set Nurse #1 who confirmed Resident #22's 12/21/22 MDS noted a GDR had not been documented by a physician as clinically contraindicated. The MDS Nurse explained that she did not look at the Psychiatric progress notes and only looked at the Medical Director's progress notes and therefore, was not aware that the GDR had been documented as being clinically contraindicated. The MDS Nurse stated she should have included the information.

An interview was conducted with the Director of Nursing (DON) on 01/26/23 1:50 PM. The DON indicated that her expectation was that the MDS Nurse review the entire medical record when she completed the MDS assessments and answer the questions appropriately.

The Administrator was interviewed on 01/26/23 3:31 PM who explained that in the few weeks he had been at the facility he has identified some concerns with the completion of MDS's but had not had time to address them yet. He stated his expectation was for the MDS to be coded accurately with all the required information.

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#2. Resident #51 was admitted to the facility on 12/30/22 with diagnoses that included stage IV pressure wound, muscle weakness, and cognitive communication deficit.

A review of Resident #51's Admission Minimum Data Set (MDS) assessment dated 01/06/23 revealed resident to be cognitively intact. Resident #51 was noted as having an indwelling catheter.

A review of Resident #51's physician orders revealed no order for the use of a urinary catheter.

A review of Resident #51's medical record revealed no mention of the resident being admitted with an indwelling urinary catheter.

An observation of Resident #51 on 01/23/23 at 12:07 PM revealed Resident #51 did not have an indwelling urinary catheter.

During an interview with Resident #51's family on 01/23/23 at 12:19 PM, they reported the resident never had a catheter while admitted to the facility.

During an interview with Nurse #4 on 01/26/23 at 10:53 AM, she reported she was familiar with Resident #51. She stated she had never seen or heard that Resident #51 had a urinary catheter.

During an interview with the Assistant Director of Nursing on 01/26/23 at 12:15 PM, he reported he was familiar with Resident #51, and he did not believe Resident #51 had utilized an indwelling urinary catheter since admission.

During an interview with MDS Nurse #1 on

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F 641	Continued From page 15 01/26/23 at 1:22 PM she reported she did not complete the Minimum Data Set assessment that indicted Resident #51 had utilized an indwelling urinary catheter. She reported it was most likely noted that way because data entry by a nurse aide on 01/01/23 indicated Resident #51's bladder incontinence could not be rated due to the use of an indwelling catheter. She reported if she would have seen that documentation, she would have verified it was correct by reviewing physician orders, speaking to the hall nurses and she would have made a visual observation of Resident #51. She reported it appeared to her as though the MDS assessment was inaccurate. During an interview with the Director of Nursing on 01/26/23 at 3:15 PM, she reported the MDS nurse that completed the assessment should have verified the documentation in Resident #51's medical record was accurate before she noted the use of an indwelling urinary catheter. She reported she expected MDS assessments to be correct and accurate.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		3/10/23

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F 656	Continued From page 16 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interview's the facility failed to implement a comprehensive care plan for a resident that wandered daily (Resident #43) and for a resident that verbalized a desire to lose	F 656	Resident #43 was placed on hospice on 2/2/23 and is no longer wandering. Resident #54 comprehensive care plan was updated on 1/25/23 by the MDS coordinator to address the desired weight	

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F 656	Continued From page 17 weight (Resident #54) for 2 of 4 residents reviewed. The findings included: 1. Resident #43 was admitted to the facility on 01/17/20 with diagnoses of dementia. Review of the comprehensive annual Minimum Data Set (MDS) dated 11/04/22 revealed that Resident #43 was severely cognitively impaired for daily decision making and had no behaviors, rejection of care or wandering. The MDS further indicated that Resident #43 used a wheelchair for mobility and required one person assistance with mobility on and off the unit. Nurse Aide (NA) #9 and #10 were interviewed on 01/24/23 at 9:42 AM. Both confirmed that they worked on the unit where Resident #43 resided. When asked which residents wandered on their unit, they both replied Resident #43, "she wanders all over the place" but was easily redirected and indicated that wandering was not new issue for Resident #43. They both indicated Resident #43 has wandered daily for quite some time. Review of Resident #43's medical record revealed no care plan for wandering. An observation of Resident #43 was made on 01/23/23 at 1:31 PM. Resident #43 was up in her wheelchair and was propelling herself in/out of other resident rooms on the unit. An observation of Resident #43 was made on 01/24/23 at 9:55 AM. Resident #43 was up in her wheelchair and propelling herself in/out of other	F 656	loss. All current residents have the potential to be affected. An audit will be completed by 3/9/2023 by Regional Clinical Reimbursement Consultant to ensure comprehensive care plan are being updated to include wandering residents and residents that have a desired weight loss. The Minimum Data Set (MDS) Coordinator was educated on 2/28/23 by the Regional Clinical Reimbursement Consultant to ensure residents' comprehensive care plans are being updated to include wandering residents and residents that have a desired weight loss. MDS coordinators will not be allowed to work until the education is completed. New hires also will be required to complete the education. The MDS Coordinator will complete audits of the facility comprehensive care plans to ensure comprehensive care plans continue to be updated to include wandering residents and residents with desired weight loss weekly for 4 weeks and monthly for 2 months to ensure continued compliance. The MDS Coordinator will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review to ensure the facility's continued compliance.	

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resident rooms on and off the unit where she resided.

An observation of Resident #43 was made on 01/24/23 at 3:25 PM. Resident #43 was noted to be propelling herself on another unit then where she resided. She was observed in/out of other resident rooms and common areas.

Nurse #3 was interviewed on 01/24/23 at 3:26 PM and confirmed that she worked on the unit where Resident #43 resided. When asked which residents on her unit wandered, she replied Resident #43, and added that Resident #43 wandered on and off the unit but was easily redirected.

MDS Nurse #1 was interviewed on 01/25/23 at 3:01 PM and confirmed that Resident #43 wandered all over the building daily but was easily redirected. She stated that she did not have a wander guard (signaling device that residents wore to alert staff if they exited the facility) in place and to her knowledge they have never care planned her wandering behavior. She again confirmed that Resident #43 wandered on a daily basis but was not captured on the MDS because no one documented her wandering behavior and stated, "if it had been on the MDS it would have certainly been care planned."
An observation of Resident #43 was made on 01/25/23 at 4:34 PM. Resident #43 was up in her wheelchair and was propelling herself on the unit and was observed going in/out of other resident rooms and common areas.

The Assisted Director of Nursing (ADON) was interviewed on 01/26/23 at 11:23 AM who confirmed that Resident #43 wandered all over

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the building but was easily redirected. The ADON stated that the staff on the other side of the building where aware that Resident #43 did not belong over there and would assist her in getting back to the appropriate unit. The ADON stated "I would think her wandering behavior would be care planned." He stated that each morning in their clinical meeting they discussed all events that occurred during the previous day, and care plans were updated right then and there. He stated that they also discussed any other issues or things that needed closer observation by the staff and again the care plans were updated right then and there. The ADON stated the wandering behavior would require close observation for safety and should be care planned.

An observation of Resident #43 was made on 01/26/23 at 12:12 PM revealed that Resident #43 was up in her wheelchair and was propelling herself on/off the unit and in/out of rooms and common areas.
The Director of Nursing (DON) was interviewed on 01/26/23 at 1:03 PM and stated that she had only been at the facility for a few weeks, and she was not familiar with the residents that wandered. The DON stated she would expect that if the resident wandered daily that it would be care planned.

2. Resident #54 was readmitted to the facility on 03/02/22.

Review of the quarterly Minimum Data Set (MDS) dated 12/13/22 revealed that Resident #54 was cognitively intact and required set up assistance with eating. The MDS further revealed that Resident #54 weighed 311 pounds and had no weight loss or gain noted during the observation

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period.

Review of a physician order dated 01/18/23 read, regular diet, sugar free beverages and condiments, fruit for dessert, large portion of vegetables and protein. Large protein portions all three meals, no bread, no tea, and no dessert.

An interview was conducted with Resident #54 on 01/23/23 at 2:48 PM. Resident #54 stated that on 01/16/23 he had an appointment with his surgeon and his surgeon advised that before he could have surgery, he needed to lose about 50 pounds. Resident #54 stated that he met with the Physician Assistant (PA) at the facility to address his desire to lose weight so that he could undergo the surgery that he needed to have. Resident #54 stated that he agreed with the PA's recommendations of dietary changes and restrictions to achieve his goal of weight loss.

Review of Resident #54's medical record revealed no care plan that addressed his desire to lose weight, or the nutritional interventions implemented to help him achieve his goal.

The Registered Dietician (RD) was interviewed via phone on 01/25/23 at 9:27 AM. The RD stated that the PA at the facility called to discuss Resident #54's desire to lose weight. Although in the nursing facility they try to liberalize the diets but because Resident #54 had verbalized a desire to loose weight they had come up with dietary restrictions and changes that would help Resident #54 achieve his goal of losing weight. The RD stated she had not care planned the interventions or Resident #54's desire to lose weight but stated she was only at the facility once a month and that in between her visits the MDS

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F 656	Continued From page 21 Nurse could make any adjustments that were needed, she added it was a collaborative effort to update the care plans. MDS Nurse #1 was interviewed on 01/25/23 at 2:31 PM. She stated that she generally did not care plan diet or dietary restrictions and generally only care planned assistive devices. MDS Nurse #1 stated that each morning in their clinical meeting they went over any new orders and if we had discussed Resident #54's desire to lose weight and interventions to help him with the weight loss I would have immediately care planned that information. The Assistant Director of Nursing (ADON) was interviewed on 01/26/23 at 11:23 AM. The ADON stated that the PA had informed him that Resident #54 had verbalized that he wished to lose weight and had agreed to a specific diet with no bread and extra protein. The ADON stated that Resident #54's desire to lose weight and interventions implemented to help him achieve his weight loss should be documented on the care plan. The Director of Nursing (DON) was interviewed on 01/26/23 at 1:03 PM. The DON stated that she had only been at the facility for a few weeks but stated she expected Resident #54's desire to lose weight and implemented interventions to be documented on the care plan.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		3/10/23

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F 677	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews, the facility failed to provide dependent residents with showers (Resident #74, #183, #184 and #186) and failed to provide nail care (Resident #53) and failed to provide shaves (Resident#75) to 6 of 8 residents reviewed for activities of daily living. The findings include: 1. Resident #74 was admitted to the facility on 01/05/23 with diagnoses that include chronic obstructive pulmonary disease. The admission Minimum Data Set (MDS) assessment dated 01/12/23 revealed Resident #74 was cognitively intact and was totally dependent on staff for bathing. Resident #74's care plan dated 01/17/23 revealed she had a self-care deficit performance related to weakness. The goal that she would improve in her current level of functioning would be attained by providing extensive assistance of one staff for bathing. On 01/23/23 at 11:24 AM an interview and observation were made of Resident #74 of her hair appearing dry and stiff and pulled back in a ponytail. The Resident was dressed in clean clothing and there were no odors noted. The Resident explained that her hair had not been washed nor had she had a shower since she was admitted to the facility. She stated she was being wiped off but every time she had asked the "girls" (nurse aides) for a shower, she was told the hall had recently been opened to residents and the	F 677	Resident #74, #184, and #186 was showered on 2/1/2023 by the Certified Nursing Assistant. Resident #183 was discharged on 1/30/2023. Resident #53 was provided nail care on 2/1/2023 by the Certified Nursing Assistant. Resident #75 declined to be shaved on 2/1/23 by the Certified Nursing Assistant. All current residents have the potential to affected. An audit was completed on 2/1/2023 by the Director of Nursing (DON) to ensure residents are being shaves, showered, and nail care provided as required. The nursing staff to include licensed nurses, certified nursing assistants, certified medication aide and agency nursing staff will be education by 3/9/2023 related to ensuring residents are given showers, shaved and nail care provided by the DON/ designee. The nursing staff to include licensed nurses, certified nursing assistances, certified medication aides and agency nursing staff will not be allowed to work until the education is completed. New hires also will be required to complete the education. The Director of Nursing/ designee will complete audits of 10 residents weekly for 4 weeks and monthly for 2 months to ensure residents continue to be shaved,	

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F 677	Continued From page 23 shower schedule for the hall had not been made up yet. The Resident continued to express that she was used to taking two showers a week at home. On 01/24/23 at 2:59 PM an observation was made of the shower schedule book for 100/200/300 and 400 halls. There was no shower schedule made up for 400 hall. A review of Resident #74's bathing record for January 2023 reviewed documentation of being given a shower on 01/17/23 and 01/20/23 by Nurse Aide (NA) #2. An interview was conducted with Nurse Aide (NA) #2 on 01/26/23 at 10:56 AM. The NA explained that she did not work on 01/17/23 and she must have made a mistake in her documentation on 01/20/23 because she has never given any resident a shower on 400 hall. On 01/24/23 at 1:11 PM during an interview with Nurse Aide #3 she reported she worked 400 hall frequently and confirmed that no resident on 400 hall had been scheduled for a shower because the hall had recently opened to residents and the shower schedule had not been developed yet. The NA continued to explain that the Scheduler was responsible for developing the 400-hall shower schedule and it had not been done yet. During an interview with Nurse Aide #4 on 01/24/23 at 3:50 PM the NA explained that he frequently worked 400 hall and had never showered a resident on that hall until that day (01/24/23). The NA continued to explain that the hall had recently opened to residents and the shower schedule had not been made up yet.	F 677	showered, and nail care provided. The Director of Nursing will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review to ensure the facility's continued compliance.	

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On 01/24/23 at 3:55 PM an interview was conducted with Nurse Aide #6 who explained that the Scheduler was responsible for making up the shower schedule for the halls and since 400 hall had just recently opened, the shower schedule had not been developed yet. The NA stated she frequently worked 400 hall and she had not showered any resident on that hall.

On 01/25/23 at 1:50 PM an interview was conducted with Nurse Aide #5 who explained that she frequently worked 400 hall and had only showered one resident that was transferred to that hall from another hall. She stated she had never showered a new resident from the hall because the shower schedule had not been made up yet.

An interview was conducted with the Assistant Director of Nursing (ADON) on 01/24/23 at 1:52 PM who explained that the first resident was admitted to 400 hall on 01/05/23 and he was not aware that the residents on that hall had not received a shower until today. The ADON continued to explain that the Scheduler was responsible for formulating the 400-hall shower schedule but failed to do that. He stated it was unacceptable for the residents to go without their showers.

An interview was conducted with the Scheduler on 01/25/23 at 9:50 AM. The Scheduler explained that she was not responsible for formulating the shower schedule for new admissions. She stated the only thing she was responsible for as far as showers was to collect the bathing sheets and turn them into the former Director of Nursing.

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During an interview with the Director of Nursing (DON) on 01/26/23 at 1:50 PM she explained that she had only been in the DON position since early January and stated she was not aware that the Scheduler who was responsible for developing the shower schedule for 400 hall had not done that and was not aware that the residents on the hall had not had a shower since their admission. The DON stated it was not acceptable.

2. Resident #183 was admitted on 01/17/23 with diagnoses that included anemia.

The admission Minimum Data Set (MDS) assessment dated 01/23/23 revealed Resident #183 was cognitively intact and required extensive assistance of one person for bathing. The MDS also indicated the Resident did not have a behavior of rejection of care.

Resident #183's care plan dated 01/17/23 revealed he had a self-care deficit performance related to weakness. The goal that he would improve in his current level of functioning would be attained by providing extensive assistance of one staff for bathing.

During an interview and observation of Resident #183 on 01/23/23 at 2:31 PM the Resident's hair was disheveled and greasy. The Resident explained that he had was used to taking a couple of showers a week, but he had not been given or offered a shower since he was admitted. The Resident had no odors and stated he was given bed baths but when he inquired about his showers, he was told the hall was newly opened and the schedule had not been made up for the hall yet.

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On 01/24/23 at 2:59 PM an observation was made of the shower schedule book for 100/200/300 and 400 halls. There was no shower schedule made up for 400 hall.

A review of Resident #183's bathing record for January 2023 reviewed documentation of being given a shower on 01/20/23 by Nurse Aide (NA) #2.

An interview was conducted with Nurse Aide #2 on 01/26/23 at 10:56 AM. The NA explained that she must have made a mistake in her documentation on 01/20/23 because she has never given any resident a shower on 400 hall.

On 01/24/23 at 1:11 PM during an interview with Nurse Aide (NA) #3 she reported she worked 400 hall frequently and confirmed that no resident on 400 hall had been scheduled for a shower because the hall had recently opened to residents and the shower schedule had not been developed yet. The NA continued to explain that the Scheduler was responsible for developing the 400-hall shower schedule and it had not been done yet.

During an interview with Nurse Aide #4 on 01/24/23 at 3:50 PM the NA explained that he frequently worked 400 hall and had never showered a resident on that hall until that day (01/24/23). The NA continued to explain that the hall had recently opened to residents and the shower schedule had not been made up yet.

On 01/24/23 at 3:55 PM an interview was conducted with Nurse Aide #6 who explained that the Scheduler was responsible for making up the

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shower schedule for the halls and since 400 hall had just recently opened, the shower schedule had not been developed yet. The NA stated she frequently worked 400 hall and she had not showered any resident on that hall.

On 01/25/23 at 1:50 PM an interview was conducted with Nurse Aide #5 who explained that she frequently worked 400 hall and had only showered one resident that was transferred to that hall from another hall. She stated she had never showered a new resident from the hall because the shower schedule had not been made up yet.

An interview was conducted with the Assistant Director of Nursing (ADON) on 01/24/23 at 1:52 PM who explained that the first resident was admitted to 400 hall on 01/05/23 and he was not aware that the residents on that hall had not received a shower until today. The ADON continued to explain that the Scheduler was responsible for formulating the 400-hall shower schedule but failed to do that. He stated it was unacceptable for the residents to go without their showers.

An interview was conducted with the Scheduler on 01/25/23 at 9:50 AM. The Scheduler explained that she was not responsible for formulating the shower schedule for new admissions. She stated the only thing she was responsible for as far as showers was to collect the bathing sheets and turn them into the former Director of Nursing.

During an interview with the Director of Nursing (DON) on 01/26/23 at 1:50 PM she explained that she had only been in the DON position since early January and stated she was not aware that

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the Scheduler who was responsible for developing the shower schedule for 400 hall had not done that and was not aware that the residents on the hall had not had a shower since their admission. The DON stated it was not acceptable.

