STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056039	A. BUILDING _____ B. WING _____	C 11/07/2023

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WELLSPRINGS POST ACUTE CENTER	44445 NO.15TH ST. WEST LANCASTER, CA 93534

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of five complaints. Complaint Numbers: CA00865052, CA00866972 and CA00866910. Representing the Department: Nutrition Consultant: 47441 Health Facilities Evaluator Nurse: 43878 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. No deficiencies were issued for complaint numbers: CA00865052 and CA00866972. Five deficiencies were identified for the complaint number: CA00866910 (Refer to Ftag 677, Ftag 692, Ftag 760, Ftag 803 and FTag 804).	F 000	**This Plan of Correction (POC) serve as our Credible Allegation of Compliance.** **The Facility will be in Substantial Compliance bon or before 12-07-23.** **This plan of Correction does not admit guilt to any of the alleged violations nor does this interfere with the right to contest or appeal the alleged violation.**	
F 677 SS=D	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; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide the necessary services for one of 15 sampled residents (Resident 15) who was unable to carry out activities of daily living received the necessary services to maintain good grooming when Resident 15 was observed with long curled nails.	F 677	**F-677- ADL Care Provided for Dependent Residents.** *Immediate corrective action(s) for those Residents affected by the deficient practice.* ➢ Resident # 15 is a diabetic and her nails were trimmed on 11-07-23 by the Treatment Nurse Coordinator. ➢ Resident # 15 was observed by the Treatment Nurse coordinator not to have any	

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

RN, DON — 12/1/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 677	Continued From page 1 This deficient practice had the potential for Resident 15 to have discomfort. Findings: A review of Resident 15 ' s Admission Record indicated the facility admitted the resident on 9/18/2023 with diagnoses that included anoxic brain damage (caused by a complete lack of oxygen to the brain, which results in the death of brain cells after approximately four minutes of oxygen deprivation), legal blindness, and functional quadriplegia (complete immobility due to frailty or severe physical disability). A review of Resident 15 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 9/24/2023 indicated Resident 15 had the ability to understand and be understood. The MDS indicated Resident 15 was totally dependent on staff for bed mobility, transfer, location on and off the unit, dressing, eating, toilet use and personal hygiene. A review of Resident 15 ' s care plan initiated on 9/19/2023, indicated resident has actual risk for Activity of Daily Living (ADL) mobility decline and requires assistance. The interventions included hygiene assistance of nails: diabetic, nurse to trim nails, nails: trim nails with bathing schedule and am and pm care assistance. During an interview on 11/7/2023 at 10:55 a.m., Resident 15 stated her nails were long and they even curl up, she would like her nails to be cut. Resident 15 stated no one from the facility has offered to cut her nails. Resident 15 stated the nails do not hurt or dig into her hands.	F 677	trauma or dig into her palms due to her long nails. Resident #15 did not express any discomfort. • How the facility will identify other residents having the potential to be affected by the same deficient practice: o All residents that are dependent and are assisted for ADLs ie., grooming, hygiene and nail care are affected by the same alleged deficient practice. The DSD conducted a sweep for uncut nails on 11/24/23 with the CNAs. Unkept long nails were immediately corrected by the CNAs and licensed nurses. • What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice will not occur; o In-service was provided by the DSD to all CNAs on 11/28/2023 regarding their tasks and responsibilities for observing long uncut fingernails of the residents.	