3. Resident #184 was admitted to the facility on 01/10/23 with diagnoses that include diabetes mellitus.

The admission Minimum Data Set (MDS) assessment dated 01/17/23 revealed Resident #184 was cognitively intact and required extensive assistance of one person for bathing. The MDS also indicated the Resident had no behaviors of rejection of care.

Resident #184's care plan dated 01/22/23 revealed he had a self-care deficit performance related to weakness. The goal that he would improve in his current level of functioning would be attained by providing a full bath or sponge bath when a shower cannot be tolerated.

On 01/23/23 at 2:26 PM during an interview and observation with Resident #184 the Resident expressed he had not had a shower, or his hair washed since he was admitted to the facility. His hair appeared matted, dry, and disheveled. The Resident stated when he asked the staff about getting a shower, he was told the hall had recently been opened and the schedule had not been made up yet. The Resident had no odors and stated he was being wiped off, but it was not like getting a complete shower.

On 01/24/23 2:59 PM an observation was made of the shower schedule book for 100/200/300 and

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400 halls. There was no shower schedule made up for 400 hall.

A review of Resident #184's bathing record for January 2023 reviewed documentation of being given a shower on 01/17/23 and 01/20/23 by Nurse Aide (NA) #2.

An interview was conducted with Nurse Aide #2 on 01/26/23 at 10:56 AM. The NA explained that she did not work on 01/17/23 and she must have made a mistake in her documentation on 01/20/23 because she has never given any resident a shower on 400-hall.

On 01/24/23 at 1:11 PM during an interview with Nurse Aide (NA) #3 she reported she worked 400 hall frequently and confirmed that no resident on 400 hall had been scheduled for a shower because the hall had recently opened to residents and the shower schedule had not been developed yet. The NA continued to explain that the Scheduler was responsible for developing the 400-hall shower schedule and it had not been done yet.

During an interview with Nurse Aide #4 on 01/24/23 at 3:50 PM the NA explained that he frequently worked 400 hall and had never showered a resident on that hall until that day (01/24/23). The NA continued to explain that the hall had recently opened to residents and the shower schedule had not been made up yet.

On 01/24/23 at 3:55 PM an interview was conducted with Nurse Aide #6 who explained that the Scheduler was responsible for making up the shower schedule for the halls and since 400-hall had just recently opened, the shower schedule

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had not been developed yet. The NA stated she frequently worked 400 hall and she had not showered any resident on that hall.

On 01/25/23 at 1:50 PM an interview was conducted with Nurse Aide #5 who explained that she frequently worked 400 hall and had only showered one resident that was transferred to that hall from another hall. She stated she had never showered a new resident from the hall because the shower schedule had not been made up yet.

An interview was conducted with the Assistant Director of Nursing (ADON) on 01/24/23 at 1:52 PM who explained that the first resident was admitted to 400 hall on 01/05/23 and he was not aware that the residents on that hall had not received a shower until today. The ADON continued to explain that the Scheduler was responsible for formulating the 400-hall shower schedule but failed to do that. He stated it was unacceptable for the residents to go without their showers.

An interview was conducted with the Scheduler on 01/25/23 at 9:50 AM. The Scheduler explained that she was not responsible for formulating the shower schedule for new admissions. She stated the only thing she was responsible for as far as showers was to collect the bathing sheets and turn them into the former Director of Nursing.

During an interview with the Director of Nursing (DON) on 01/26/23 at 1:50 PM she explained that she had only been in the DON position since early January and stated she was not aware that the Scheduler who was responsible for developing the shower schedule for 400-hall had

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not done that and was not aware that the residents on the hall had not had a shower since their admission. The
DON stated it was not acceptable.

4. Resident #186 was admitted to the facility on 01/16/23 with diagnoses that included respiratory failure.

The admission Minimum Data Set assessment had not been completed.

The Nursing Admission assessment dated 01/16/23 revealed Resident #186 was alert and oriented and was totally dependent on staff for all activities of daily living.

Resident #186's care plan dated 01/23/23 revealed he had a self-care deficit performance related to respiratory failure. The goal that he would improve in his current level of function participation would be attained by being totally dependent of one staff for bathing.

During an observation and interview with Resident #186 on 01/23/23 at 2:10 PM the Resident was lying in bed and explained that he had not had a shower since his admission on 01/16/23. The Resident continued to explain that he was used to taking 2-3 showers a week at home but had yet to receive a shower and no one had explained to him why he had not been offered a shower. The Resident had no odors and stated he was given bed baths but would also like to receive a shower.

On 01/24/23 at 2:59 PM an observation was made of the shower schedule book for 100/200/300 and 400 halls. There was no shower

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schedule made up for 400-hall.

A review of Resident #186's bathing record for January 2023 reviewed documentation of being given a shower on 01/17/23 and 01/20/23 by Nurse Aide (NA) #2.

An interview was conducted with Nurse Aide #2 on 01/26/23 at 10:56 AM. The NA explained that she did not work on 01/17/23 and she must have made a mistake in her documentation on 01/20/23 because she has never given any resident a shower on 400-hall.

On 01/24/23 at 1:11 PM during an interview with Nurse Aide (NA) #3 she reported she worked 400 hall frequently and confirmed that no resident on 400 hall had been scheduled for a shower because the hall had recently opened to residents and the shower schedule had not been developed yet. The NA continued to explain that the Scheduler was responsible for developing the 400-hall shower schedule and it had not been done yet.

During an interview with Nurse Aide #4 on 01/24/23 at 3:50 PM the NA explained that he frequently worked 400 hall and had never showered a resident on that hall until that day (01/24/23). The NA continued to explain that the hall had recently opened to residents and the shower schedule had not been made up yet.

On 01/24/23 at 3:55 PM an interview was conducted with Nurse Aide #6 who explained that the Scheduler was responsible for making up the shower schedule for the halls and since 400 hall had just recently opened, the shower schedule had not been developed yet. The NA stated she

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frequently worked 400 hall and she had not showered any resident on that hall.

On 01/25/23 at 1:50 PM an interview was conducted with Nurse Aide #5 who explained that she frequently worked 400 hall and had only showered one resident that was transferred to that hall from another hall. She stated she had never showered a new resident from the hall because the shower schedule had not been made up yet.

An interview was conducted with the Assistant Director of Nursing (ADON) on 01/24/23 at 1:52 PM who explained that the first resident was admitted to 400 hall on 01/05/23 and he was not aware that the residents on that hall had not received a shower until today. The ADON continued to explain that the Scheduler was responsible for formulating the 400-hall shower schedule but failed to do that. He stated it was unacceptable for the residents to go without their showers.

An interview was conducted with the Scheduler on 01/25/23 at 9:50 AM. The Scheduler explained that she was not responsible for formulating the shower schedule for new admissions. She stated the only thing she was responsible for as far as showers was to collect the bathing sheets and turn them into the former Director of Nursing.

During an interview with the Director of Nursing (DON) on 01/26/23 at 1:50 PM she explained that she had only been in the DON position since early January and stated she was not aware that the Scheduler who was responsible for developing the shower schedule for 400-hall had not done that and was not aware that the

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residents on the hall had not had a shower since their admission. The DON stated it was not acceptable.

5. Resident #75 was admitted to the facility on 01/06/23 with diagnoses that included cerebral vascular accident.

The admission Minimum Data Set (MDS) assessment dated 01/13/23 revealed Resident #75's cognition was moderately impaired and required extensive assistance of one for personal hygiene.

The MDS also indicated the Resident had no behaviors of rejection of care.
Review of Resident #75's Kardex (a guide to his daily care) dated 01/23/23 revealed the Resident required extensive assistance for personal hygiene.

During an interview and observation of Resident #75 on 01/23/23 at 12:17 PM the Resident was lying in bed with facial hair approximately quarter inch long. The Resident explained that he did not like facial hair and that he shaved every day at home. The Resident stated he was given a shower yesterday (01/22/23) but was not shaved. He stated the "girl" told him she would shave him today (01/23/23).

An interview was conducted with Nurse #2 on 01/26/23 at 9:40 AM who explained that on 01/23/23 Nurse Aide #7 informed her that she could not find a razor to shave Resident #75 despite looking through the supply rooms. The Nurse stated she informed the Supply Clerk that they could not find razors and his response was that they just did not know where to look for the

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razors.

On 01/24/23 at 4:15 PM Resident #75 was lying in bed sleeping. Resident still had facial hair approximately quarter inch long.

On 01/26/23 at 9:02 AM during a conversation with Nurse #1 and Nurse Aide (NA) #7 the Nurse explained that she was the Nurse responsible for Resident #75 on 01/23/23 and 01/24/23 and Nurse Aide #7 (who assisted with Resident #75's care) informed her that she could not find a razor to shave the Resident on those days. The Nurse stated she purchased razors for Resident #75 on 01/25/23 and he would be shaved today (01/26/23).

During the interview with NA #7 on 01/26/23 at 9:02 AM she confirmed that she worked with Resident #75 on 01/23/23 and 01/24/23 and explained that he requested to be shaved but she could not find a razor to shave the Resident despite looking through two medical supply rooms. NA #7 stated she reported it to Nurse #2.

An interview and observation were conducted with Resident #75 on 01/25/23 at 12:20 PM. The Resident was lying in bed and had not been shaved. The Resident explained that the "girl" told him that she would shave him today (01/25/23).

An interview was conducted with Nurse Aide (NA) #5 on 01/25/23 at 1:50 PM. The NA explained that Resident #75 was alert and oriented and would let you know what he needed. She continued to explain that she showered the Resident on Saturday but did not shave him because he did not ask to be shaved. The NA stated they shaved on shower days and when the

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residents' ask to be shaved. The NA stated she was working with the Resident that day (01/25/23) and would make sure he got a shave.

During an observation and interview with Resident #75 on 01/26/23 at 9:00 AM the Resident was lying in bed and still had facial hair. The Resident stated the "girl" said she would shave me yesterday but never did.

An interview conducted with Nurse Aide (NA) #5 on 01/26/23 at 9:15 AM revealed she did not shave Resident #75 on 01/25/23 and could not give an explanation as to why. The NA reported there were razors available in the supply room and showed the surveyor where the razors were located. A box of approximately 12 razors were in the supply room.

An interview with the Supply Clerk (SC) was conducted on 01/26/23 at 9:45 AM. The SC explained that there were plenty of razors available to the staff, they just had to look for them.

An interview conducted with the Assistant Director of Nursing (ADON) on 01/24/23 at 1:52 PM. The ADON explained that the residents should be shaved every day if that was what they desired (they did not have to wait until their shower days).

During an interview with the Director of Nursing (DON) on 01/26/23 at 1:50 PM the DON explained that the residents should be shaved on their shower days and everyday if that was their request. She stated she was familiar with Resident #75, and he was able to voice his needs.

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An observation of Resident #75 on 01/26/23 at 4:00 PM revealed he was sleeping in bed and had no facial hair.

6. Resident #53 was admitted on 09/08/22 with diagnoses that included diabetes mellitus and dementia.

The quarterly Minimum Data Set (MDS) assessment dated 12/06/22 revealed Resident #53 was cognitively intact and required extensive assistance of one person for personal hygiene. The MDS also indicated the Resident did not have behaviors of rejection of care.

On 01/24/23 at 9:18 AM an interview and observation were made of Resident #53 while she was eating her breakfast. The Resident was feeding herself and was noted to be looking at her fingernails which were long, and approximately ¼ to ½ inches past the end of her fingertips. Her fingernails had dark brown debris under several nails and some nails had jagged edges. Resident #53 explained that she did not like to wear her nails long and she needed assistance in cutting them because she could not do it by herself.

On 01/24/23 at 1:15 PM an observation was made of Resident #53's fingernails and they remained unchanged.

An interview was made with Nurse Aide (NA) #3 on 01/24/23 at 1:19 PM who explained that she worked with Resident #53 the last 2 days and found her to be alert and oriented. The NA continued to explain that the residents' fingernails were cleaned and trimmed during their showers and if they see they need it in between. The NA

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F 677	Continued From page 38 accompanied the surveyor to Resident #53's room and observed the Resident's fingernails to be long, jagged and with brown debris underneath several of her fingernails and stated they needed to be trimmed and cleaned. The NA explained that she just finished assisting the nurse with Resident #53 and did not notice the condition of her fingernails and she needed to pay closer attention to the residents' fingernails. During an interview with the Assistant Director of Nursing on 01/24/23 at 1:52 PM he explained that the residents' fingernails should be cleaned and trimmed on their shower days and as needed. An interview conducted with the Director of Nursing (DON) on 01/26/23 at 1:50 PM revealed the residents' fingernails should be trimmed and cleaned on their shower days and as needed. The DON stated the nurse aides should always be observant of the residents' fingernails as they make care rounds and provide nail care as needed.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		3/10/23

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F 688	Continued From page 39 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interview's the facility failed to offer or apply a hand splint and palm guard as ordered for 1 of 3 residents reviewed for range of motion (Resident #48). The findings included: Resident #48 was readmitted to the facility on 05/31/21 with diagnoses that included cerebral infarction, osteoarthritis, and others. Review of a care plan revised on 06/09/22 read, Resident #48 was resistive to care with a history of refusals of wearing splints. The interventions included: educate resident on possible outcomes of noncompliance and praise the resident when behavior is appropriate. Review of a document titled Rehab to Restorative Transition Record dated 09/21/22 indicated that Occupational Therapy (OT) was referring Resident #48 to the Nurse Aides (NAs) for the following program: Resident #48 will tolerate wearing bilateral splints up to six hours a day (he prefers to wear the splints at night) and staff to place palm guard on left hand following wearing splints and may wear as long as preferred. The plan included numerous photographs of Resident #48 wearing splints and palm guard and provided education to the NAs that cared for Resident #48.	F 688	Resident #48 splint was applied by the licensed nurse on 2/1/2023. All current residents that wear splints have the potential to affected. An audit was completed on 2/1/2023 by the Director of Nursing (DON) to ensure residents' splints are being applied as ordered. The nursing staff to include licensed nurses, certified nursing assistants, certified medication aide and agency nursing staff will be educated by 3/9/2023 by the DON/ designee related to ensuring residents' splints are being applied as ordered. The nursing staff to include licensed nurses, certified nursing assistances, certified medication aides and agency nursing staff will not be allowed to work until the education is completed. New hires also will be required to complete the education. The Director of Nursing/ designee will complete audits of residents with splints weekly for 4 weeks and monthly for 2 months to ensure residents with splints continue to their splint in place as ordered.	

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F 688	Continued From page 40 Review of a physician order dated 09/27/22 read; Wrist, Hand, Finger, Orthosis (WHFO splint) up to six hours a day with patient preferring splints to be donned in the evening after his evening medication pass. Don in the evening and Doff in the morning. Staff to place left palm guard on left hand following doffing of bilateral WHFO. Review of a quarterly Minimum Data Set (MDS) dated 12/23/22 revealed that Resident #48 was cognitively intact for daily decision making and required extensive to total assistant with activities of daily living. The MDS further indicated that Resident #48 had impairments to bilateral upper extremities that interfered with activities of daily living. No refusal of care was noted during the assessment reference period. Review of a physician order dated 01/03/23 read; Wrist, Hand, Finger, Orthosis (WHFO splint) up to six hours a day with patient preferring splints to be donned in the evening after his evening medication pass. Don in the evening and Doff in the morning. Staff to place left palm guard on left hand following doffing of bilateral WHFO. Review of the Medication Administration Record (MAR) dated January 2023 revealed no record of the splint or palm guard application. Review of the Treatment Administration Record (TAR) dated January 2023 revealed no record of the splint or palm guard application. An observation and interview were conducted with Resident #48 on 01/23/23 at 3:03 PM. Resident #48 was resting in bed. His bilateral fingers were curled towards the palm of his hand.	F 688	The Director of Nursing will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review and will follow up as needed to ensure the facility's continued compliance.	

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Resident #48 stated that he could not open his hand and stated I "cannot get anyone to help me open them." There were no splints or palm guard noted in place and none were observed in Resident #48's room.

An observation and interview were conducted with Resident #48 on 01/24/23 at 9:52 AM. Resident #48 was resting in bed and had no splints or palm guard in place. Resident #48 stated that none of the staff offered to or applied the splints last night. When Resident #48 was asked if he refused the splints or palm guard he replied, "lord no I wish they would put them on, I can't get anyone to straighten out my fingers." Resident #48 further explained that several months ago therapy fitted him for splints, and they put them on for about two weeks then stated they could not find them anymore and he has not seen them since then.

An observation and interview were conducted with Resident #48 on 01/24/23 at 3:30 PM. Resident #48's bilateral hands remained curled toward his palm and there were no splints or palm guard in place or noted in his room. Resident #48 again stated that no one had offered to put them on and was adamant that he would not refuse the application of them.

An observation of Resident #48 was made on 01/25/23 at 9:46 AM. Resident #48 was resting in bed; his bilateral hands and fingers were curled towards his palm. There was no splint or palm guard in place, and none were visible in his room.

The Therapy Director was interviewed on 01/25/23 at 10:03 AM and stated Resident #48 was seen by Occupational Therapy in September

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2022 and a splitting schedule was developed and the staff educated on the application process. The Therapy Director explained that the facility did not have a formal restorative program so the application fell to the NAs to do and once the resident was discharged from therapy, they really did not have any further follow up.

NA #10 was interviewed on 01/25/23 at 11:47 AM and confirmed that she routinely cared for Resident #48 on the day shift. She stated that was unaware of any splints or palm guard that needed to be applied to Resident #48. NA #10 further stated that Resident #48 did not have any splints in place when she arrived for duty.

Nurse #3 was interviewed on 01/25/23 at 11:48 AM and stated that therapy was applying the palm guard when the splints came off but Resident #48 would refuse them when they were applied during the day so they switched them to the evening shift. Nurse #3 stated that they currently did not have an order for the splints or palm guard and Resident #48 was not working with therapy, so he was currently not receiving any splints or palm guard.

NA #9 was interviewed on 01/25/23 at 11:54 AM and confirmed she routinely worked day shift on the unit where Resident #48 resided. She stated she was unaware of any splints or palm guard that needed to be applied to Resident #48 and added that when she arrived for duty Resident #48 did not have any splints in place that needed to be removed.