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F 677	Continued From page 2 During a concurrent observation and interview on 11/7/2023 at 11:15 a.m. with Certified Nursing Assistant 3 (CNA 3) at Resident 15's bedside, CNA 3 stated Resident 15 nails are long and they curl up at the ends, but Resident 15 refuses to get her nails cut. CNA 3 stated she has offered Resident 15 multiple times to cut her nails, CNA 3 stated if resident is refusing should be documented and informed to the charge nurse, CNA 3 stated not sure if its documented. During an interview on 11/7/2023 at 1:29 p.m. , Treatment Nurse 1 (TN 1) stated or Resident 15 the treatment nurse can trim her nails but not sure if they have offered to trim Resident 15 ' s nails. TN 1 stated not offering Resident 15 to trim her nails is a right and she should be offered it. TN 1 stated not trimming Resident 15 nails can be a risk for Resident 15 to have pain if nails are long, they can dig into her hand, she is contracted. TN 1 stated nails are daily care but for toenails since she is diabetic needs to be done by podiatrist, is being seen today by podiatrist for toenails. During an interview on 11/7/2023 at 1:44 p.m., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) stated that Resident 15 ' s nails are long and curly. The ADON stated there is a care plan for ADL but nothing regarding Resident 15 refusing to have her nails cut. The ADON stated there is no progress note of Resident 15 refusing nail care. The ADON stated nails should have been cut and trimmed and if she refused should have communicated and documented it. The DON stated not providing Resident 15 with trimming of nails is a risk for continuity of care and a risk for discomfort to	F 677	This includes trimming and cutting of nails of nondiabetic patients. In addition, reinforcement was provided to the CNAs to report all diabetic long nails and refusals to the DSD and to the licensed nurses for further follow up. o In-service was given to the licensed nurses by the DON and ADON on 11/28/23 and 11/29/23 regarding nail cutting and trimming of diabetic patients and patients that adamantly refused nail care. They were instructed to refer noncompliant patients to the RN Supervisor and to document and care plan noncompliance and refusals with nail care cutting and trimming. o CNAs will now maintain and provide nail care every Sunday and forward all refusals to the attention of the licensed nurses and DSD. Licensed nurses will intervene accordingly and report noncompliance to RN Supervisor, with	

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F 677	Continued From page 3 resident. During an interview on 11/7/2023 at 2:28 p.m. with the Administrator (Adm) stated Resident 15 ' s nails appear long. The Adm stated he felt like Resident 15 is refusing the care and his staff did not document it appropriately. The Adm stated if Resident 15 is wanting her nails to be cut the facility should be providing it. The Adm stated not providing nail trimming is an issue should be respecting the resident right to dignity. A review of the facility ' s policies and procedures titled, "Fingernails/Toenails, Care of," last revised on 2/2018 indicated nail care includes daily cleaning and regular trimming, trimmed and smooth nails prevent the residents from accidentally scratching and injuring his or her skin. Reporting indicated notify the supervisor if the resident refuses the care, report other information in accordance with facility policy and professional standard of practice. A review of the facility ' s policies and procedures titled, "Activities of Daily Living (ADLs), Supporting," last revised on 3/2018 indicated resident will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. A review of the facility ' s policies and procedures, titled "Resident Rights," last revised on 12/2016 indicated employees shall treat all resident with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all resident	F 677	documentation in resident's records. • How the facility plans to monitor its performance to make sure that solutions are sustained. o Significant findings will be forwarded to the DON and Administrator and QA monthly for trending and analysis for three months and quarterly thereafter. **Completion Date: 12/2/23**	

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F 677	Continued From page 4 of this facility. These rights include the resident ' s right to: a. A dignified existence. b. Be treated with respect, kindness, and dignity.	F 677	**F 692: Nutrition/Hydration Status Maintenance** ***Immediate corrective action(s) for those Residents affected by the deficient practice.***	***Completion Date(s):***
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 observation, interview, and record review, the facility failed to provide adequate nutritional and hydration care and services to residents when: 1. The facility failed to provide physician ordered	F 692	On 11-02-23 Resident's 1 high protein supplement in chocolate flavor was ordered from Dairy King and it was delivered on 11-4-23. The chocolate flavor of ensure is now provided to resident 1 as her choice or preference for supplemental nourishment. The Charge Nurse that received and carried out new order for ensure inform the prescribing physician to discontinue the current supplement to replace by the new order of ensure per resident's 1 choice instead of resource 2.0. ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken.*** All residents that has an order and receiving supplemental nourishment were checked and reviewed, No other residents had issues nor complaint or affected by the same deficient practice. ***Facility measures and systemic changes to ensure the deficient practice does not recur.*** On 11.28.23, an inservice was provided to all Food Service Staff by the RD and FSD on the following: 1. Food Garnishing and Tray	**11-04-23** **11-28-23**

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F 692	Continued From page 5 high calorie (Kcal, a unit of energy used to express the nutritional value of foods), high protein (a type of nutrient a person needed for growth and development of muscles) nutritional supplement (product used to add kcal and protein in the diet) of preference. 2. The facility failed to prepare foods by methods that conserved flavor and appearance for Resident 1 causing varied oral intake (PO intake). These deficient practiced caused 14.4% severe unplanned weight loss in six (6) months of one (1) of three (3) sampled residents (Resident 1). Findings: A review of Resident 1 ' s Admission Record, dated 10/31/2023, indicated Resident 1 was initially admitted to the facility on 4/28/2021 and then readmitted on 12/27/2022 with diagnoses including malignant neoplasm of upper lobe, right bronchus or lung (a type of lung cancer that begins in the upper part of the right lung), chronic obstructive pulmonary disease (COPD, a lung disease characterized by persistent cough and progressive breathing) and unspecified protein-calorie malnutrition (a condition of insufficient food intake resulting to weight loss, muscle loss and impaired growth and development). A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 8/8/2023, indicated Resident 1 was cognitively intact (able to understand and make decisions), able to eat with limited assistance, and needed one-person physical assist when eating.	F 692	Presentation; 2. Food Portion, Sizes; 3. Trayline Accuracy; 4. Recipe Compliance Adherence These inservices were provided **to ensure the food served to the residents is prepared by methods that conserve flavor, palatable, attractive and/or appears appetizing**. Staff members completed the corresponding quizzes with 100% pass rate to measure staff level of competency. ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process.*** The Department Managers will conduct observation during mealtime daily and interview **15 random alert** and oriented residents to determine **if the food served was flavorful, palatable, attractive and/or appears appetizing.** Findings will be reported to the Administrator for appropriate action as needed. **Completion Date** 12-07-23	11-28-23 12-07-23

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F 692	Continued From page 6 A review of Resident 1 ' s diet type report order by physician, dated 7/18/2023, indicated fortified regular (adding high kcal, high protein food items to the tray such as butter, milk, and margarine), soft mechanical chopped meat (a diet including foods that are chopped to help residents having chewing issues), regular thin liquid consistency. A review of Resident ' s 1 supplement order by physician, dated 9/27/2023 at 11:19 PM, indicated, "Ensure Supplement two times (BID) a day for supplement chocolate Ensure Plus." A review of Resident ' s 1 care plan, revised 7/10/2023, indicated, "Potential weight loss interventions included Ensure three times a day (TID)." During an interview with Resident 1 on 10/31/2023 at 10:38 AM, Resident 1 stated the menu served was not followed regularly, large amount of starch such as rice and pasta were served, and vegetables like green beans were not seasoned. Resident 1 stated that the tuna sandwich tasted like cardboard, powdered eggs were used instead of real eggs, zesty spinach were not zesty, breaded fish fillet had so much breading than fish and the menu sounds delicious, but the food served was not edible. Resident 1 stated, the sandwiches sold in the gasoline station was a better tasting than the food served in the facility. Resident 1 stated that she sometimes would request soup and was given vegetable soup diluted with water that has no nutrients. Resident 1 stated she had a physician ' s order of Ensure (a brand of nutritional shake and drink) high kcal, high protein drink but was substituted with a different brand, Resource 2.0	F 692		

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(a brand of oral supplement that is high protein, high kcal). Resident stated she has informed the Dietary Supervisor (DS), Certified Nursing Assistants (CNA), and other Licensed Vocational Nurses (LVN) of the food concerns and that she prefers drinking Ensure chocolate but was told that the facility could not provide the Ensure as it ' s not part of their formulary. Resident 1 stated, Resource 2.0 and Boost (a brand of nutritional drink, high in kcal, and protein) supplement made her sick as it contained more sugar. Resident 1 stated she has lost ten (10) pounds (lbs, a unit of measurement) but not sure for how long.