NA #11 was interviewed on 01/25/23 at 2:21 PM and confirmed that he routinely cared for Resident #48 on the day and evening shift. He

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was unaware of any splints or palm guard that Resident #48 was supposed to wear. He confirmed that he had not been offering to apply any splint or palm guard because he had no idea that Resident #48 had any that needed to be applied.

Nurse #4 was interviewed via phone on 01/25/23 at 4:28 PM who confirmed that he routinely worked the night shift with Resident #48. He stated that he did not recall any splint schedule for Resident #48 and that he would look on the MAR or TAR to see which residents required splints and then either he or the NAs would apply them as ordered. Nurse #4 again confirmed that he was not aware of any splints or palm guard that Resident #48 required.

NA #12 was interviewed via phone on 01/25/23 at 3:50 PM and confirmed that she routinely cared for Resident #48 on the night shift. NA #12 stated "I know nothing about his splints, and no one has instructed me to apply any splints at nighttime."

NA #13 was interviewed via phone on 01/25/23 at 3:55 PM and confirmed that she routinely cared for Resident #48 on the night shift. NA #13 stated she was unaware of any splints that he wore. She stated that a while ago he had a splint, but she had no knowledge if he was still supposed to wear it or not. NA #13 stated that she did not apply or offer to apply any splints to Resident #48 when she cared for him on the night shift.

The Assistant Director of Nursing (ADON) was interviewed on 01/26/23 at 11:49 AM who stated that Resident #48 should be wearing his splints as ordered. He stated that he had heard rumors that Resident #48 refused them in the past but

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F 688	Continued From page 44 stated that the staff should be offering them and applying them as ordered and then documenting on the TAR his acceptance or refusal of the splints and palm guard. The Director of Nursing (DON) was interviewed on 01/26/23 at 1:14 PM who stated that Resident #48 had an order for splints and palm guard and they should be applied as ordered and then documented on the MAR or TAR.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review and Registered Dietician (RD), Medical Director (MD)	F 692	Resident #22 will be provided the required nutritional supplement.	3/10/23

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F 692	Continued From page 45 and staff interviews the facility failed to provide a nutritional supplement as recommended by the Registered Dietician for a resident with significant weight loss for 1 of 2 residents reviewed for nutrition (Resident 22). The findings included: Resident #22 was admitted to the facility on 02/27/18 with diagnoses that included Alzheimer's Disease, known weight loss, and dementia. Review of a care plan revised on 10/22/22 read in part, Resident #22 was at risk for significant weight loss due to a mechanically altered diet. The goal for Resident #22 was that she would maintain adequate nutritional status with no significant weight changes through the next review. The interventions included: offer fluids throughout the day, supplements as ordered, monitor weights, provide, and serve diet as ordered, provide assistance as needed during meals. Review of a RD note date dated 12/19/22 read in part, Resident #22's weights continue to be concerning with overall loss of 33 pounds. Pureed diet ordered with large portions. Intake range from 0-100% of meals but averages 51-75% of meals. Recommendations: begin whole milk at meals three times a day. Review of the quarterly Minimum Data Set (MDS) dated 12/21/22 revealed that Resident #22 had long and short-term memory problems and was moderately impaired for daily decision making. The MDS revealed that Resident #22 required extensive assistance with eating, weighted 127 pounds (lbs.), and received a mechanically	F 692	All current residents have the potential to affected. An audit will be completed by 3/9/2023 by the Director of Nursing (DON) to ensure residents are provided nutritional supplements as ordered. The nursing staff to include licensed nurses, certified nursing assistants, certified medication aide and agency nursing staff will be education by 3/9/2023 related to ensuring residents are provided nutritional supplements as ordered by the DON/ designee. The dietary staff to include agency staff will be educated by 3/9/2023 related to ensuring nutritional supplements as ordered are on resident meal trays. The Dietary staff to include agency dietary staff will not be allowed to work until the education is completed. New hires also will be required to complete the education. The nursing staff to include licensed nurses, certified nursing assistances, certified medication aides and agency nursing staff will not be allowed to work until the education is completed. New hires also will be required to complete the education. The Director of Nursing/ designee will complete audits of at least 10 residents that require nutritional supplements weekly for 4 weeks and monthly for 2 months to ensure residents with nutritional supplements continue to receive the	

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F 692	Continued From page 46 altered diet. The MDS further revealed the resident has a weight loss of 5% or more in the last month/or a weight loss of 10% in the last 6 months. Review of the RD progress note dated 01/10/23 read in part, Resident #22 continues to have concerning weight trends with 40 pounds (25% weight loss x 180 days and 14 pounds (10.4%) x 30 days. Eating 50-100% of meals on a pureed diet. Whole milk added TID (three times a day) on 12/20/22. Refused supplement in the past. Also receives frozen nutritional treat BID (twice a day) and large portions. The recommendations included: discontinue supplement due to refusals, begin large potions due to good intake, and begin frozen nutritional treat BID with meals. An observation of Resident #22's breakfast tray was made on 01/24/23 at 09:05 AM. The meal ticket on Resident #22's tray indicated she was to receive whole milk with her meal. There was no whole milk on the meal tray. Large portions were noted on the meal plate. An observation of Resident #22's lunch tray was made on 01/24/23 at 12:15 PM. The meal ticket on Resident # 22's tray indicated she was to receive whole milk with her meal. There was no whole milk noted on the meal tray. Large portions were noted on the meal plate. In an interview with Nurse Aide (NA) # 6 on 01/24/23 at 12:51 PM she stated she feeds resident #22 at times and she stated she had never noticed any milk on her meal trays An observation of Resident #22's breakfast tray was made on 01/25/23 at 09:10 AM. The meal	F 692	nutritional supplement as ordered. The Director of Nursing will submit the findings to the Quality Assurance Program Interdisciplinary (QAPI) committee monthly meeting for 3 months for review and follow up with recommendations to ensure the facility□s continued compliance.	

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ticket on Resident # 22's tray indicated she was to receive whole milk with her meal. There was no whole milk noted on the meal tray. Large portions were noted on the meal plate.

In interviews with NA #5 and NA #14 on 01/25/23 at 09:13 AM, they stated Resident #22 received large amounts of food with each meal and ate a good amount of her meals without difficulty. They further stated they always worked on this unit and fed Resident #22 frequently and did not recall ever seeing milk on her meal trays.

In an interview with the RD on 01/25/23 at 09:39 AM. The RD has been following Resident # 22 since June 2022 for weight loss. She stated they had added whole milk with meals to increase her caloric intake and Resident #22 also received a frozen nutrition cup and large portions. She further stated that it was difficult for residents on pureed meals to get the same nutrition as with a regular diet and that was why they often see weight loss when residents go on a pureed diet. The RD stated as residents start to decline due to their disease process, and although they may be eating adequately, they start losing weight and there is only so much they could do to maintain their weight. Additionally, she stated over the last seven months they tried many nutritional interventions including supplements, some Resident #22 refused and some she accepted, to continue to see what might have been effective with increasing Resident's #22's caloric intake to prevent further weight loss.

An interview was conducted on 01/25/23 at 10:18 AM with interim Dietary Manager (DM). The DM stated she has been working at the facility for 4 days as the regular DM was out on emergency

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leave. She stated she could see in the computer that whole milk with each meal was on Resident # 22's Kardex (a system that gives a quick and brief overview of each resident) and Resident #22 should be receiving whole milk with each meal. The DM could not explain why the whole milk was not on Resident #22's meal trays as ordered.

An observation of Resident #22's lunch tray was made on 01/25/23 at 12:30 PM. The meal ticket on Resident #22's tray indicated she was to receive whole milk with her meal. There was no whole milk noted on the meal tray. Large portions were noted on the meal plate.

In an interview with the (MD) on 01/24/23 at 03:05 PM, the MD stated Resident #22 has had a significant decline in mental status along with her dementia in last year. The MD stated there was really nothing else they could do besides continuing the interventions already put in place; whole milk three times a day with meals, nutritional cup twice a day and large meal portions to change Resident #22's weight loss and outcome as she was "coming towards the end-of-life phase."

An interview was conducted with the Director of Nursing on 01/26/23 01:48 PM, and she stated it was her expectation that all residents receive the diet and nutrient supplements as recommended by the RD.

An interview was conducted with the Administrator on 01/26/23 03:32 PM, and he stated it was his expectation that all residents receive the food and nutrient supplements as recommended by the RD.

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F 695	Continued From page 49	F 695		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview's the facility failed to administer oxygen at the prescribed rate and failed to clean the oxygen concentrator filter for 1 of 3 residents reviewed for respiratory care (Resident #11). The findings included: Resident #11 was admitted to the facility on 09/06/22 with diagnoses that included acute respiratory failure and chronic obstructive pulmonary disease. Review of a physician order dated 09/07/22 read, oxygen at two liters via nasal cannula for respiratory failure. Rinse or replace oxygen concentrator filters weekly and as needed. Review of the Medication Administration Record (MAR) dated January 2022 revealed the following: Rinse or replace oxygen concentrator filter weekly on Wednesday's and as needed on night shift. The MAR indicated this was last done on 01/18/23 by Nurse #5.	F 695	Resident #1 oxygen concentrator was adjusted to the prescribed rate and the filter cleaned on 2/1/2023 by the licensed nurse. All current residents have the potential to be affected. An audit was completed on 2/1/2023 by the Director of Nursing (DON) to ensure residents' oxygen concentrators filters are cleaned and oxygen is being administrated at the prescribed rate. The licensed nurses will be educated by 3/9/2023 by the DON/ designee related to ensuring residents' oxygen concentrators filters are clean and the oxygen is being administrated at the prescribed rate. The licensed nurses to include agency licensed nurses will not be allowed to work until the education is completed. New hires also will be required to complete the education. The Director of Nursing/ designee will	3/10/23

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F 695	Continued From page 50 Review of the quarterly Minimum Data Set (MDS) dated 01/06/23 revealed that Resident #11 was moderately cognitively impaired for daily decision making and required extensive assistance with activities of daily living. The MDS further revealed that Resident #11 used oxygen and had no shortness of breath during the assessment reference period. An observation of Resident #11 was made on 01/23/23 at 12:01 PM. Resident #11 was resting in bed in no acute distress. She was observed to have an oxygen cannula in her nose that was connected to a concentrator sitting next to her bed and was set to deliver one liter of oxygen. The filter on the back of the concentrator was completely white with dust particles. An observation of Resident #11 was made on 01/24/23 at 9:13 AM. Resident #11 was resting in bed in no acute distress. She was observed to have an oxygen cannula in her nose that was connected to a concentrator sitting next to her bed and was set to deliver one liter of oxygen. The filter on the back of the concentrator was completely white with dust particles. An observation of Resident #11 was made on 01/24/23 at 4:34 PM. Resident #11 was resting in bed in no acute distress. She was observed to have an oxygen cannula in her nose that was connected to a concentrator sitting next to her bed and was set to deliver one liter of oxygen. The filter on the back of the concentrator was completely white with dust particles. An observation of Resident #11 was made on 01/25/23 at 9:52 AM. Resident #11 was resting in bed in no acute distress. She was observed to	F 695	complete audits of at least 10 residents that have oxygen concentrators weekly for 4 weeks and monthly for 2 months to ensure residents' oxygen concentrators filters continue to be cleaned and the oxygen is being administered at the prescribed rate. The Director of Nursing will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for review to ensure the facility's continued compliance.	

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F 695	Continued From page 51	F 695		

have an oxygen cannula in her nose that was connected to a concentrator sitting next to her bed and was set to deliver one liter of oxygen. The filter on the back of the concentrator was completely white with dust particles.

An observation of Resident #11 was made on 01/25/23 at 11:57 AM. Resident #11 was resting in bed in no acute distress. She was observed to have an oxygen cannula in her nose that was connected to a concentrator sitting next to her bed and was set to deliver one liter of oxygen. The filter on the back of the concentrator was completely white with dust particles.

Nurse #6 was interviewed on 01/25/23 at 11:59 AM who confirmed that she was caring for Resident #11. Nurse #6 stated that Resident #11 wore oxygen at two liters and would not be able to change the rate on her own. She further stated that the nurses should be checking the oxygen flow rate throughout their shift but stated she had not checked Resident #11's thus far on her shift. Nurse #6 entered Resident #11's room and confirmed that her concentrator was set to deliver one liter of oxygen and should be on two liters. Nurse #6 returned the oxygen flow rate to two liters as ordered. She added that the oxygen tubing and filters were cleaned weekly on night shift. Nurse #6 also confirmed that oxygen concentrator filter was dusty and needed to be cleaned or replaced.

Nurse #5 was interviewed via phone on 01/25/23 at 2:01 PM. Nurse #5 confirmed that she routinely worked the night shift at the facility. She stated that weekly they were promoted on the MAR to change oxygen tubing and when it promoted her to do so she would go the resident rooms and

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F 695	Continued From page 52 change out the tubing as instructed. Nurse #5 stated she had never looked at or cleaned an oxygen concentrator filter and was not aware that they were responsible for cleaning or changing them. The Assistant Director of Nursing (ADON) was interviewed on 01/26/23 at 11:57 AM and stated that there had been some miscommunication on who was responsible for cleaning or replacing oxygen concentrator filters. At one point maintenance department took care of them, then it was moved to the central supply clerk, and then back to the nursing department. The ADON stated that oxygen tubing was changed at least weekly and as needed and the filters were cleaned or replaced monthly. The ADON stated that the nurses should be checking the oxygen flow rate at least once per shift to ensure the correct dose was being administered and they should be cleaning or replacing filters as ordered. The Director of Nursing (DON) was interviewed on 01/26/23 at 1:19 PM and stated that the oxygen cannulas were changed weekly and as needed and during the same time the oxygen concentrator filters should be cleaned or replaced. She stated she expected the nurses on the units to check the oxygen flow rate at least once on their shift and document on the MAR to ensure that the correct dose of oxygen was being administered.	F 695		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily	F 732		3/10/23

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F 732	Continued From page 53 basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to post current daily nurse staffing information for 3 of 4 days from 1/23/23 through 1/26/23.	F 732	The identified missing daily nurse staffing information data sheets were completed by the Director of Nursing on 2/1/2023.	

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F 732	Continued From page 54 The finding included: During the entrance into the facility on 1/23/23 at 9:18 AM, the daily posted nurse staffing information was observed in the front lobby at the receptionist's desk and was dated 1/21/23. An observation on 1/23/23 at 4:00 PM of the daily posted nurse staffing information visible at the receptionist's desk in the front lobby had not been updated with the correctly dated form. An observation on 1/24/23 at 1:30 PM of the daily posted nurse staffing information visible at the receptionist's desk in the front lobby was dated 1/23/23. During an interview with the Administrator on 1/24/23 at 1:36 PM he explained that the scheduling coordinator was assigned to ensure the posting was placed in the front lobby first thing in the morning and was left for staff to post over the weekend. Attempts were made to contact the scheduling coordinator without success. During an observation on 1/25/23 at 9:36 AM of the front lobby receptionist's desk, there was no daily posted nurse staffing information visible, and the plastic frame from previous posting observations was laid flat against the desk. An interview with the Assistant Director of Nursing on 1/25/23 at 11:00 AM revealed the scheduler had quit the day before and he was going to attempt to take over the duty but was not familiar with how to complete the posting.	F 732	An audit will be completed by 3/9/2023 by the Director of Nursing/ designee of the daily nursing staffing information data sheets to ensure that the facility is maintaining 18 months of postings. The scheduler will be education by 3/9/2023 by the DON/ designee related to ensuring the daily nursing staffing information data sheets are being completed and updated daily as required. The schedule will not be allowed to work until the education is completed. New hire schedulers also will be required to complete the education. The Director of Nursing/ designee will complete audits of the daily nursing staffing information data sheets weekly for 4 weeks and monthly for 2 months to ensure nursing staffing information data sheets are being completed and updated daily as required. The Director of Nursing will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review and follow up with recommendations to ensure the facility's continued compliance.	

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F 732	Continued From page 55 A follow-up interview with the Administrator on 1/26/23 at 3:00 PM revealed he expected the staff posting to be accurate and visible to visitors and staff at the receptionist's desk each morning.	F 732		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Psychiatric Nurse Practitioner, Nurse Practitioner, and Medical Director interviews the facility failed to implement Psychiatric Nurse Practitioner recommendations for medication changes and labs (blood draws) for 3 of 5 residents reviewed for unnecessary	F 757	Resident #42, Resident #43, and Resident #22 Psychiatric recommendations were reviewed by the Nurse Practitioner on 2/1/2023. All current residents who receive	3/10/23

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F 757	Continued From page 56 medications (Resident #42, Resident #43, and Resident #22). The finding included: 1. Resident #42 was readmitted to the facility on 07/31/21 with diagnoses that included dementia, major depressive disorder, anxiety, and insomnia. Review of a Depakote (medication used to stabilize mood) level dated 09/23/22 revealed Resident #42's level to be 75 micrograms per milliliter (mcg/ml) which was in the therapeutic reference range. Review of a physician order dated 09/24/22 read, Depakote Sprinkles 125 milligrams (mg) by mouth give four capsule two times a day. Review of a quarterly Minimum Data Set (MDS) dated 11/10/22 revealed that Resident #42 was moderately impaired for daily decision making and required extensive to total assistance with activities of daily living. The MDS further revealed that Resident #42 had received seven days of an antipsychotic and antidepressant medication during the assessment reference period. Review of a Psychiatric Nurse Practitioner (NP) progress note dated 12/27/22 read in part, Chief complaint: Medication Management. The progress note listed Resident #42's current medications, current diagnoses, and review of system. Orders and plan: check Depakote level, Sodium (NA) level, Liver Function panel (LFP), and Platelet count. The report was electronically signed by the PNP. Review of Resident #42's medical record	F 757	psychiatric services have the potential to affected. An audit will be completed by 3/9/2023 by the Director of Nursing(DON)/designee of the current residents' psychiatric recommendations for the last 60 days to ensure that follow up has been completed as required. The licensed nurses will be education by 3/9/2023 by the DON/ designee related to ensuring residents' who receive psychiatric services recommendations are being followed up as required. The licensed nurses to include agency licensed nurses will not be allowed to work until the education is completed. New hires also will be required to complete the education. The Director of Nursing/ designee will complete audits of the residents who received psychiatric services monthly for 3 months to ensure residents' psychiatric recommendations are being followed up as required. The Director of Nursing will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review and follow up with recommendations to ensure the facility's continued compliance.	