During a record review facility document titled, "Weights and Vitals Summary," dated 10/31/2023, indicated, resident ' s weight was eighty-eight (88) lbs on 4/11/2023, eighty-five (85) lbs on 5/9/2023, eighty-four (84) lbs on 6/14/2023, eighty-three (83) lbs on 8/8/20234, and seventy-five (75) lbs on 10/11/2023. Resident had 9.63% weight loss in two (2) months and 14.77% in 6 months indicative of severe weight loss. During a concurrent interview with LVN 1 and record review of Resident 1 ' s PO intake on 10/31/2023 at 3:30 PM, LVN 1 stated she did not physically take care of Resident 1 but monitored Resident 1 ' s weight and PO intake. LVN 1 stated she weighed Resident 1 on 10/11/2023 with a weight of 75 lbs., however, Resident 1 refused to be weighed in 9/2023. LVN 1 stated there was an eight (8) lbs weight loss from 83 lbs. in 8/8/2023 to 75 lbs. in 10/11/2023. LVN 1 stated Resident 1 disliked Resource 2.0, Glucerna, health shakes, and milk but interested in having her food preferences catered by the kitchen. LVN 1 stated Resident 1 ' s PO intake records varied but were mostly ranging from 50-100% and on 10/30/2023 Resident 1 ate 50-75% for breakfast, 50-75% for

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F 692	Continued From page 8	F 692		

lunch and refused her dinner meal. LVN 1 stated that further PO intake records indicated were as follows: 10/29/2023 76-100% for breakfast, refused her meal for lunch, 50-75% for dinner. LVN 1 stated Resident 1 ' s PO intake varied from 50-100%, 3 episodes of meal refusals and oral supplement refusals on 10/16/2023.

During an interview with CNA 1 on 10/31/2023 at 4:07 PM, CNA 1 stated she took good care of Resident 1 and Resident 1 was very particular with her food and eat some of her food but would not finish what was served to her because she does not like the quality of the food.

During an interview with LVN 2 on 10/31/2023 at 4:23 PM, LVN 2 stated Resident 1 loss weight and there were changes in appetite due to pain. LVN 2 stated Resident 1 was on pain medications such as Norco, ibuprofen, morphine, Robaxin and oxycodone (medications for pain).

During a concurrent interview with the DS and record review of Resident 1 ' s medical records on 11/1/2023 at 10:50 AM, DS stated on 10/12/2023 at 4:26 PM, she visited Resident 1 for food preferences and Resident 1 added a lot of seasoning on the side in her trays and does not like a lot of pork but requested small portions of pork to taste. DS stated Resident 1 liked small portions of food. DS stated she revisited Resident 1 on 10/16/2023 at 10:55 AM to talk about food preferences and that Resident 1 requested for chocolate pudding, peanut butter, and black pepper for breakfast. DS stated Resource 2.0 was ordered by the physician on 1/25/2023 and with a discontinue date of 8/28/2023. DS stated she heard from LVN1, Resident 1 liked Ensure and was ordered by the physician on 9/28/2023 at

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9:00 AM with indefinite ending date. DS stated she saw that there was an order of Ensure on 10/16/2023 but nurses always gave Resource as a substitute. DS stated, "we can always ask our supplier to get Ensure, it ' s not a problem."

A review of Resident ' s 1 progress notes written by DS on 9/21/2023 at 12:50 PM, indicated, Resident 1 ' s food preferences in the morning were hard-boiled eggs, small amount of tuna, cottage cheese mixed with tomatoes and seasonings of her choice. Resident 1 liked fruits such as melon, grapes or sliced oranges, and disliked salt as a condiment but preferred black pepper instead. Resident 1 stated she does not like liquid eggs and juice in a box. Resident 1 concerned was to get certain items quickly in the morning.

During an interview with LVN 1 on 11/1/2023 at 11:10 AM, LVN 1 stated the physician ordered Ensure on 9/28/2023 with an indefinite ending date for Resident 1 and Resource 2.0 was also a standing order since 1/25/2023. LVN 1 stated, LVN 4 who worked from 3 p.m. to 11 p.m. was the one who put the order in the medical records.

During an interview with CNA 2 on 11/1/2023 at 11:33 PM, CNA 2 stated Resident 1 ' s appetite was getting less for the past two weeks because she had a lot of pain in her tooth. CNA 2 stated she usually eat tomatoes in the morning and sometimes does not like the food for lunch as it does not taste good. CNA 2 stated, Resident 1 did not drink Resource 2.0 today, but she drank some of it the other days. CNA 2 stated, Resident 1 liked chocolate flavor of Ensure a week ago or so. CNA 2 stated she told the charge nurse and was told Ensure was not available and the facility

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F 692	Continued From page 10	F 692		

only had Boost (brand of high kcal, high protein supplement) and Resource 2.0. CNA 2 stated Resident 1 did not get the Ensure supplement. CNA 2 stated high kcal, high protein shakes were given to residents with weight loss as it contained vitamins (are nutrient needed for growth and development), high protein, and high kcal. CNA 2 stated, Resident 1 was not eating enough nutrients and was not getting the supplement she preferred resulting to more weight loss.

During a concurrent interview with LVN 3 and record review of Resident 1 ' s weight records on 11/1/2023 at 11:53 AM, weight records for Resident 1, indicated 75 lbs on 10/11/2023 and 83 lbs on 8/8/2023. LVN 3 stated Resident 1 liked small portions of food and eat approximately half of the meals. LVN 3 stated, Resident 1 eat some food for lunch and set aside some food for snacks however, Resident 1 did not have a snack order in place. LVN 3 stated Resident 1 refused Resource 2.0 oral supplements a lot of times and that Resident 1 did not want to drink it. LVN 3 stated oral supplements like Resource 2.0 and Ensure provided high kcal, high protein and nutrients for residents who were not eating their meals and were losing weight. LVN 3 stated the possible outcome for resident who were not eating were weight loss and skin injury. LVN 3 stated she was aware of Ensure and Resource 2.0 as two active orders of oral supplement for Resident 1. LVN 3 stated resident 1 got Ensure once in October as she liked it better than Resource 2.0 but cannot recall the exact the date. LVN 3 stated Ensure could have helped Resident 1 prevent weight loss as she will drink it more because it was her preference.

During a phone interview with the Registered

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Dietitian (RD) on 11/1/2023 at 1:00 PM, RD stated she is familiar with Resident 1 ' s weight loss concerns but did not recall going at bedside. RD stated Resident 1 ' s weight loss was discussed in the interdisciplinary meeting on 10/25/2023 and that Resident 1 has low Body Mass Index (BMI, weight to height ratio calculating the degree of obesity and underweight), undergoing treatment for cancer, low PO intake however Resident 1 was on an oral supplementation but she does not exactly recall which type of supplement. RD stated that she was not aware of two oral supplements were ordered by a physician for Resident 1 and didn ' t know that Resident 1 had preference of Ensure to drink. RD stated Ensure would have helped Resident 1 with weight loss.

A review of Resident 1 ' s Progress notes written by RD on 10/25/2023 at 11:01 PM, indicated, Resident 1 assessed on monthly weight variance by Interdisciplinary Team (IDT) for significant weight loss of thirteen (13) lbs in 6 months (14.8%). The weight of Resident 1 at the time of review was 75lbs which was below Resident 1 ' susual body weight (UBW, normal or healthy weight) of 90-95lbs. Resident 1 ' s BMI=13.7 severely underweight status There were multiple interventions in place to prevent weight loss and per Interdisciplinary team (IDT, team consist of different health professionals) to continue monthly weights.

During an interview with Resident 1 on 11/1/2023 at 2:03 PM, Resident 1 stated that facility never got her Ensure but her oncologist gave her 5-6 cans of Ensure last 10/2023 during her oncology visit. Resident 1 stated when she told the facility that she preferred Ensure, she was told that it

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F 692	Continued From page 12 was not in facility formulary (a set of formula, supplements a facility have on hand), and it was not possible to get. Resident 1 stated, she loved the taste of the creamy Ensure dark chocolate but it was unfortunate that facility could not get it. Resident 1 stated, she wanted to get her weight back to 85 lbs and wanted to gain muscles and not just fat. During an interview with LVN 4 on 11/1/2023 at 3:30 PM, LVN 4 stated he placed the order for Ensure on 9/27/2023 and that this order was carried out from Resident 1 ' s oncologist appointment. LVN 4 stated he substituted Ensure with Resource 2.0 as he assumed that the facility did not have Ensure. LVN 4 stated he should have asked the facility if Ensure was available. LVN 4 stated Resident 1 ' s PO intake varied from 70-75% that was why it was important for Resident 1 to drink the supplements. LVN 4 stated Resident 1 ' s weight was low, Resident 1 was on the thin side and oral supplements were necessary to complete the rest of the nutrients Resident 1 was not getting from the rest of the food. LVN 4 stated the possible outcome for Resident 1 not getting all the nutrients needed for the day was weight loss, muscle breakdown, weakness of the bones, loss of important nutrients such as calcium (a nutrient needed for maintenance of bones and teeth), phosphorus (important mineral needed to maintain normal function of the body) and other essential vitamins. LVN 4 stated if Ensure was the Resident ' s preference for oral supplement, it would have helped her prevent further weight loss if she drank it. LVN 4 stated he endorsed the Ensure orders to the upcoming shifts but not sure how it got missed.	F 692		