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revealed no physician orders for the labs recommended by the Psychiatric NP on 12/27/22, further review of Resident #42's medical record revealed no lab results for the Depakote level or the platelet count. The NA level and LFP were obtained on 12/30/22.

The facility's Nurse Practitioner (NP) was interviewed on 01/25/23 at 2:17 PM who stated she did not review the Psychiatric NP notes because she did not have access to them. She was unsure of what the process was for getting the PNP orders carried out and implemented as she had only been at the facility since July 2022, and they had new provider Psychiatric NP as of December 2022.

An interview with the Customer Service Representative from the Psychiatric providers office was conducted via phone on 01/25/23 at 3:06 PM. She stated that the Psychiatric NP was new to the facility and had only one visit to the facility. She stated that they had their own electronic health record and once the provider visited with the resident and the provider dictated their progress note their electronic system securely emailed the facility staff usually the Director of Nursing (DON)/Assistant Director of Nursing (ADON)/ Administrator the midnight after the note was completed. Then it would be up to the facility staff to print off the notes, carry out any recommendations/orders and then upload into their own electronic health record.

A phone interview was conducted with the Psychiatric NP on 01/25/23 at 3:14 PM who stated that after she had visited with the resident and dictated her note along with her recommendations/orders were electronically sent

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to the facility staff usually the DON/ADON. She further stated that at times she would order labs to be drawn within 10 days but other times they were routine, and she would review them on her next schedule visit. The next scheduled visit was different for each resident some were seen every 2-3 weeks, and some were seen every 4-6 weeks. The Psychiatric NP stated that if the labs ordered were abnormal, she would expect the staff to contact her. Depakote levels were checked for residents that were on Depakote and we also look at other labs that ensure organ function was within safe parameter and if they were not then she would refer the resident to their primary care physician for a workup. The PNP was not sure of the process once her recommendation/orders arrived at the facility, she stated sometimes they go to the Medical Director (MD) for approval and at other facility's they did not. Either way she stated she would expect her recommendations/orders to be carried out by the facility staff and if there was an issue for them to let her know.

The MD was interviewed on 01/25/23 at 5:10 PM who stated that she visited the facility once a week and she no longer received or reviewed the psychiatric recommendations/orders because the facility's NP was in the building every day. She stated she assumed the NP reviewed them because she was no longer getting them, she could not speak to the process in the facility since she no longer reviewed them but stated she expected all orders and labs for medication monitoring to be completed within a week.

The ADON was interviewed on 01/26/23 at 11:23 AM who stated he had only been at the facility since the middle of December 2022. He stated

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that he was unaware of the process at the facility for processing the psychiatric progress notes. He stated that the facility had a new provider and she had not yet come to the facility. The ADON stated that he was included in the email that was received but the email was just a summary of the resident she saw it did not include her notes or recommendations/orders. The ADON stated "it was my impression that if a consulting provider come to the facility and made recommendations they would be given to the Medical Director for approval or not." He added that he would reach out to the Psychiatric NP and see if she had access to the electronic medical record and if not, he could give that to her so she could enter her own recommendations/orders and then the MD could approve them that way.

The DON was interviewed on 01/26/23 at 1:09 PM who stated she had only been at the facility for three weeks. She stated she had not received any recommendations/orders from the Psychiatric NP. She stated that typically those recommendations would come to the DON or NP for approval but again stated that she had not received any from the Psychiatric NP. The DON stated that she expected the recommendations/orders from the Psychiatric NP to be approved by the NP or MD and then entered and carried out by the facility staff within the week of receiving the recommendations.

2. Resident #43 was admitted to the facility on 01/17/20 with diagnoses that included dementia, major depressive disorder, anxiety, and insomnia.

Review of a physician order dated 02/09/22 read, Depakote Sprinkles (medication used to stabilize mood) 125 milligrams (mg) by mouth give four

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capsule two times a day.

Review of a comprehensive annual Minimum Data Set (MDS) dated 11/04/22 revealed that Resident #43 was severely cognitively impaired for daily decision making and required extensive to total assistance with activities of daily living. The MDS further revealed that Resident #43 received 7 days of an antipsychotic, antidepressant, and hypnotic medication during the assessment reference period.

Review of Depakote level dated 11/23/22 revealed that Resident #43's Depakote level was 59 micrograms per milliliter (mcg/ml) which was in the therapeutic range.

Review of a Psychiatric Nurse Practitioner (NP) progress note dated 12/27/22 read in part, Chief complaint: Medication Management. The progress note listed Resident #43's current medications, current diagnoses, and review of system. Orders and plan: check Depakote level, Sodium (NA) level, Liver Function panel (LFP), and Platelet count. The report was electronically signed by the PNP.

Review of Resident #43's medical record revealed no physician orders for the labs recommended by the Psychiatric NP on 12/27/22, further review of Resident #43's medical record revealed no lab results for the Depakote level, NA level, LFP or the platelet count.

The facility's Nurse Practitioner (NP) was interviewed on 01/25/23 at 2:17 PM who stated she did not review the Psychiatric NP notes because she did not have access to them. She was unsure of what the process was for getting

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the Psychiatric NP orders carried out and implemented as she had only been at the facility since July 2022, and they had new provider PsychiatricNP as of December 2022.

An interview with the Customer Service Representative from the Psychiatric providers office was conducted via phone on 01/25/23 at 3:06 PM. She stated that the Psychiatric NP was new to the facility and had only one visit to the facility. She stated that they had their own electronic health record and once the provider visited with the resident and the provider dictated their progress note their electronic system securely emailed the facility staff usually the Director of Nursing (DON)/Assistant Director of Nursing (ADON)/ Administrator the midnight after the note was completed. Then it would be up to the facility staff to print off the notes, carry out any recommendations/orders and then upload into their own electronic health record.

A phone interview was conducted with the Psychiatric NP on 01/25/23 at 3:14 PM who stated that after she had visited with the resident and dictated her note along with her recommendations/orders were electronically sent to the facility staff usually the DON/ADON. She further stated that at times she would order labs to be drawn within 10 days but other times they were routine, and she would review them on her next scheduled visit. The next schedule visit was different for each resident some were seen every 2-3 weeks, and some were seen every 4-6 weeks. The Psychiatric NP stated that if the labs ordered were abnormal, she would expect the staff to contact her. Depakote levels were checked for residents that were on Depakote and we also look at other labs that ensure organ

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function was within safe parameter and if they were not then she would refer the resident to their primary care physician for a workup. The Psychiatric NP was not sure of the process once her recommendation/orders arrived at the facility, she stated sometimes they go to the Medical Director (MD) for approval and at other facility's they did not. Either way she stated she would expect her recommendations/orders to be carried out by the facility staff and if there was an issue for them to let her know.

The MD was interviewed on 01/25/23 at 5:10 PM who stated that she visited the facility once a week and she no longer received or reviewed the psychiatric recommendations/orders because the facility's NP was in the building every day. She stated she assumed the NP reviewed them because she was no longer getting them, she could not speak to the process in the facility since she no longer reviewed them but stated she expected all orders and labs for medication monitoring to be completed within a week.

The ADON was interviewed on 01/26/23 at 11:23 AM who stated he had only been at the facility since the middle of December 2022. He stated that he was unaware of the process at the facility for processing the psychiatric progress notes. He stated that the facility had a new provider and she had not yet come to the facility. The ADON stated that he was included in the email that was received but the email was just a summary of the residents she saw it did not include her notes or recommendations/orders. The ADON stated "it was my impression that if a consulting provider come to the facility and made recommendations they would be given to the Medical Director for approval or not." He added that he would reach

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out to the Psychiatric NP and see if she had access to the electronic medical record and if not, he could give that to her so she could enter her own recommendations/orders and then the MD could approve them that way.

The DON was interviewed on 01/26/23 at 1:09 PM who stated she had only been at the facility for three weeks. She stated she had not received any recommendations/orders from the Psychiatric NP. She stated that typically those recommendations would come to the DON or NP for approval but again stated that she had not received any from the Psychiatric NP. The DON stated that she expected the recommendations/orders from the Psychiatric NP to be approved by the NP or MD and then entered and carried out by the facility staff within the week of receiving the recommendations.

3. Resident #22 was admitted to the facility on 02/27/18 with diagnoses that included major depressive disorder with behavioral disturbances, depression, and Alzheimer's disease.

A review of Resident #22's medical record revealed the last valproic acid (Depakote) level was obtained in June 2022 at a level of 3 which was low.

A review of Resident #22's physician orders for 12/27/22 revealed orders for *Bupropion SR (antidepressant) 100 milligrams (mg) by mouth every day. *Valproic Acid (Depakote) (mood stabilizer) 250 mg/5 milliliters (ml) give 2.5 ml by mouth twice a day.

The quarterly Minimum Data Set (MDS) assessment dated 12/21/22 revealed Resident

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#22 had severe cognitive impairment and received 7 days of an antianxiety and antidepressant medication.

A review of Resident #22's Psychiatry progress notes dated 12/27/22 revealed the reason for review was for Medical Management. The notes included a summary of the visit and recommendations (the orders/plan) were to: *Change Depakote to 250 milligrams mg every morning and 500 mg every bedtime, check level in 7 days. *Decrease Bupropion SR to 100 mg by mouth every day for 14 days then discontinue. The summary was electronically signed by the Psychiatric Nurse Practitioner.

A review of Resident #22's medical record on 01/24/23 revealed there were no medication changes or lab work results related to the Psychiatric review.

A review of Resident #22's January 2023 Medication Administration Record revealed the Resident received Bupropion SR 100 mg by mouth every day and Valproic Acid 250 mg/5 ml give 2.5 ml by mouth twice a day.

On 01/25/23 at 3:06 PM an interview was conducted with the Customer Service Representative with the Psychiatric Services utilized by the facility. The Customer Service Representative explained that their company had their own electronic health record and once their providers do their visits and dictate their notes their system securely emailed the notes to the facility staff which was usually the Director of Nursing, Assistant Director of Nursing and or the Administrator, the night after the notes were done. Then it was the facility's responsibility to

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upload the notes into their system by the process they have developed.

On 01/25/23 at 3:14 PM an interview was made with the Psychiatric Nurse Practitioner (NP) who conducted Resident #22's Psychiatry visit on 12/27/22. The Psychiatric NP explained that the summary of her visit along with her orders or recommendations was sent electronically to the Director of Nursing or Assistant Director of Nursing via email and in this case the previous Director of Nursing was still employed by the facility. The Psychiatric NP continued to explain that she wrote recommendations only and expected the Medical Director to review her summary and recommendations and determine if they wished to carry them out or not.

The Medical Director was interviewed on 01/25/23 at 5:10 PM who stated that she visited the facility once a week and she no longer received or reviewed the Psychiatric recommendations/orders because the facility's NP was in the building every day. She stated she assumed the NP reviewed them because she was no longer getting them, she could not speak to the process in the facility since she no longer reviewed them but stated she expected all orders and labs for medication monitoring to be completed within a week.

On 01/25/23 at 2:17 PM during an interview with the facility's Nurse Practitioner (NP) she explained that she had only been employed since July 2022 and she did not review the psychiatric progress notes because she did not have access to them. The NP stated she did not know what the process was for getting the psychiatric orders into the residents' electric health record or the

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F 757	Continued From page 66 orders carried out. During an interview with the Assistant Director of Nursing (ADON) on 01/26/23 at 11:23 AM he had only been at the facility since the middle of December 2022 and that he was unaware of the process at the facility for process at the facility for processing the psychiatric progress notes. He stated that the facility had a new provider and she had not yet come to the facility. The ADON continued to explain that he was included in the email that was received by the email was just a summary of the resident she reviewed, and it did not include in her notes or recommendations/orders. The ADON stated "it was my impression that if a consulting provider came to the facility and made recommendations they would be given to the Medical Director for approval or not." He added that he would reach out to the Psychiatric NP and see if she had access to the electronic medical record and if not, he could give that to he so she could enter her own recommendations/orders and then the Medical Director could approve them that way. On 01/26/23 at 1:00 PM an interview was conducted with the previous Director of Nursing who explained that the Psychiatric NP's summaries and recommendations from their visits were sent electronically to the facility. She stated they were only recommendations that were reviewed by the Medical Director or Nurse Practitioner and if they approved the recommendations then they were responsible to process the recommendations as orders or change them as they deemed appropriate. The Director of Nursing (DON) was interviewed on 01/26/23 at 1:09 PM who stated she had only	F 757		

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F 757	Continued From page 67 been at the facility for three weeks and had not received any recommendations/orders from the Psychiatric NP. She stated that typically those recommendations would come to the DON or NP for approval but again stated that she had not received any from the Psychiatric NP. The DON stated that she expected the recommendations/orders from the Psychiatric NP to be approved by the NP or MD and then entered and carried out by the facility staff within the week of receiving the recommendations.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		3/10/23

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F 758	Continued From page 68 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff, Psychiatric Nurse Practitioner, Nurse Practitioner and Medical Director interviews the facility failed to implement Psychiatry recommendations for psychotropic medication changes for 1 of 5 residents reviewed for unnecessary medications (Resident #22). The findings include: Resident #22 was admitted to the facility on 02/27/18 with diagnoses that included major depressive disorder with behavioral disturbances, depression, and Alzheimer's disease.	F 758	Resident #22 Psychiatric recommendations for psychotropic medication changes were reviewed by the Director of Nursing on 3/9/2023 and orders were updated as required. All current residents who receive psychiatric services have the potential to affected. An audit will be completed by 3/9/2023 by the Director of Nursing/designee of the current residents' psychiatric recommendations for the last 60 days to ensure psychotropic medication changes have been completed as required.	

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F 758	Continued From page 69 A review of Resident #22's physician orders revealed an order dated 06/01/22 for Seroquel (antipsychotic) 25 milligrams (mg) by mouth twice a day for Major Depressive Disorder with behavioral disturbances. The quarterly Minimum Data Set (MDS) assessment dated 12/21/22 revealed Resident #22 had severe cognitive impairment and received 7 days of an antipsychotic medication. A review of Resident #22's Psychiatry progress notes dated 12/27/22 revealed the reason for review was for Medical Management. The notes included a summary of the visit and recommendations (the orders/plan) were to: *Decrease Seroquel (antipsychotic) to 25 mg by mouth every bedtime. The summary was electronically signed by the Psychiatric Nurse Practitioner. A review of Resident #22's medical record on 01/24/23 revealed there were no medication changes related to the Psychiatric review. A review of Resident #22's January 2023 Medication Administration Record revealed the Resident received Seroquel 25 mg by mouth twice a mouth. On 01/25/23 at 3:06 PM an interview was conducted with the Customer Service Representative (CSR) with the Psychiatric Services utilized by the facility. The CSR explained that their company had their own electronic health record and once their providers do their visits and dictate their notes their system securely emailed the notes to the facility staff which was usually the Director of Nursing,	F 758	The licensed nurses will be education by 3/9/2023 by the DON/ designee related to ensuring residents' who receive psychiatric services psychotropic medication changes are being completed as required. The licensed nurses to include agency licensed nurses will not be allowed to work until the education is completed. New hires also will be required to complete the education. The Director of Nursing/ designee will complete audits of the residents who received psychiatric services monthly for 3 months to ensure residents' psychotropic medication changes are being completed as required. The Director of Nursing will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review and follow up with recommendations to ensure the facility's continued compliance.	

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Assistant Director of Nursing and or the Administrator, the night after the notes were done. Then it was the facility's responsibility to upload the notes into their system by the process they have developed.

On 01/25/23 at 3:14 PM an interview was made with the Psychiatric Nurse Practitioner (NP) who conducted Resident #22's Psychiatry visit on 12/27/22. The Psychiatric NP explained that the summary of her visit along with her orders or recommendations was sent electronically to the Director of Nursing or Assistant Director of Nursing via email and in this case the previous Director of Nursing was still employed by the facility. The Psychiatric NP continued to explain that she wrote recommendations only and expected the Medical Director to review her summary and recommendations and determine if they wished to carry them out or not.

The Medical Director was interviewed on 01/25/23 at 5:10 PM who stated that she visited the facility once a week and she no longer received or reviewed the Psychiatric recommendations/orders because the facility's NP was in the building every day. She stated she assumed the NP reviewed them because she was no longer getting them, she could not speak to the process in the facility since she no longer reviewed them but stated she expected all orders and labs for medication monitoring to be completed within a week.