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F 692	Continued From page 13 During an interview with LVN 5 on 11/1/2023 at 3:51 PM, LVN 5 stated Resident 1 PO intake was minimal because she did not tolerate food much due to pain and lung cancer, it was difficult for Resident 1 to consume food. LVN 5 stated Resident 1 liked and drank liquids as she tolerated it better than solid foods. LVN 5 stated she gave Resident 1 broth and Resource 2.0 in the morning however, Resident 1 only drank half of the Resource 2.0. LVN 5 stated she was not aware Resident 1 prefers to have Ensure than Resource 2.0 as Ensure would have helped Resident 1 lose more weight. LVN 5 stated Resident 1 was given oral supplement and made sure she had all the nutrient she needed and to keep weight stable. LVN 5 stated, "The supplement order fell off through the cracks and I don ' t know why I missed it." LVN 5 stated, Resident 1 might have consumed Ensure with better tolerance if that was her preference. During an interview with Director of Nursing (DON) on 11/1/2023 at 4:09 PM, DON stated she was not aware of Resident 1 ' s weight loss and the two oral supplement order for Resident 1. DON stated "we do not have Ensure here at the facility, so we provided alternative. We usually honor resident ' s preferences of what they need. It was a miscommunication because the LVN monitoring the weights was not aware of the Ensure order. DON stated supplements were given to residents to prevent further weight loss and Ensure will probably help Resident 1 as she would have drank it more than what was given to her. DON stated, she could have discussed resident ' s request with the Administrator, however it was not done because she wasn ' t aware of supplement preference.	F 692		

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F 692	Continued From page 14 During an interview with LVN 1 on 11/1/2023, LVN 1 stated the last laboratory orders for Resident 1 was on 9/29/2023 for complete blood count (CBC, blood test to look at overall health and find a wide range of conditions) with comprehensive metabolic panel (CMP, test that measures 14 different substance in the blood) and LDH (Lactate Dehydrogenase, a type of blood test) and had the following results: Albumin 3.3, Protein 5.9, Hemoglobin 9.5, Hematocrit 28.9. LVN 1 stated there were no recent laboratory weights ordered for Resident 1 ' s weight loss. A review of facility ' s policy and procedure (P&P) titled "Food Preferences" dated 2018, indicated "POLICY: Resident ' s food preferences will be adhered to within reasons. Substitutes for all foods disliked will be given for appropriate food group." "PROCEDURE: Food preferences will be obtained as soon as possible through the initial resident screen. Assessment must be completed within 7 days of admission by the FNS Director. Food preferences will be done as residents ' needs change and/or during the quarterly review. A review of facility ' s P&P titled "Nutritional Screening/Assessment/Resident Care Planning" dated 2020, indicated "POLICY: The resident ' s nutritional status and his nutritional needs will be assessed. A nutritional program specific to his needs will be planned and implemented, and then reassessed periodically for progress. Change in eating habits, difference is eating pattern, eating problems, weight and other problems will be recorded in the dietary progress notes and resident care plan." A review of facility ' s P&P titled "Nutrition (Impaired)/Unplanned Weight Loss-Clinical	F 692		

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F 692	Continued From page 15 Protocol" revised 9/2017 indicated "Treatment/Management (1) the staff and physician will identify pertinent interventions based on identified causes and overall resident condition, prognosis, and wishes. Monitoring: (1) The physician and staff will monitor nutritional status, an individual ' s response to interventions, and possible complications of such interventions (for example, additional weight gain or loss, nausea, or vomiting)."	F 692		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one of 15 sampled residents (Resident 1) was free from significant medication error by failing to ensured licensed staff did not administer oxycodone (a pain-relief medicine used to treat severe pain) with Gabapentin (medication used to treat epilepsy [a disorder of the brain characterized by repeated seizures] also taken for nerve pain) to Resident 15. This deficient practice placed Resident 15 at risk for respiratory depression, coma, and death. Findings: A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 4/28/2021 and readmitted the resident on 12/27/2022 with diagnoses that included chronic obstructive pulmonary disease (COPD- is a	F 760	**F760 Residents Free of Significant Med Errors** • How corrective actions will be accomplished for those residents found to have been affected by the deficient practice: o Resident #1 was assessed by ADON on 11/8/23 for signs and symptoms of CNS depression and sedation due to concurrent administration of Gabapentin and Oxycodone. Resident #1 did not exhibit signs of CNS depression and sedation. Resident #1's attending physician gave orders to continue med to be administered per prescribed orders. • How the facility will identify other residents having the potential to be affected by the same deficient practice: o All residents that are currently on simultaneous	

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F 760	Continued From page 16 common lung disease causing restricted airflow and breathing problems), emphysema (a chronic obstructive pulmonary disease that causes coughing and breathing difficulties), and chronic pain syndrome (CPS- when people have symptoms beyond pain alone, like depression and anxiety, which interfere with their daily lives). A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 8/8/2023, indicated Resident 1 had the ability to understand and be understood. The MDS indicated Resident 1 required extensive assistance with bed mobility, dressing, toilet use and personal hygiene. A review of the Physician ' s Order for Resident 1, dated 9/14/2023, indicated Gabapentin Oral Capsule 400 milligrams (mg - a unit of measurement) by mouth three times a day for CPS resident prefers this time 4 a.m., 12 p.m., and 8 p.m. A review of the Physician ' s Order for Resident 1, dated 8/4/2023, indicated Oxycodone 15 mg by mouth every 4 hours as needed for moderate pain (4 to 6 in the pain scale, with 10 as the highest) and severe pain (7 to 10 in the pain scale). A review of Resident 1 ' s Medication Administration Record (MAR- a report detailing the drugs administered to a patient by a healthcare professional at a treatment facility) for 11/5/2023 at 11p.m. indicated Resident 1 ' s blood pressure was 118/68 (Normal blood pressure for most adults is defined as a systolic pressure of less than 120 and a diastolic pressure of less than 80), pulse rate of 60 (normal range from 60	F 760	administration of Gabapentin and Oxycodone, and/or other pain opioids are affected by the same deficient practice. On 11/8/23 and 11/9/23, the Medical Records Department, DON/ADON did an audit of current residents on similar medications via medical records on PCC on EMAR to identify similar administration deficiencies. None was identified. • What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice will not occur. o In-service was given to licensed nurses by DON and ADON on 11/28/23 and 11/29/23 regarding the consequences of simultaneous administration of medications that have the potential to induce CNS depression and sedation. In addition, they were given reinforcement regarding identifying black box	

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F 760	Continued From page 17 to 100 beats per minute), respiration rate of 17 (normal respiration rates for an adult person at rest range from 12 to 16 breaths per minute), and oxygen saturation of 97 (normal is between 95% and 100%.). A review of Resident 1 ' s MAR on 11/5/2023 indicated Gabapentin 400 mg was given at 4 a.m. and Oxycodone 15 mg was given at 4:11 a.m. A review of the facilities Black Box Warning (is the strictest and most serious type of warning that the FDA gives a medication. A black box warning is meant to draw attention to a medication's serious or life-threatening side effects or risks) indicated concomitant use of opioids with other CNS depressants, may result in profound sedation, respiratory depression, comma, and death. During an interview on 11/7/2023 at 12p.m., Resident 1 stated on 11/5/2023 around 4 a.m. Licensed Vocational Nurse 6 (LVN 6) refused to give her gabapentin and oxycodone. Resident 1 stated LVN 6 informed her that she could not give those two medications together due to it would cause an interaction. Resident 1 stated LVN 6 came in around 4 and gave her the gabapentin then around 4:15 gave her the oxycodone. During an interview on 11/9/2023 at 4:15 p.m. with LVN 6 stated she worked with Resident 1 on 11/5/2023 from 11 p.m. to 7 a.m. shift. LVN 6 stated she did initially refuse to give Resident 1 the gabapentin and oxycodone. LVN 6 stated she educated Resident 1 she could not give the medication because it would suppress her respiration. LVN 6 stated Resident 1 was heavily sedated she had to shake Resident 1 to wake her	F 760	warnings that are visibly present and highlighted next to PCC orders and in the EMARs. o Medical records will assist DON and ADON to do daily audits of medication orders from previous days. o Admission nurses will review and verify admission orders to prevent recurrence of the alleged deficiency and forward admission orders to RN Supervisor for reconciliation. o The pharmacy consultant will do off site review to identify similar occurring deficiencies and report her findings immediately to the DON/ADON and /or schedule monthly DRR visit. • How the facility plans to monitor its performance to make sure that solutions are sustained. o Significant findings will be forwarded to the DON and Administrator and QA monthly for trending and	