On 01/25/23 at 2:17 PM during an interview with the facility's Nurse Practitioner (NP) she explained that she had only been employed since July 2022 and she did not review the psychiatric progress notes because she did not have access

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F 758	Continued From page 71 to them. The NP stated she did not know what the process was for getting the psychiatric orders into the residents' electric health record or the orders carried out. On 01/26/23 at 1:00 PM an interview was conducted with the previous Director of Nursing who explained that the Psychiatric NP's summaries and recommendations from their visits were sent electronically to the facility. She stated they were only recommendations that were reviewed by the Medical Director or Nurse Practitioner and if they approved the recommendations then they were responsible to process the recommendations as orders or change them as they deemed appropriate. The Director of Nursing (DON) was interviewed on 01/26/23 at 1:09 PM who stated she had only been at the facility for three weeks and had not received any recommendations/orders from the Psychiatric NP. She stated that typically those recommendations would come to the DON or NP for approval but again stated that she had not received any from the PNP. The DON stated that she expected the recommendations/orders from the Psychiatric NP to be approved by the NP or MD and then entered and carried out by the facility staff within the week of receiving the recommendations.	F 758		
F 802 SS=K	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments,	F 802		3/10/23

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F 802	Continued From page 72 individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to have effective systems in place to ensure there were dietary staff to prepare meals when dietary staff did not arrive to work on the 1/22/23. The Central Supply Clerk and three Nurse Aides (NAs) prepared breakfast, lunch, and dinner resident meals without checking the internal temperature of cooked foods before serving and did not serve resident mechanically altered diets as ordered. This led to the high likelihood for residents to be at risk of choking or aspiration. This situation affected 9 of 9 residents (Resident #1, Resident #22, Resident #53, Resident #69, Resident #31, Resident #57, Resident #8, Resident #17, and Resident #26) for 3 of 3 meals. The staff also prepared breakfast, lunch, and dinner resident meals without checking the internal temperature of cooked foods before serving for 91 of 91 residents. The Immediate Jeopardy (IJ) began on 1/22/23 when dietary staff did not arrive to work their scheduled shift to ensure meal service was	F 802	Resident #1, Resident #22, Resident #53, Resident #69, Resident #31, Resident #57, Resident #8, Resident #17, and Resident #26 were assessed for choking or aspiration by the Director of Nursing on 2/3/2023 with no changes in condition noted. Residents 91 0f 91 were also checked by the Director of Nursing/ designee on 2/3/2023 with no signs or symptoms of food borne illness noted. All current residents have the potential to affected. The Administrator was educated on 2/4/2023 and 3/2/2023 by the Chief Nursing Officer related to ensuring the dietary department is sufficiently staffed and appropriate food and nutritional competencies have been completed. The Dietary Manager will be education by	

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F 802	Continued From page 73 provided by trained and competent staff. This resulted in 9 of 9 residents not receiving a pureed diet for 3 of 3 meals. The immediate jeopardy was removed on 2/7/23 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity "E" (no actual harm that is immediate jeopardy) to ensure monitoring systems are put into place are effective. Findings included: An interview with the Central Supply clerk was conducted on Sunday, 1/24/23 at 1:30 PM. The Central Supply clerk indicated he was working in the facility on 1/22/23 as a medication aide when he and other nursing staff discovered the meal trays for the breakfast meal had not arrived at the floor for distribution around 8:45 AM. He indicated the breakfast meal trays should begin arriving on the unit shortly after 7:30 AM each morning. The Central Supply clerk stated he, along with Nurse Aide #5, went to the dietary department and began knocking on the door. They discovered there were no visible lights on and both doors were securely locked. Following this observation, the Central Supply clerk notified the Administrator via text message that no dietary staff had arrived to prepare food for the residents. The Administrator directed him, NA #5, NA #10, and NA #11 to obtain a master key to enter the dietary department and prepare the breakfast meal. Central Supply clerk explained since he and NA #11 had worked in a kitchen during employment with other companies, they went to the walk-in fridge and walk-in-freezer and began pulling items they recalled were normally served to the residents for the breakfast meal and began	F 802	3/9/2023 by the Administrator related to ensuring the dietary department is sufficiently staffed and appropriate food and nutritional competencies have been completed. The dietary staff to include agency dietary staff will not be allowed to work until the education is completed. New hires also will be required to complete the education. The Administrator/ designee will review the dietary staff schedule during morning meeting as well as the weekend schedule each Friday for 3 months to ensure the dietary department is adequately staff. The Administrator will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review and follow up with recommendations to ensure the facility's continued compliance.	

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prepping them to cook. He stated the following items were prepped and cooked: omelets, sausage patties, oatmeal, grits, scrambled eggs, and French toast sticks. The Central Supply clerk indicated they were unable to puree food, so they cut it in very small pieces and then mashed it with a potato masher to serve to residents on mechanically altered diets such as chopped or ground meats, and puree. The Central Supply clerk stated meal tickets had already been printed which allowed them to serve items based on the tray card; however, they did not call the Dietary Manager, Regional Dietary Manager nor the Consulting Registered Dietician when the menu was altered and to let them know they were unable to use of all kitchen equipment. Central Supply clerk indicated the breakfast meal was delivered to the units for residents shortly after 10 AM on 1/22/23. He acknowledged he and the other staff improvised the best they could and did not obtain temperatures of the food before delivery nor provide the proper textured diets for each resident. The Central Supply clerk indicated at approximately 10:30 AM, a dietary aide (Dietary Aide #2) arrived to work who attempted to assist the nursing staff to wash dishes in the dish machine; however, no one checked to ensure the temperatures were meeting required levels for sanitation during usage. The Central Supply clerk stated he and NA #11 also used the 3-in-1 sink to wash cook wear but did not perform the chemical strip controls to ensure proper levels of chemicals were used to maintain sanitation. The Central Supply clerk further explained no one else from the dietary department arrived to assist on 1/22/23 and therefore, he and NA #11 prepared all meals for residents on that day. He stated they prepared and served the following: lunch- roast beef, sweet potato casserole,

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spinach, peaches, and cornbread and for supper they served: meatloaf, mashed potatoes, squash casserole, mandarin oranges, and a biscuit.

An interview with the Administrator was conducted on 1/23/23 at 12:30 PM. The Administrator indicated he became aware staff from the dietary department had not arrived at work on the morning of 1/22/23 at approximately 8:45 AM when nursing staff and the central supply clerk discovered no meal trays had been delivered to the units and no residents had received their breakfast meal which should have been delivered beginning at 7:30 AM. He indicated he lived out of state came back to the facility as soon as he could. The Administrator gave the authorization for the Central Supply Clerk and the 3 nurse aides (NA #5, NA #10, and NA #11) to begin meal preparation and delivery of the breakfast meal. He arrived at the facility several hours later that day between 2:00-3:00 PM on 1/22/23 at which time breakfast and lunch had already been served to all residents. The Administrator indicated he contacted the Regional Dietary Consultant after being unable to reach the DM on 1/22/23 but was not assisted with providing staff to cover the meal delivery in the facility. The Administrator did not have previous food service experience and told the Central Supply clerk to serve meals based on the residents' meal ticket but was unable to provide any further guidance on preparation or meal service. He did not give any directive regarding preparing snacks at the time.

A telephone interview with Cook #1 was conducted on 1/26/23 at 10:17 AM. Cook #1 revealed he had worked on 1/21/23. Cook #1 indicated on 1/21/23 at 4:28 PM, he tried to

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contact the DM by telephone without success so he followed the call with a text message which would alert the DM he could not work his scheduled shift of 5:30 AM to 5 PM on 1/22/23. Cook #1 stated he had not been contacted by the facility to answer any questions about what food was to be prepared or how to use the kitchen equipment on 1/22/23 and did not receive a return call from the DM. Cook #1 was also able to verify that they frequently only had 1 cook and 2 dietary aides scheduled to work on the weekends.

A review of the monthly dietary schedule revealed the following for 1/22/23:
Cook #1 was assigned from 5:30 AM to 5:00 PM.
Dietary Aide #1 was assigned from 6:30 AM to 2:30 PM.
Dietary Aide #2 was assigned from 10:30 AM to 7:30 PM.

A review of the monthly dietary scheduled reflected this was the schedule every other week on Sunday and on the opposite Sunday revealed one cook would be scheduled from 5:30 AM to 2 PM and an additional cook would be scheduled to work from 12:30 PM to 7:30 PM.

An interview with Dietary Aide #1 (DA) was conducted on 1/25/23 at 11:30 AM. DA #1 indicated she was scheduled to work on the morning of 1/22/23; however, informed the DM around 3 AM that she would not be able to work her scheduled shift for that day. The DA #1 stated she initially called the DM with no response and then followed it with a text message on 1/22/23 and did not receive a reply from the DM.

Multiple attempts were made to contact Dietary

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Aide #2 without success.

Multiple attempts were made to contact the former DM without success as she no longer works with the contracted food service company.

An interview with NA # 10 on 1/24/23 at 1:59 PM revealed she arrived to work on 1/22/23 at around 7:00 AM and she along with other nursing staff members began noticing residents' meals had not been delivered around 8:30 AM. NA #10 stated the Central Supply clerk and NA #11 went in the kitchen and began cooking the food and she and NA #5 plated additional items such as drinks and desserts before they were delivered to each unit. NA #10 stated she assisted to serve both breakfast and lunch on 1/22/23, but did not aide in the evening meal because she was scheduled to leave at 4:00 PM. NA #10 explained they were not able to use all of the kitchen equipment and therefore attempted to mechanically alter the puree diet trays by cutting up items really small and then using a potato masher to get the food as smooth as possible before delivering it to the residents. NA #10 reviewed the items listed that were served to the Central Supply clerk's list and agreed those were the items served and that single use disposable wear was used because of lack of dishes and trays. NA #10 also indicated during the lunch meal a few pizzas were ordered by a staff member but the pizza's delivered were too hard for most residents and they instead consumed the meal served by the nursing staff who prepared the meal that day for lunch.

An interview with NA #5 on 1/25/23 at 10:30 AM revealed she was assigned to work the unit as a nurse aide on 1/22/23 when she learned the

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dietary staff members had not arrived to work and residents had not yet had breakfast at around 9 AM. NA #5 indicated she along with the Central Supply clerk (who was assigned to work as a medication aide on 1/22/23), NA #10, and NA #11 went to the kitchen and began getting breakfast ready so residents could have something to eat. NA #5 stated they did the best they could to get residents something to eat although she acknowledged she was aware they were unable to use the kitchen equipment to mechanically alter the foods for residents on a puree diet and therefore those items were cut up finely and mashed with a potato masher to get as best consistency as possible and all meals served were delivered on single serve disposable wear. NA #5 recalled providing residents the food items provided by the Central Supply clerk during his interview.

An interview with NA #11 on 1/25/23 at 10:45 AM revealed he was scheduled to work as a nurse aide on 1/22/23 when he was notified the dietary department had not arrived at the facility to prepare meals to the residents. NA #11 stated he, the Central Supply clerk, NA #5, and NA #10 then obtained a key to enter the dietary department where he and the Central Supply clerk had realized they each had some previous culinary experience and therefore they the two of them were the staff members who prepared the food items while NA #5 and NA #10 plated additional items such as desserts and drinks. NA #11 stated they were not able to use the kitchen equipment and therefore they were unable to properly prepare the texture for the puree consistency and therefore cut the items up as small as possible and then mashed them with a potato masher before serving the item to the resident on

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prescribed puree diets. NA #11 acknowledged they did not follow a menu on 1/22/23; they strictly looked in the walk-in-fridge and walk-in-freezer to find items that were accessible and verified they prepared the following items for residents for breakfast were: scrambled eggs, omelets, oatmeal, grits, French toast, and sausage; for lunch: roast beef, sweet potato casserole, spinach, peaches, and cornbread and for supper they served: meatloaf, mashed potatoes, squash casserole, mandarin oranges, and a biscuit.

An interview with the Regional Dietary Consultant was conducted on 1/23/23 at 10:08 AM. She indicated she was contacted on 1/22/23 by the facility Administrator who notified her that the staff from the dietary department had not shown up to prepare food on 1/22/23 and that facility nursing staff were attempting to prepare meals for all residents in the facility. The Consultant indicated she was unsure at the time what occurred further than the staff did not arrive to work.

An interview with the Regional Dietary Manager on 1/24/23 at 9:28 AM revealed she was without a phone over the weekend and did not learn of the events of 1/22/23 until the morning of 1/23/23 when she was asked to come to the facility by the Regional Dietary Consultant therefore she did not come to the facility on 1/22/23 to aide in meal service and was unsure what was prepared or what occurred in the department on 1/22/23. She provided the surveyor the monthly schedule and verified it was accurate in how staff were scheduled in the department at the time.

A follow-up interview was conducted with the Regional Dietary Manager on 1/24/23 at 2:30 PM. She indicated she was not made aware the

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dietary cook had made the Dietary Manager (DM) aware on 1/21/23 that he would not be able to work his shift on 1/22/23 and further indicated when the DM was made aware, she should have ensured coverage was obtained with other dietary staff.

A telephone interview with the Consulting Registered Dietician (CRD) was conducted on 1/25/23 at 9:27 AM. She stated she was not involved in dietary staffing, schedules, or menu alterations in the facility and had not been contacted regarding the foods to be prepared by nursing staff on 1/22/23.

The Administrator was notified of the Immediate Jeopardy on 2/3/23 at 9:14 AM.

The facility provided the following credible allegation of compliance with a compliance date of 2/7/23.

The facility provided the following credible allegation of compliance with a compliance date of 2/7/23.
o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

The facility failed to ensure adequately trained and competent staff were on duty for meal preparation and service and failed to ensure dishes were sanitized correctly on 1/22/23.

On 1/22/23, one untrained Central supply Clerk and 3 Nurse aides prepared 3 meals for 91 of 91 residents when the scheduled dietary staff did not show up for work. In addition, the one untrained

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Central supply Clerk and 3 Nurse aides prepared 3 meals for 91 of 91 residents without taking food temperatures, without being trained on the use of the dish machine and unaware of the 3-sink compartment dish sanitization procedure. As a result, the identified staff were unaware that the dish machine was not working properly, and dishes were not sanitized as required.

On 2/3/23 the Director of Nursing, Assistant Director of Nursing, and Charge Nurses completed assessments of the current facility residents to include the 91 residents on 1/22/2023 that still remain in the facility. No signs/symptoms of foodborne illnesses were identified.

On 2/3/23, the current facility residents were reviewed by the Director of Nursing and Assistant Director of Nursing to identify any changes of condition related to unsafe food preparation and the wide range of dietary restrictions and diets.

The results of this failure impacted all 91 of the facility residents on 1/22/2023.

The current residents are at risk as a result of this deficient practice.

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

Starting 2/3/23, the nursing staff will be educated by the Director of Nursing/ designee related to identifying the signs and symptoms of foodborne illnesses. The education will continue at the

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beginning of each shift until each staff member receives the education by 2/6/2023. No staff member including agency staff and new hires will be permitted to work until the education is received.

Starting 2/3/23, the facility staff will be educated by the Director of Nursing and Assistant Director of Nursing to call the Administrator and the Dietary Manager immediately if dietary staff is not available to prepare meals to ensure trained dietary staff to include dietary staff that are scheduled off, dietary contract staff, and dietary staff from other sister facilities can be called in to prepare, cook, and serve the meals by 2/6/2023. The Administrator and the Dietary Manager contact information will be posted at each nursing station. The Dietary Manager and the Administrator will have the dietary staff contact information to include other sister facilities contact information to assist with managing dietary call out when they are in or out of the building.

The Administrator and the Dietary Manager will review the dietary staffing weekly and monthly schedule during morning report to ensure that the dietary department is adequately staff. On each Friday, the Administrator and the Dietary Manager will review the weekend dietary staffing schedule to ensure any staffing concerns have been addressed.
By 2/5/2023, the Dietary Manager to include the dietary staff will be educated by the Administrator related to ensuring that the Administrator is notified of any dietary staffing concerns. The Administrator and the Dietary Manager contact information will be posted in the kitchen and on each facility nursing unit. In addition, the dietary

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F 802	Continued From page 83 manager will ensure the dietary staff has the dietary manager and the administrator's contact information in addition to calling the facility if they are unable to locate the contact information. Effective 2/3/2023 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance. Alleged Date of IJ Removal: 2/07/2023 On 2/8/23 the credible allegation of IJ removal with a completion date of 2/7/23 was validated through staff interview and review of in-service training records. Staff were able to verbalize and demonstrate examples of how to prepare and serve meals, read meal tickets to ensure residents received the correct consistency of diet as ordered, able to identify symptoms of a foodborne illness and potential risk of a resident receiving the incorrect texture of food for consumption. Each were able to verbalize they were to report anytime the dietary department staff were not present in the building by the start of day shift to the Administrator and the Director of Nursing to include weekends.	F 802		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing	F 804		3/10/23

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F 804	Continued From page 84 temperature. This REQUIREMENT is not met as evidenced by: Based on observations, record review, test tray, resident, and staff interview's the facility failed to provide palatable food that was appetizing in temperature and texture for 5 of 5 residents reviewed with food concerns (Resident #9, Resident #12, Resident #27, Resident #30, and Resident #35). The findings included: a. Resident #9 was admitted to the facility on 09/13/22. Review of the quarterly Minimum Data Set (MDS) dated 11/11/22 revealed that Resident #9 was cognitively intact for daily decision making and required set up assistance with eating. An observation and interview were conducted with Resident #9 on 01/26/23 at 12:55 PM. Resident #9 was in his room with his lunch tray in front of him. The meal plate was not served on a hot plate and there was no visible steam coming off his food tray that consisted of chicken fried rice, carrots, and an egg roll. Resident #9 stated that his food was "lukewarm", but the taste was "ok" he indicated that he was hungry and would eat enough to get full. Resident #9 stated that in the past he had asked the staff to reheat his food and it took so long to get his tray back that he did not ask again. b. Resident #12 was readmitted to the facility on 12/18/20. Review of the quarterly Minimum Data Set (MDS) dated 12/22/22 revealed that Resident #12 was	F 804	Resident #9, Resident #12, Resident #27, Resident #30, and Resident #35 will be reviewed by 3/9/2023 for food concerns to include texture and temperature by the dietary manager. The current residents have the potential to be affected. A dietary audit of the current residents will be completed by 3/9/2023 by the dietary manager/designee to ensure food concerns to include temperature and texture are being addressed. The Dietary Manager will be educated by 3/9/2023 by the Administrator to ensure food concerns to include temperature and texture are being addressed. The dietary staff will be educated by 3/9/2023 by the dietary manager related to ensuring food is being served at the required temperatures and physician ordered textures. The dietary staff to include agency dietary staff will not be allowed to work until the education is completed. New hires also will be required to complete the education. The Administrator/ Dietary Manager will review 10 resident meals weekly for 4 weeks and monthly for 2 months to ensure resident meals continue to be served at the required temperature and ordered texture.	

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F 804	Continued From page 85 cognitively intact for daily decision making and required set up assistance with eating. An observation and interview were conducted with Resident #12 on 01/26/23 at 12:57 PM. Resident #12 was in her room with her lunch tray in front of her. The meal plate was not served on a hot plate and when the cover was removed there was no visible steam coming off the food and the plate was cool to touch. The meal consisted of chicken fried rice, carrots, and an egg roll. Resident #12 stated that her food was cold, the rice was mushy and over cooked. She stated she would have enjoyed the meal much better if it would have been warm or even hot but explained that most of the meals in the facility were cold and she had gotten used to eating cold or cool food. Occasionally Resident #12 stated she would get some food out of the freezer in the nourishment room and heat it up in the microwave if she just could not eat the cold food served by the facility. c. Resident #27 was admitted to the facility on 08/21/13. Review of the quarterly Minimum Data Set (MDS) dated 11/08/22 revealed that Resident #27 was cognitively intact for daily decision making and required set up assistance with eating. An observation and interview were conducted with Resident #27 on 01/26/23 at 1:00 PM. Resident #27 was in her room with her meal tray in front of her. The meal plate was not served on a hot plate and when the lid was removed there was no visible steam noted and the plate was cool to touch. Resident #27 stated that her food was cold and she "had anticipated it to be better	F 804	The Administrator/ Dietary Manager will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review and follow up with recommendations to ensure the facility's continued compliance.	

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as it was the resident selected meal of the month." Resident #27 explained that most of the meals served in the facility were cold and for the last month or, so they had been using Styrofoam containers and they "don't hold any heat" so everything was cold by the time it got delivered to the residents. She added that she had complained several times to the dietary manager and staff, and nothing really improved.

d. Resident #30 was readmitted to the facility on 01/21/20.

Review of the quarterly Minimum Data Set (MDS) dated 11/03/22 revealed that Resident #30 was moderately cognitively impaired for daily decision making and required set up assistance with eating.

An observation and interview were conducted with Resident #30 on 01/26/23 at 1:03 PM. Resident #30 was in her room with her lunch tray in front of her. The meal plate was not served on a hot plate and when the tray was lifted there was no visible steam, and the plate was cool to touch. Resident #30 began to eat her lunch that consisted of shrimp and chicken fried rice, carrots, and an egg roll. She stated that the food was cold, and the rice was mushy. Resident #30 stated that rice was one of her favorite foods and when at home ate rice at almost every meal, but this rice was overcooked and mushy and she was not sure how much she would be able to eat.

e. Resident #35 was readmitted to the facility on 03/03/21.

Review of the quarterly Minimum Data Set (MDS) dated 11/11/22 revealed that Resident #35 was

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cognitively intact for daily decision making and required set up assistance with eating.

An observation and interview were conducted with Resident #35 on 01/26/23 at 1:10 PM. Resident #35 was in his room with his lunch tray in front of him. He had eaten approximately 50% of the meal tray and stated that the food was cold, and the rice was mushy, and he had eaten all he was going to eat. Resident #35 stated that a lot of times the food was cold and when it was cold he would eat a few bites then snack on some snacks that he had at bedside to get him through the day.

An observation of the lunch tray line was conducted on 01/26/23 at 11:28 AM and a test tray was requested. The menu included shrimp fried rice, chicken fried rice, carrots, and an egg roll. The test tray was plated and placed on the tray cart and left the kitchen on 01/26/23 at 12:22 PM. Once all the trays on the unit had been passed to the residents the test tray was sampled with the interim DM on 01/26/23 at 12:45. The observation revealed the following: the meal plate had no hot plate and when the lid was removed, and the plate was cool to touch and there was no visible steam to the food. The food remained in the scoop shape as it has been when plated in the kitchen. The shrimp fried rice was cold, and the chicken fried rice was a little warmer, but the rice was mushy and appeared overcooked. The carrots were very cold and had no flavor despite adding salt and pepper to them prior to tasting them.

The interim DM was interviewed on 01/26/23 at 1:00 PM and confirmed that the food was cold, and the carrots needed some seasoning for

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F 804	Continued From page 88 flavor. She stated they cooked the carrots with no seasoning but added salt and pepper to the tray. The interim DM stated that the facility had no hot plates to help keep the food warm, but they had ordered them and were waiting for equipment needed to use them to be installed. The interim DM further stated that they did not have insulated tray carts and they covered the tray carts with clear trash bags to help hold the heat in but that really did not do a good job. She stated that the facility was trying to get approval to order the insulated tray carts and hoped that the hot plates and insulated tray carts would help keep the resident food hot. The Administrator was interviewed on 01/26/23 at 3:00 PM who stated that he had only been at the facility for three weeks. He stated he quickly identified big issues and concerns in the kitchen, and he was working to correct them, but he had just not had enough time. The Administrator stated that the facility had purchased the plate warmers but needed to have the warmer installed by a licensed electrician and they were working on securing that and they were exploring purchasing new insulated carts to help with the many complaints of cold food.	F 804		
F 805 SS=K	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff	F 805	Resident #1, Resident #22, Resident #53,	3/10/23

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F 805	Continued From page 89 interviews, the facility failed to provide pureed foods as ordered by the physician for 9 of 9 residents. (Resident #1, Resident #22, Resident #53, Resident #69, Resident #31, Resident #57, Resident #8, Resident #17, and Resident #26). On 01/22/23 dietary staff did not arrive for work. A central supply clerk and three nurse aides (NAs) prepared and served breakfast, lunch, and dinner to residents on pureed diets by chopping food into small pieces and not smooth consistencies. The staff had not been trained on food production and did not have skills to operate the food processor. This resulted in the high likelihood for residents to choke or aspirate. The Immediate Jeopardy (IJ) began on 1/22/23 when residents with orders for a puree diet were not served 3 of 3 meals pureed to a smooth consistency. The immediate jeopardy was removed on 2/7/23 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity "E" (no actual harm that is immediate jeopardy) to ensure monitoring systems are put into place are effective. The findings included: a. Resident #53 was admitted to the facility on 9/8/22 with diagnosis that included dementia, protein calorie malnutrition, and diabetes. A physician's order dated 9/8/22 indicated Resident #53 was to receive a puree diet with thin liquids. A quarterly MDS dated 12/16/22 revealed Resident #53 was cognitively intact and required set-up assistance with eating.	F 805	Resident #69, Resident #31, Resident #57, Resident #8, Resident #17, and Resident #26 were assessed on 2/3/2023 by the Director of Nursing with no changes in condition noted. The current residents prescribed pureed diets have the potential to be affected. A dietary audit of the current residents prescribed pureed diets will be completed by 3/9/2023 by the dietary manager/designee to ensure residents received pureed diets as prescribed. The Dietary Manager will be educated by 3/9/2023 by the Administrator to ensure residents receive pureed diets as prescribed. The dietary staff will be educated by 3/9/2023 by the dietary manager related to ensuring residents receive pureed diets as prescribed. The dietary staff to include agency dietary staff will not be allowed to work until the education is completed. New hires also will be required to complete the education. The Administrator/ Dietary Manager will review resident with pureed diets weekly for 4 weeks and monthly for 2 months to ensure resident continue to be served pureed diets a prescribed. The Administrator/ Dietary Manager will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review and follow up with	

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F 805	Continued From page 90 An interview with Resident #53 was conducted on 1/26/23 at 5:25 PM which revealed she was ordered a puree diet and was delivered items such as French toast and sausage for breakfast, roast beef, sweet potato casserole, spinach and peaches for lunch, and meat loaf, squash casserole, and orange slices which she realized she could not have on her prescribed diet and was unable to eat and no other food items were available to be served on 1/22/23 which was of the puree consistency due to kitchen staff not being available. b. Resident #1 was re-admitted to the facility on 10/14/21 with diagnoses that included a cerebral infarction and abnormal weight loss. A physician's order dated 10/12/22 indicated Resident #1 was to receive a puree diet with thin liquids. A quarterly Minimum Data Set (MDS) dated 1/4/23 revealed Resident #1 was cognitively impaired with short- and long-term memory problems and required extensive assistance with eating. c. Resident #22 was admitted to the facility on 5/22/21 with diagnoses that included Alzheimer's dementia. A physician's order dated 2/14/22 indicated Resident #22 was to receive a puree diet with thin liquids. A quarterly MDS dated 12/21/22 revealed Resident #22 was cognitively impaired with short- and long-term memory problems and required	F 805	recommendations to ensure the facility's continued compliance.	

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extensive assistance with eating.

d. Resident #69 was admitted to the facility on 9/29/22 with diagnoses that included esophageal obstruction, dysphagia, and dementia.

A physician's order dated 1/4/23 indicated Resident #69 was to receive a puree diet with thin liquids.

A quarterly MDS dated 1/5/23 revealed Resident #69 was cognitively impaired and required minimal assistance with eating.

e. Resident #31 was admitted to the facility on 8/19/22 with diagnosis that included Alzheimer's, Parkinson's disease, and malnutrition.

A physician's order dated 10/7/21 indicted Resident #31 was to receive a puree diet with nectar thickened liquids.

A quarterly MDS dated 11/16/22 revealed Resident #31 was cognitively impaired and required extensive assistance with eating.

f. Resident #57 was admitted to the facility on 11/29/22 with diagnoses that included dementia, cerebral infarction, and abnormal weight loss.

A physician's order dated 11/19/22 revealed Resident #57 was to receive a Regular diet with puree meats and thin liquids.

A quarterly MDS dated 12/5/22 indicated Resident #57 was mildly cognitively impaired and required supervision assistance with eating.

g. Resident #8 was readmitted to the facility on

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10/1/22 with diagnosis that included functional quadriplegia, dementia, and protein calorie malnutrition.

A physician's order dated 8/31/22 indicated Resident #8 was to receive a puree diet with thin liquids.

A quarterly MD dated 10/29/22 indicated Resident #8 had short and long-term memory problems and required extensive assistance from staff for eating.

h. Resident #17 was re-admitted to the facility on 8/1/22 with diagnoses that included dementia and gastrointestinal esophageal reflux disease.

A physician's order dated 2/19/21 indicated Resident #17 was to receive a puree diet with thin liquids.

A quarterly MDS dated 1/22/22 indicated Resident #17 had short- and long-term memory problems and was dependent for eating.

i. Resident #26 was admitted to the facility 9/7/22 with diagnoses that include malnutrition and end of life care.

A physician's order dated 12/30/22 indicated Resident #26 was to receive a mechanical soft diet with puree meats and thin liquids.

A Significant Change MDS dated 1/30/23 indicated Resident #26 was cognitively intact and required supervision assistance for eating.

A brief interview with the Regional Dietary Consultant was conducted on 1/23/23 at 10:08

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AM. She indicated she was contacted on 1/22/23 by the facility Administrator who notified her that the staff from the dietary department had not shown up to prepare food on 1/22/23 and that facility nursing staff were attempting to prepare meals for all residents in the facility. The Regional Dietary Consultant stated she attempted to contact the former Dietary Manager and the Regional Dietary Manager but did not come to the facility to assist with meal service or offer instructions on how to prepare meals via phone on 1/22/23 when she gained knowledge no dietary personnel were present and was unaware kitchen equipment was unable to be properly used to mechanically alter diets as prescribed.

An interview with the Administrator was conducted on 1/23/23 at 12:30 PM. The Administrator indicated he became aware staff from the dietary department had not arrived at work on the morning of 1/22/23 at approximately 8:45 AM when nursing staff and the central supply clerk discovered no meal trays had been delivered to the units and no residents had received their breakfast meal which should have been delivered beginning at 7:30 AM. He indicated he lived out of state but arrived at the facility later in the day at approximately 2-3 PM on 1/22/23 to ensure meals were delivered to residents. The Administrator had no previous dietary experience and therefore did not offer additional direction on meal service other than to follow the dietary meal tickets. The Administrator was unable to reach the Dietary Manager to determine why staff did not arrive to the facility on 1/22/23.

An interview with the Central Supply clerk was conducted on 1/24/23 at 1:30 PM. The Central

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Supply clerk indicated he was working in the facility on 1/22/23 as a medication aide when he and other nursing staff discovered the meal trays for the breakfast meal had not arrived at the floor for distribution at around 8:45 AM. The Central Supply Clerk indicated they were able to locate the meal tickets which had been printed the day before to determine what foods would need to be prepared. The Central Supply clerk explained since he and NA #11 had some kitchen experience from a previous employment, they went to the walk-in fridge and walk-in-freezer and began pulling items they recalled were normally served to the residents for the breakfast meal and began prepping them to cook. He stated the following items were prepped and cooked: omelets, sausage patties, oatmeal, grits, scrambled eggs, and French toast sticks. The Central Supply clerk indicated they were unable to use the grinder machine that day and instead attempted to cut items in very small pieces and then mash them with a potato masher to serve to residents on mechanically altered diets such as chopped or ground meats, and puree. The Central Supply clerk described them to be more of a chopped or ground consistency. The Central Supply clerk further explained no one else from the dietary department arrived to assist with meal preparation on 1/22/23 and therefore, he and NA #11 prepared all meals for residents on that day. The Central Supply clerk verified that Dietary Aide #2 arrived at his scheduled time of 10:30 AM; however, he only washed dishes during his shift and did not assist with meal preparation on 1/22/23. The Central Supply clerk stated they prepared and served the following: lunch - roast beef, sweet potato casserole, spinach, peaches, and cornbread and for supper they served: meatloaf, mashed potatoes, squash casserole,

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mandarin oranges, and a biscuit. The Central Supply clerk stated the roast beef had been thawing to serve on Monday and therefore he selected that item because it was readily accessible for lunch, and they made the consistency as close to chopped and ground as possible.

An interview with NA #11 on 1/25/23 at 10:45 AM revealed he worked on 1/22/23 when he was notified the dietary department had not arrived at the facility to prepare meals to the residents. NA #11 stated they were not able to use the kitchen equipment and therefore they were unable to properly prepare the texture for the puree consistency and therefore cut the items up as small as possible and then mashed them with a potato masher before serving the item to the resident on prescribed puree diets. NA #11 described the consistency of the meats to be chopped. NA #11 acknowledged they did not follow a menu on 1/22/23; they strictly looked in the walk-in-fridge and walk-in-freezer to find items that were accessible and verified they prepared the following items for residents for breakfast were: scrambled eggs, omelets, oatmeal, grits, French toast, and sausage; for lunch: roast beef, sweet potato casserole, spinach, peaches, and cornbread and for supper they served: meatloaf, mashed potatoes, squash casserole, mandarin oranges, and a biscuit.

Multiple attempts were made to contact Dietary Aide #2 were unsuccessful.

An interview with NA #10 on 1/24/23 at 1:59 PM revealed she worked on 1/22/23 and she was asked to help plate and serve food in the dietary department when dietary staff did not arrive at

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work that morning. NA #10 said she entered the kitchen along with the Central Supply clerk and 2 other NAs and began assisting to ensure the breakfast meal could be served to residents. She explained that the Central Supply clerk and NA #11 cooked the food; however, no one was able to use the grinder machine that day and therefore, they attempted to make the puree items as small and fine as possible by cutting it in very mall bites and some items were mashed using a potato masher before delivering the meal to the resident for consumption. NA #10 verified they served the following items to residents on 1/22/23 and none of the items were of the traditional puree consistency and texture: scrambled eggs, oatmeal, grits, sausage; for lunch: roast beef, sweet potato casserole, spinach, peaches, and cornbread and for supper they served: meatloaf, mashed potatoes, squash casserole, mandarin oranges, and a biscuit. NA #10 described the consistency of most items served as chopped.

An interview with NA #5 on 1/25/23 at 10:30 AM revealed she worked on 1/22/23 when she learned the dietary staff members had not arrived to work and residents had not yet had breakfast at around 9 AM. NA #5 stated they did the best they could to get residents something to eat although she acknowledged she was aware they were unable to use the kitchen equipment to mechanically alter the foods for residents on a puree diet and therefore those items were cut up finely and mashed with a potato masher to get as best consistency as possible. NA #5 indicated the following items were served, but they were unable to puree them: scrambled eggs, omelets, oatmeal, grits, French toast, and sausage; for lunch: roast beef, sweet potato casserole,

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spinach, peaches, and cornbread and for supper they served: meatloaf, mashed potatoes, squash casserole, mandarin oranges, and a biscuit. NA #5 indicated most food items served were of a ground consistency.

An interview with the Medical Director was conducted on 1/26/23 at 1:00 PM which revealed she had been notified of the residents receiving the wrong texture diet when they were prescribed a puree diet but had not been made aware of any adverse effects from not receiving a puree diet on 1/22/23 nor did she know full details of why residents did not receive the correct consistency.

A follow-up interview with the Administrator on 1/26/23 at 3:00 PM revealed he was not made aware the staff were unable to use the kitchen equipment which resulted in being unable to ensure the proper textures were provided to residents with a mechanically altered consistency and indicated staff should have made administration aware before delivering meals to those residents ordered a puree diet for safety.

The Administrator was notified of the Immediate Jeopardy on 2/3/23 at 9:14 AM.

The facility provided the following credible allegation of compliance with a compliance date of 2/7/23.

F805
o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

The facility failed to ensure 9 of 9 residents prescribed a puree diet received the correct

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F 805	Continued From page 98 texture on 1/22/2023 for 3 of 3 meals when non dietary staff were unable to utilize the kitchen equipment needed to provide residents menu items which required puree textures. On 2/3/23, the current facility residents on puree diets were reviewed by the Director of Nursing and Assistant Director of Nursing to identify any changes of condition related to unsafe food preparation and the wide range of dietary restrictions for the pureed diets with no concerns noted. On 2/3/2023, the Nurse Practitioner was made aware. The current residents on puree diets are at risk as a result of this deficient practice. 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 Starting 2/3/23, All facility staff will be educated to call the Administrator and the Dietary Manager immediately if dietary staff is not available to prepare meals to ensure trained dietary staff to include dietary staff that are scheduled off, dietary contract staff, and dietary staff from other sister facilities can be called in to prepare, cook, and serve the prescribed diets to include pureed diets by 2/6/2023. Starting 2/3/23, the dietary staff will be educated by the dietary manager in food preparation and use of the kitchen equipment to puree prescribed diets to ensure residents received the prescribed pureed diets by 2/6/2023.	F 805		

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F 805	Continued From page 99	F 805		

Starting 2/3/23, the dietary staff will be educated by the Dietary Manager to ensure staff that prepare and serve food are competent in preparing all textures of diets including puree diets by 2/6/2023.

Starting 2/3/23, All facility staff will be educated by the Administrator or designee related to only trained staff in safe food service preparation are allowed to prepare, cook, and serve resident prescribed diets to include pureed diets by 2/6/2023.

Starting 2/3/2023, The education for the facility staff to include the dietary staff will continue at the beginning of each shift until each staff member receives the education. No staff member including agency staff, dietary and new hire will be permitted to work until the education is completed.

Starting 2/6/2023, The Administrator and the Dietary Manager will review the dietary weekly and monthly staffing schedules during morning report to ensure that the dietary department is adequately staffed. On Fridays, the Administrator and the Dietary Manager will review the weekend schedule to ensure weekend staffing concerns have been addressed.

By 2/6/2023, the Dietary Manager will be educated by the Administrator related to ensuring that the Administrator is notified of any dietary staffing concerns.

Starting 2/6/2023, the Director of Nursing/designee will observe the current residents' meal trays that receive pureed diets at

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F 805	Continued From page 100 least 3 times a week for breakfast, lunch, and dinner to ensure that the residents continue to receive their prescribed pureed diets for at least 12 weeks. Effective 2/3/2023 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance. Alleged Date of IJ Removal: 2/07/2023 On 2/8/23 the credible allegation of IJ removal with a completion date of 2/7/23 was validated through staff interview and review of in-service training records. Staff were able to verbalize and demonstrate examples of how to prepare and serve meals, how to use the dish machine and 3-in-1 sink chemical test strips, how to properly read meal tickets to ensure residents received the correct consistency of diet as ordered, able to identify symptoms of a foodborne illness and potential risk of a resident receiving the incorrect texture of food for consumption. Each were able to verbalize they were to report anytime the dietary department staff were not present in the building by the start of day shift to the Administrator and the Director of Nursing to include weekends.	F 805		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.	F 809		3/10/23

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F 809	Continued From page 101 §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to provide snacks when requested for 5 of 5 residents reviewed for resident council (Resident #9, Resident #12, Resident #27, Resident #30, and Resident #35). The findings included: An observation of the nutrition rooms on the 200/400 hall nurses' station on 1/23/23 at 10:30 AM revealed there were no snacks available for consumption. a. Resident #9 was admitted to the facility on 09/13/22. Review of the quarterly Minimum Data Set (MDS) dated 11/11/22 revealed that Resident #9 was cognitively intact for daily decision making and required set up assistance with eating. b. Resident #12 was readmitted to the facility on 12/18/20.	F 809	Resident #9, Resident #12, Resident #27, Resident #30, and Resident #35 are being provided snacks when requested. The current residents have the potential to be affected. The nutrition rooms were checked on 2/1/2023 by the Administrator/ Director of Nursing to ensure that snacks were available for the residents when requested. The Dietary Manager will be educated by 3/9/2023 by the Administrator to ensure snacks are available for the residents in the nutrition rooms. The dietary staff will be educated by 3/9/2023 by the dietary manager related to ensuring the nutrition rooms are being stocked to ensure snacks are available for the residents. The dietary staff to include agency dietary staff will not be allowed to work until the education is completed. New hires also will be required to complete the education.	

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F 809	Continued From page 102 Review of the quarterly Minimum Data Set (MDS) dated 12/22/22 revealed that Resident #12 was cognitively intact for daily decision making and required set up assistance with eating. c. Resident #27 was admitted to the facility on 08/21/13. Review of the quarterly Minimum Data Set (MDS) dated 11/08/22 revealed that Resident #27 was cognitively intact for daily decision making and required set up assistance with eating. d. Resident #30 was readmitted to the facility on 01/21/20. Review of the quarterly Minimum Data Set (MDS) dated 11/03/22 revealed that Resident #30 was moderately cognitively impaired for daily decision making and required set up assistance with eating. e. Resident #35 was readmitted to the facility on 03/03/21. Review of the quarterly Minimum Data Set (MDS) dated 11/11/22 revealed that Resident #35 was cognitively intact for daily decision making and required set up assistance with eating. Interviews conducted with 5 residents during Resident Council on 1/25/23 at 3:00 PM revealed residents voiced concerns about snacks not being available after the supper meal. Residents reported sometimes no snacks were available and other times, the dietary department would send a tray with a few graham crackers and saltine crackers and occasionally a sandwich on	F 809	The Administrator/ Dietary Manager will check the nutrition room 3x weekly for 12 weeks to ensure residents continue to have snacks available when requested and nutrition rooms remain stocked with snacks. The Administrator/ Dietary Manager will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review to ensure the facility's continued compliance.	

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F 809	Continued From page 103 the bottom of the supper meal carts; however, each resident voiced if they did not ask for a snack at that time then the tray was returned to the kitchen and no other snacks were available later in the night if they became hungry. Resident #9, Resident #12, and Resident #30 stated they had given up asking because they were told by nursing staff (Nurse Aides and Nurses) they did not have snacks available. An interview with the Activity Director on 1/25/23 at 3:30 PM revealed the lack of snacks had been a concern in the facility and they were not available if a resident requested to have additional food after the supper trays were collected in the evening. An interview with the Assistant Director of Nursing (ADON) on 1/26/23 at 11:23 AM revealed he was aware that snacks had been an ongoing concern from residents, and he had been working to find a resolution for this concern. The ADON indicated he expected snacks to be always available for residents and the facility was working to use additional funds to purchase snack to keep on hand.	F 809		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		3/10/23

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F 812	Continued From page 104 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews and manufacturer's recommendations, the facility failed to follow manufacturer's recommendations for the sanitary operation of a high temperature dish machine. The facility also failed to have testing equipment to measure the chemical concentration of the dish machine and test the chemical concentration of the 3-in 1 sink prior to use. The facility also failed to remove expired food items stored for use and date leftover foods stored for use in 1 of 1 reach-in refrigerator, 1 of 1 walk-in refrigerator and 1 of 1 freezer. These practices had the potential to affect all residents. Findings included: 1. A Health Department document titled, Request for service/complaint investigation report" dated 12/29/22 indicated following a water pipe break on 12/24/22, the local Health Department inspected the kitchen and discovered the hot water at the dish machine could only reach 154 degrees Fahrenheit. The hot water required for sanitation for the final rinse to dispense water at 180 degrees Fahrenheit so food contact surfaces could be sanitized above 161 degrees	F 812	The testing equipment was obtained on 2/3/2023 by the dietary manager to measure the chemical concentration of the dish machine and the 3-in 1 sink. Expired food items and leftover foods stored in the reach in refrigerator, walk in refrigerator, and the freezer were discarded on 1/2/2023 by the dietary manager. The current residents have the potential to be affected. The dietary manager completed an audit on 3/2/2023 to ensure expired food have been discarded from the reach in and walk in refrigerator and the freezer. The Dietary Manager will be educated by 3/9/2023 by the Administrator related to ensuring expired foods are being discards from the reach in and walk in refrigerators and the freezer as well as testing equipment is available to measure the chemical concentration of the dish machine and the 3-in 1 sink. The dietary staff will be educated by 3/9/2023 by the dietary manager related to ensuring expired foods are being discards from the reach in and walk in	

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F 812	Continued From page 105 Fahrenheit. The document indicated the machine needed to be evaluated for repair and could only be used for washing food contact surfaces and then each item must be transferred to the 3-in-1 sink to be sanitized and a follow-up would be performed the following week. An observation and interview with the Health Department inspector and the Regional Dietary Manager on 1/26/23 at 11:28 AM revealed the dish machine gauges read as follows: 170 degrees Fahrenheit for the wash cycle and 185 degrees Fahrenheit on the final rinse cycle. When the Health Department inspector request the temperature logs which were recommended on a previous visit to determine if the dish machine was reaching the required temperature for sanitation during the final rinse cycle, the Regional Dietary Manager was unable to provide these to the inspector or the surveyor. The Health Department also asked the Regional Dietary Manager about the use of chlorine test strips to determine the proper concentration being used in the dish machine for chemical sanitation and the facility did not have any of these available on hand to use for verification during usage. The Health Department inspector discussed the use of the 3-in-1 sink with the Regional Dietary Manager and the Regional Dietary Manager was able to vocalize knowledge of the correct use of the sink and indicated she would ensure that her staff had knowledge of how to use it. The Health Department inspector indicated the dish machine must meet a hot temperature of 150 degrees during the wash cycle and the hot temperature must reach a minimum of 180 degrees Fahrenheit to ensure dishes were sanitized properly.	F 812	refrigerators and the freezer as well as testing equipment is available to measure the chemical concentration of the dish machine and the 3-in 1 sink. The dietary staff to include agency dietary staff will not be allowed to work until the education is completed. New hires also will be required to complete the education. The Administrator/ Dietary Manager will check the kitchen weekly for 12 weeks to ensure that expired foods are being discards from the reach in and walk in refrigerators and the freezer as well as testing equipment is available to measure the chemical concentration of the dish machine and the 3-in 1 sink. The Administrator/ Dietary Manager will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review and follow up with recommendations to ensure the facility's continued compliance.	

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An observation and interview with Dietary Aide #1 on 1/23/23 at 9:26 AM revealed Dietary Aide #1 using the dish machine to run a rack of miscellaneous dishes off the metal table. The observation revealed the gauges on the dish machine to register 148 degrees Fahrenheit during the wash cycle and 174 degrees Fahrenheit during the final rinse cycle. After the rack exited the machine, it remained on the end of the table to dry. The machine had a visible sticker next to the gauges which indicated the final rinse temperature must reach 185 degrees Fahrenheit. On drying racks adjacent to the dish machine, a rack of bowls was sitting faced down with dried food material and white spots on them ready for use. Dietary Aide #1 indicated she had not checked temperatures before use of the dish machine on 1/23/23 and was not sure who had washed the rack of bowls, but they were in the area where items were stored ready for use, but agreed they were not clean.

An observation on 1/24/23 at 9:28 AM revealed Dietary Aide #1 using the dish machine to clean and sanitize breakfast dishes. A large rack of metal cooking dishes was loaded, and the temperature gauges measured 158 degrees Fahrenheit during the washing cycle and 180 degrees on the final rinse cycle.

An interview with the Regional Dietary Manager who was serving as the facility Interim Dietary Manager on 1/24/23 at 2:30 PM revealed she was aware there had been some problems with the dish machine not meeting the required temperature of 185 degrees Fahrenheit on the final rinse cycle and the 3-in-1 sink should have had test strip controls ran each time the sink was emptied and refilled.

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An observation and interview with Cook #3 on 1/24/23 at 2:30 PM revealed she was placing dirty cookware in the 3-in-1 sink. She indicated she had not been taught how to use the chemical testing strips for the 3-in-1 sink and thought the chemical testing for concentration was only checked in the morning by other staff members and stated she had not ever tested them while using the sink during any of her shifts. Cook #3 had added chemicals to the sink through a hose attached to the chemicals which were premixed. During this observation there were no chemical test strips available.

An observation on 1/25/23 at 11:27 AM revealed Cook #2 place cooking utensils on a rack and slide them into the dish machine and walk away. The gauges on the dish machine at the time read: 170 degrees Fahrenheit during the wash cycle and 170 degrees Fahrenheit during the final rinse cycle.

A follow-up visit document from the Health Department dated 1/26/23 indicated the Health Inspector met with the interim Administrator who notified her the dish machine had been modified to provide hot water and chemical sanitation during the final rinse. During this visit the hot water temperature reached 182 degrees Fahrenheit and per test from the inspector the chlorine concentration measured 100 ppm; however, the facility had no current testing supplies to verify the chemical concentration of the chlorine being used. The recommendations by the inspector were that the facility maintain a log of dish machine temperatures as well as provide chlorine testing supplies to ensure the proper concentration of chlorine was used for

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sanitation of the dishes in the dish machine.

2. A brief tour of the kitchen was conducted on 1/23/23 beginning at 9:26 AM and ending at 10:05 AM with Dietary Aide #1 and then concluded with the Regional Dietary Consultant. The tour revealed the following:

In the reach in fridge:

-A partially used and unsealed bag of parsley unlabeled or dated with visible spoilage on the leaves to include brown leaves and a slimy film on the surface of the leaves

-A partially used head of lettuce unlabeled or dated

-A plastic gallon sized resealable plastic bag with bologna with a used by date of 1/19/23.

-4 ½ sized peanut butter sandwiches with baggies open to air and the bread was hardened.

-A partially used container of chicken salad with a use by 1/18/23

-A partially used box of pasteurized eggs which had a use by date of 12/23/22.

In the dry storage:

A rack containing two bags of buns with no label or date.

In the walk-in freezer:

-A partially used bag of Italian sausage links opened and unlabeled which showed visible frost

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and ice on the surface of the link

-A partially used box of sliced carrots with a brown substance visible on the surface unlabeled or dated and unsealed

-A partially used bag of 14 cubed beef steaks unlabeled or dated

-A partially used bag of approximately 30 French toast sticks unlabeled or dated

-A partially used bag of 4 breaded chicken patties unlabeled or dated

-A partially used bag of 8 hamburger patties unlabeled or dated

In the walk-in fridge:

-2 bags of opened long stem onions with visible spoilage of sticky and slimy greenage labeled 1/6/23.

-1/2 a pound cake in a zip lock bag unlabeled or dated.

-2 large bags containing heads of lettuce with visible brown spoilage on the leaves.

-A metal container with chicken noodle soup unlabeled or dated

An interview with the Regional Dietary Consultant on 1/23/23 at 10:00 AM revealed she was in the building on this morning due to an emergency with the current Dietary Manager and indicated the reason why many items were left unlabeled or dated and items left past the expiration date was

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F 812	Continued From page 110 due to a lack of staff on 1/22/23. The Regional Dietary Manager indicated all dietary personnel had been trained to label and date all items when they are opened and to discard all food items when they are showing signs of spoilage or reached their expiration date or use by date. She stated these items listed above should not have been readily available for usage by staff.	F 812		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to ensure the area around the dumpster was free of debris and trash was contained in an enclosed receptacle for 2 of 2 dumpsters reviewed. The finding included: An observation of the dumpster area on 1/23/23 at 10:06 AM was made while accompanied by the Regional Dietary Consultant (RDC) which revealed two dumpsters that contained overflowing bags of trash and 1 receptacle which was overflowing with cardboard. The area on the ground around the dumpster was littered with approximately 25 bags of trash which contained used briefs. There were semi-flattened cardboard boxes piled approximately 3-4 feet tall which had been dampened by a recent rain. Scattered debris consisted of single use meal containers, briefs, plastic bottles, in addition to a drain adjacent to the dumpsters which was clogged with cigarette butts which was obstructing its full	F 814	The debris and trash around the dumpster was cleaned up and placed in the dumpster on 1/24/2023 by the Maintenance Director. The current residents have the potential to be affected. The Maintenance Staff, the housekeeping Manager and the dietary manager will be educated by 3/9/2023 by the Administrator related to ensuring the dumpster is closed and no debris and trash is around the dumpster area. The housekeeping and dietary staff will be educated by the Maintenance Director/ Administrator related to ensuring the dumpster is closed and no debris and trash is around the dumpster area. The Maintenance staff, housekeeping and dietary staff will not be allowed to work until the education is completed. New hires also will be required to complete the education.	3/10/23

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F 814	Continued From page 111 drainage potential. An interview was conducted with the RCD on 1/23/23 at 10:08 AM which revealed she thought the dumpsters were consistently emptied twice weekly. The RDC was unsure why the dumpster areas were left in the observed condition and stated these conditions would place an increased risk for pest, rodents and potentially local wildlife in the area. An interview with Cook #2 on 1/23/23 at 10:10 AM revealed the dumpsters were emptied twice weekly on Tuesdays and Fridays. Cook #2 indicated he was unsure why the dumpsters had collected this amount of disposal since the dumpsters were emptied on Friday 1/17/23. He acknowledged the conditions could potentially evoke a risk for pests, rodents, and local wildlife in the area. An interview with the Maintenance Director on 1/24/23 at 3:15 PM revealed he was unaware the dumpster areas were in the condition observed on 1/23/23 until he was made aware later that day. The Maintenance Director indicated he had intentions to contact the trash disposal company but had not yet been able request they change to a 3 times per week pick-up to prevent the overflow of receptacles and acknowledged it would increase the potential for hosting pest and rodents in the facility. He further explained it should be a joint effort of all staff to ensure the area was without loose debris. An interview with the Administrator on 1/26/23 at 3:00 PM revealed he was not aware the dumpsters were overflowing during the observation made along with the RDC on 1/23/23	F 814	The Administrator will check the dumpster area weekly for 12 weeks to ensure the dumpster is closed and no debris and trash is around the dumpster area. The Administrator will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review and follow up with recommendations to ensure the facility's continued compliance.	

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F 814	Continued From page 112 and should be everyone's responsibility to pick-up after themselves when the dispose of trash in the dumpster areas.	F 814		
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff interviews, the facility Administration failed to provide effective leadership and oversight to ensure effective systems were in place to have trained dietary staff available to prepare meals for residents. On 1/22/23 dietary staff did not arrive to work and the Central Supply Clerk and three Nurse Aides (NAs) prepared breakfast, lunch, and dinner resident meals without serving 9 of 9 residents mechanically altered meals as ordered (Resident #1, Resident #22, Resident #53, Resident #69, Resident #31, Resident #57, Resident #8, Resident #17, and Resident #26). This led to the high likelihood of aspiration or choking. The Immediate Jeopardy (IJ) began on 1/22/23 when systems were not in place to ensure trained dietary staff were available to prepare resident meals. The immediate jeopardy was removed on 2/7/23 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity "E" (no actual harm that is	F 835	Resident #1, Resident #22, Resident #53, Resident #69, Resident #31, Resident #57, Resident #8, Resident #17, and Resident #2 were assessed by the licensed nurses on 2/3/2023 with no signs and symptoms of aspiration/choking noted. The current residents with mechanically altered meals have the potential to be affected. An audits will be completed by 3/9/2023 of the residents with mechanically altered meals by the Director of Nursing/ designee. The Dietary Manager will be educated by 3/9/2023 by the Administrator to ensure residents receive mechanically altered diets as prescribed and the Administrator is notified of any dietary staffing concerns. The dietary staff and the nursing staff will be educated by 3/9/2023 by the dietary manager related to ensuring residents	3/10/23

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F 835	Continued From page 113 immediate jeopardy) to ensure monitoring systems are put into place are effective. Findings included: Cross Refer to F802 Based on staff interviews and record reviews, the facility failed to have effective systems in place to ensure there were dietary staff to prepare meals when dietary staff did not arrive to work on the 1/22/23. The Central Supply Clerk and three Nurse Aides (NAs) prepared breakfast, lunch, and dinner resident meals without checking the internal temperature of cooked foods before serving, did not serve resident mechanically altered diets as ordered, and did not ensure kitchen items were sanitized. This led to the high likelihood for residents to be at risk of choking or aspiration. This situation affected 91 of 91 residents for 3 of 3 meals. Cross Refer to F805 Based on record reviews, resident and staff interviews, the facility failed to provide pureed foods as ordered by the physician for 9 of 9 residents. (Resident #1, Resident #22, Resident #53, Resident #69, Resident #31, Resident #57, Resident #8, Resident #17, and Resident #26). On 01/22/23 dietary staff did not arrive for work. A central supply clerk and three nurse aides (NAs) prepared and served breakfast, lunch, and dinner to residents on pureed diets by chopping food into small pieces and not smooth consistencies. The staff had not been trained on food production and did not have skills to operate the food processor. This resulted in the high likelihood for residents to choke or aspirate. The Administrator was notified of the Immediate Jeopardy on 2/3/23 at 9:14 AM.	F 835	receive the mechanically altered diets as prescribed. The dietary and the nursing staff will be educated by 3/9/2023 related to notifying the Administrator and/or the Dietary manager if there are concerns with dietary staff. They will also be made aware the Administrator and the Dietary contact information is posted at each nursing station and in the kitchen. The dietary staff and the nursing staff to include agency staff will not be allowed to work until the education is completed. New hires also will be required to complete the education. The Administrator will review the dietary staff daily in morning report and in addition on Fridays the weekend schedule will be reviewed to ensure dietary staffing concerns are addressed. The dietary manager will call the Administrator when staff callout to ensure the facility continues to have adequate dietary staffing. The Administrator and the Dietary Manager contact information will be posted at the nursing stations and in the kitchen to ensure that if staff notice dietary staffing concerns they can notify the Administrator and/or the Dietary Manager. The Administrator/ Dietary Manager will review 10 residents with mechanically altered diets weekly for 4 weeks and monthly for 2 months to ensure residents continue to be served mechanically altered diets a prescribed.	

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F 835	Continued From page 114 The facility provided the following credible allegation of compliance with a compliance date of 2/7/23. The Administration failed to ensure that an acceptable plan was implemented during the kitchen emergency of no kitchen staff. On, 1/22/2023 at about 8:45 am, the facility staff identified that there was no dietary staff in the kitchen to prepare breakfast. The Administrator was notified immediately about 9:00 am. The Administrator notified corporate leadership at 9:00 am. The Administrator also attempted to notify the dietary manager at about 9:05 am and was unable to reach the dietary manager. Dietary regional support was notified by the Administrator about 9:15am who was able to reach the dietary manager. Later that afternoon, the Administrator was made aware that the dietary manager was unable to be reached due to a personal medical emergency by the dietary regional manager. Facility leadership staff to include the Assistant Director of Nursing (ADON), the Activity Director, Maintenance and the Supply Manager were called on 1/22/2023 by the Administrator about 9:20 am and began coming to the facility to assist with resident meals about 9:35am. The identified facility leadership attempted to obtain breakfast from an outside vendor when they arrived in the building about 9:35 am. The Administrator arrived at the facility to assist with meals after lunch. On 1/22/2023, the Administrator notified the Dietary Facility Regional manager who provided assistance by phone by attempting to call the dietary staff to come to assist with the meals. This was not successful.	F 835	The Administrator/ Dietary Manager will submit the findings to the Quality Assurance Performance Improvement (QAPI) committee monthly meeting for 3 months for review and follow up with recommendations to ensure the facility□s continued compliance.	

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F 835	Continued From page 115 Starting 1/23/2023 the Dietary Regional support was in the facility to provide ongoing leadership in the dietary Department to ensure the safe preparation of the residents' physician ordered diets. The facility residents on 1/22/2023 were at risk as a result of this deficient practice. 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 Starting 1/22/2023, the Administrator and Maple Health Group Corporate leadership will provide ongoing follow up to ensure that the dietary department continues to be staffed as required. On 2/4/2023, the Administrator was educated by the Chief Nursing Officer on the emergency preparedness plan updates to include the dietary staffing schedule review process and that the dietary manager and the Administrator contact information will be provided to the dietary staff and posted on the nursing units and in the kitchen so that the facility will be aware of dietary staff call outs. The Administrator is aware that he is responsible for ensuring the emergency plan is being followed. Starting 2/4/2023, the Dietary Kitchen Oversight checklist which includes monitoring for dietary staffing, dietary staffing competencies completion, residents' receiving pureed diets, dish machine at appropriate temperature, and dietary supervision will be completed by the	F 835		

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facility interdisciplinary team staff. The interdisciplinary team to include social services, Assistant Director of Nursing, Medical Records, maintenance, Business office, admissions, supply clerk, and activities were educated on the oversight checklist by the Administrator.

On 2/6/2023, the facility Emergency Preparedness Plan updates will be reviewed in the Quality Improvement meeting by the Administrator to include the dietary staffing schedule review process and that the dietary manager and the Administrator contact information will be provided to the dietary staff and posted on the nursing units and in the kitchen so that the facility will be aware of dietary staff call outs. The Administrator is aware that he is responsible for ensuring the emergency plan is being followed.

Starting 2/6/2023, the Maple Health Group Chief Nursing Officer or the Chief Operation Officer will complete facility rounds to include the kitchen at least monthly to ensure the updated Kitchen /dietary Emergency Preparedness Plan continues to be followed as required.

Starting 2/3/23, all current dietary staff and new hire dietary staff will be required to complete the facility education related to ensuring residents receive diets as ordered, foods temps checks are completed, training on the use of the kitchen equipment, and notification of Administrator and Dietary Management with staff concerns occur by 2/6/2023 by the Regional Dietary Manager.

The emergency phone numbers of the Dietary Manager and the Administrator will be posted in the kitchen and on each nursing unit by 2/6/2023.

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F 835	Continued From page 117 Effective 2/3/2023 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance. Alleged Date of IJ Removal: 2/07/2023	F 835		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:	F 849		3/10/23

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(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs

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necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.

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The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

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F 849	Continued From page 121 §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure there was an active order to initiate hospice services for 1 of 1 resident reviewed for hospice. (Resident #65) The findings included: Resident #65 was admitted to the facility on 01/26/22 with diagnoses that included brain cancer and hemiplegia. Review of Resident #65's medical record revealed hospice care plan documentation that he received hospice services beginning on 03/09/22. A review of Resident #65's most recent quarterly Minimum Data Set assessment dated 12/19/22 revealed Resident #65 to be moderately impaired. Resident #65 was coded as having a condition or chronic disease that may result in a life expectancy of less than 6 months. Resident #65 was also coded as receiving hospice services while a resident. A review of Resident #65's physician orders revealed no active order admitting Resident #65 to hospice care.	F 849	Resident #65 order for hospice services was obtained on 1/26/23 by the licensed nurse. The current residents on hospice services have the potential to be affected. An audit was completed on 2/1/2023 by the licensed nurse to ensure residents receiving hospice services have a physician order. The licensed nurses to include agency licensed nurses will be education by 3/9/2023 related to ensuring they are obtaining physician orders for residents receiving hospice service. New hire licensed nurses will not be able to work until the education is completed. The Director of Nursing will review current residents weekly for 4 weeks and monthly for 2 months to ensure licensed nurses are obtaining physician orders for residents receiving hospice services. The Director of Nursing will submit the findings to the Quality Assurance Performance Improvement (QAPI)	

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F 849	Continued From page 122 During an interview with Nurse #3 on 01/26/23 at 10:44 AM, she reported she was aware Resident #65 received hospice care. She stated there should be an active order in Resident #65's chart showing when Resident #65 was admitted to hospice care. She reported she could not locate an active order for Resident #65 to be admitted to hospice. During an interview with the Assistant Director of Nursing on 01/26/23 at 12:10 PM, he reported Resident #65 should have an active physician order showing he was admitted to hospice care. He did not indicate why Resident #65 did not have an active physician order showing he was admitted to hospice. During an interview with the Director of Nursing on 01/26/23 at 3:15 PM, she reported she was made aware of Resident #65 not having an active physician order for hospice services earlier in the day by Nurse #3. She reported she contacted the hospice company that serviced Resident #65 and verified his admission date and then requested a physician order from the Medical Director that stated Resident #65's admission date to hospice and the hospice company that provided the service to Resident #65. She stated Resident #65 should have an active physician order for hospice services and assumed the error was overlooked by the previous administration. The Director of Nursing indicated she expected all residents who received hospice services to have an active physician order indicating the start date and hospice company that provided the service.	F 849	committee monthly meeting for 3 months for review and follow up with recommendations to ensure the facility's continued compliance.	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)	F 867		3/10/23

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F 867	Continued From page 123 §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.	F 867		

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F 867	Continued From page 124 §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the	F 867		

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F 867	Continued From page 125 facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place	F 867	Quality Assessment and Assurance (QAA) Committee was held on 3/2/2023 by the Administrator related to ensuring the facility has effective systems to obtain information and/or feedback from facility	

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F 867	Continued From page 126 following the recertification and complaint survey conducted on 06/25/21, the complaint investigation survey conducted on 06/15/22 and the focused infection control and complaint investigation surveys conducted on 04/29/22 and 12/07/20. This failure was for 9 deficiencies that were originally cited in the areas of Safe, Clean, Comfortable and Homelike Environment (F584), Develop and Implement Comprehensive Care Plans (656), ADL (Activities of Daily Living) Care Provided for Dependent Resident (F677), Increase or Prevent Decrease ROM (Range of Motion) or Mobility (F688), Respiratory or Tracheostomy Care and Suctioning (F695), Sufficient Dietary Support Personnel (802), Nutritive Value and Appearance, Palatable and Preferred Temperature (F804), Frequency of Meals and Snacks at Bedtime (F809), and Food Procurement, Storage, Prepared and Served Under Sanitary Conditions (F812) that were subsequently recited on the current recertification and complaint investigation survey on 02/08/23. The repeat deficiencies during five federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA program. The findings include: This tag is cross referenced to: F-584: Based on observations, record review, and staff interviews the facility failed to repair exposed damaged dry wall on 1 of 7 units (100 hall) and affected 5 of 12 occupied rooms (Room #103, Room #107, Room #108, Room #109, and Room #111), the facility also failed to label personal care items located in shared bathrooms on 1 of 7 units (400 hall) and affected 3 of 6	F 867	staff, residents and residents representatives to identify problems and opportunities for improvement. The current residents are at risk related to this deficient practice. The interdisciplinary team was educated on 3/2/2023 by the Chief Nursing Officer related to ensuring the QAA Committee maintain and implement processes to obtain information and/or feedback from facility staff, residents and residents representatives to identify problems and opportunities for improvement. The Administrator will be responsible for monitoring the Quality Assurance Performance Improvement Plan process monthly for 3 months to ensure that the facility remains in compliance for identified deficiencies. The Administrator will report findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) meeting for at least 3 months for review to ensure compliance.	

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shared bathrooms (Rooms #400/402, Rooms #401/403, and Rooms #405/407).

During the recertification and complaint survey conducted on 06/25/21 the facility failed to clean and sanitize the doorframes, label and store residents' personal care items and failed to label and store residents' personal care items in 2 of 8 bathrooms (shared bathroom of rooms #107-109,#202-204, and #204-#206) and failed to ensure walls and doors were free from holes and scratches for 2 of 8 bathrooms (shared bathroom of rooms #107-109 and #202-204). The facility also failed to ensure 2 of 3 community shower rooms (500 hall and the 200 hall male shower rooms) were free of clutter, clean, sanitized and in good repair for areas reviewed for environment.

During the focused infection control and complaint investigation survey conducted on 04/29/22 the facility 1) failed to ensure baseboard was in good repair in 1 of 6 resident bathrooms (Room #112); 2) failed to maintain a homelike environment in 4 of 31 resident rooms/bathrooms (Room #112, #204, #301, and #308) observed to have damaged and splintered wooden wall borders and doors, scuff marks and peeling sheetrock on the walls, and holes in the wall and back of a room door; 3) failed to clean a bathroom with a strong odor of urine in 1 of 6 resident bathrooms (Room #300) on 3 of 4 resident halls (100 Hall, 200 Hall, and 300 Hall).

F-656: Based on observations, record review, resident, and staff interview's the facility failed to implement a comprehensive care plan for a resident that wandered daily (Resident #43) and for a resident that verbalized a desire to lose

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weight (Resident #54) for 2 of 4 residents reviewed.

During the focused infection control and complaint investigation survey conducted on 04/29/22 the 1) failed to implement interventions by not applying a hand splint as specified in the comprehensive care plan and 2) failed to complete and individualize an activity of daily living care plan for 2 of 3 sampled residents reviewed (Resident #5 and Resident #11).

F-677: Based on observations, record reviews, staff and resident interviews, the facility failed to provide dependent residents with showers (Resident #74, #183, #184 and #186) and failed to provide nail care (Resident #53) and failed to provide shaves (Resident#75) to 6 of 8 residents reviewed for activities of daily living.

During the recertification and complaint investigation survey conducted on 06/25/21 the facility failed to perform routine incontinent care (Resident #7) and failed to provide scheduled showers (Resident #24, Resident #37, Resident #17, and Resident #45) for 5 of 10 residents reviewed for activities of daily living.

During the complaint investigation survey conducted on 06/15/22 the facility failed to perform routine incontinent care (Resident #7) and failed to provide scheduled showers (Resident #24, Resident #37, Resident #17, and Resident #45) for 5 of 10 residents reviewed for activities of daily living.

F-688: Based on observations, record review, resident, and staff interview's the facility failed to offer or apply a hand splint and palm guard as

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ordered for 1 of 3 residents reviewed for range of motion (Resident #48).

During the recertification and complaint investigation survey conducted on 06/25/21 the facility failed to assist ambulation for 1 of 1 (Resident #21) and failed to provide splints for 2 of 2 (Residents #13 and #44) reviewed for positioning and mobility services.
During the focus infection control and complaint investigation survey conducted on 04/29/22 the facility failed to apply a hand splint for contractures management per physician's order for 1 of 1 sampled resident reviewed (Resident #5).

F-695: Based on observations, record review, and staff interview's the facility failed to administer oxygen at the prescribed rate and failed to clean the oxygen concentrator filter for 1 of 3 residents reviewed for respiratory care (Resident #11).

During the recertification and complaint investigation survey conducted on 06/25/21 the facility failed to administer oxygen at the prescribed rate for 1 of 1 resident (Resident #45) reviewed for respiratory care.

During the focus infection control and complaint investigation survey conducted on 04/29/22 the facility failed to administer oxygen as prescribed by the Physician for 1 of 2 residents (Resident #3) reviewed for oxygen therapy.

F-802: Based on staff interviews and record reviews, the facility failed to have effective systems in place to ensure there were dietary staff to prepare meals when dietary staff did not

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arrive to work on the 1/22/23. The Central Supply Clerk and three Nurse Aides (NAs) prepared breakfast, lunch, and dinner resident meals without checking the internal temperature of cooked foods before serving and did not serve resident mechanically altered diets as ordered. This led to the high likelihood for residents to be at risk of choking or aspiration. This situation affected 9 of 9 residents (Resident #1, Resident #22, Resident #53, Resident #69, Resident #31, Resident #57, Resident #8, Resident #17, and Resident #26) for 3 of 3 meals. The staff also prepared breakfast, lunch, and dinner resident meals without checking the internal temperature of cooked foods before serving for 91 of 91 residents.

During the focus infection control and complaint investigation survey conducted on 04/29/22 the facility failed to have sufficient dietary staff to ensure the menu was followed. On 04/24/22 a dietary aide was the only staff member that reported to work and made the decision without consultation from the Dietary Manager or Regional Dietary Manager to serve residents sandwiches for the evening meal. This affected all residents with diet orders.

F-804: Based on observations, record review, test tray, resident, and staff interview's the facility failed to provide palatable food that was appetizing in temperature and texture for 5 of 5 residents reviewed with food concerns (Resident #9, Resident #12, Resident #27, Resident #30, and Resident #35).

During the recertification and complaint investigation survey conducted on 06/25/21 the facility failed to provide palatable food that was

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appetizing in appearance, taste, and temperature for 6 of 6 residents reviewed with food concerns (Resident #09, Resident #10, Resident #15, Resident #20, Resident #24, and Resident #40).

F-809: Based on observations, resident and staff interviews, the facility failed to provide snacks when requested for 5 of 5 residents reviewed for resident council (Resident #9, Resident #12, Resident #27, Resident #30, and Resident #35). During the recertification and complaint investigation survey conducted on 06/25/21 the facility failed to provide snacks when requested for 1 of 1 resident (Resident #30) reviewed for snacks.

F-812: Based on observations, record review, staff interviews and manufacturer's recommendations, the facility failed to follow manufacturer's recommendations for the sanitary operation of a high temperature dish machine. The facility also failed to have testing equipment to measure the chemical concentration of the dish machine and ensure staff tested the chemical concentration of the 3-in 1 sink. The facility also failed to remove expired food items stored for use and date leftover foods stored for use in 1 of 1 reach-in refrigerator, 1 of 1 walk-in refrigerator and 1 of 1 freezer.
During the recertification and complaint investigation survey conducted on 06/25/21 the facility failed to label and date opened food items in 1 of 1 reach-in refrigerators, 1 of 1 dry goods storage areas, and 2 of 2 nourishment room refrigerators, failed to remove a case of expired individual packets of sour cream from 1 of 1 walk-in refrigerators, and failed to store four, 10-pound packages of ground beef in a way that prevented cross contamination when they were

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stored on a wire shelf directly above a cardboard box of melons in 1 of 1 walk in refrigerators.

During the focus infection control and complaint investigation survey conducted on 04/29/22 the facility failed to label, and date opened food items in 1 of 1 walk-in refrigerators, and 2 of 2 nourishment room refrigerators, and failed to remove expired food items from 1 of 1 walk-in refrigerators, 1 of 1 reach in refrigerators, and 2 of 2 nourishment rooms, and failed to ensure the walk-in refrigerator and walk in freezer were free from dirt and debris. These practices had the potential to affect food served to residents.

An interview was conducted with the Administrator on 01/26/23 at 4:28 PM who expressed that he was new at the facility (01/04/23) and had not attended a QA meeting since his arrival to the facility because they had to reschedule the meeting due to the recertification survey. The Administrator acknowledged the multiple deficiencies that were recites from previous federal surveys and explained that since his employment he had identified several issues that required his immediate attention and some of them involved several deficiencies identified in the recertification survey.