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F 760	Continued From page 18 up, initially thought Resident 1 had passed away. LVN 6 stated she did give the oxycodone within 30 minutes after she gave the gabapentin. LVN 6 stated facility is giving into Resident 1 and are going to end up killing her. During a concurrent record review and interview on 11/7/2023, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) stated oxycodone has a black box warning indicating a black box warning with drugs that may cause CNS depression and gabapentin could be one. The ADON stated that the gabapentin was given at 4 a.m. and oxycodone was given at 4:11 a.m. The DON stated that was 11 minutes in between each medication it was given too close in between. The DON stated in this case possibility of CNS depressant, could have risked decrease of respiration, level of consciousness, and sedation. During an interview on 11/15/2023 at 2:36 p.m., the facility's Pharmacist Consultant (PC) stated only complaint for giving oxycodone with gabapentin is if the resident is dizzy, drowsy and or is having difficulty breathing. The PC stated if the resident is having these complaints can be a risk for further respiratory depression and sedation. A review of the facility ' s policies and procedures titled, "Medication Administration," indicated medications are administered in accordance with the written orders of the attending physician.	F 760		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy.	F 803	**F 803 : Menus Meet Resident Needs / Prep in Advance / Followed** ***Immediate corrective action(s) for those Residents affected by the deficient practice.***	***Completion Date(s):***

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F 803	Continued From page 19 Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow menu for residents when: - Ninety (90) out of two hundred forty-seven (247) residents on soft mechanical chopped meats diet got of big pieces of chicken that measured one and a half inches (1 ½") to two (2) inches in size. - Ten (10) out of 247 residents on regular diet got 2 oz of chicken with rosemary sauce instead of 3 oz and 1 oz of boiled potatoes instead of 4 oz.	F 803	On 11-02-23 the FSD visited resident1 to re-evaluate her food preferences, which includes seasoning-fresh chopped onions to be added on her meal tray. Resident 1 was seen by RD on 11-17-23 to evaluate and reassessed resident's Diet, type ordered by her physician is serve and prepared as indicated Fortifies Soft Mechanical Chopped meat to help her chewing and swallowing issues, ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken.*** On 12.4.23, the DON or designees reviewed residents on mechanical chopped meats diet who were served with big pieces of chicken to ensure no one had difficulty eating, swallowing, or choking episode between 10.31.23 to 11.1.23. Currently, there **105 residents** on mechanical chopped meats diets. No finding of difficulty of eating, swallowing, or choking. On 12.4.23, the DON or designee reviewed residents on regular diet served to ensure they did not have any significant weight loss for the month of November 2023. Currently, there are **92 residents** on regular diets. Any findings were reported to their attending physician for appropriate intervention.	11-02-23 11-17-23 12-04-23 12-04-23

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F 803	Continued From page 20 These deficient practices had the potential to decreased nutritional value for carbohydrate, and protein content not consistent to the physician ' s diet order. Furthermore, soft mechanical chopped diet receiving 1 ½ to 2" of meat may result to difficulty eating, swallowing, and choking (blocked airway causing difficulty in breathing) which decreased food intake resulting to weight loss. Findings: During an interview with Resident 3 on 10/31/2023 at 10:23 AM, Resident 1 stated the menu was not accurate with what was written and what was served for type of food and portions. Resident 1 stated she received some type of macaroni and tomato sauce, a big red-hot dog, a little relish and mustard yesterday but did not know what it was exactly. Resident 3 stated, "I didn ' t like the food." A review of Resident 3 ' s Admission Record, dated 10/31/2023, indicated Resident 3 was admitted to the facility on 7/19/2023 with diagnoses including malignant neoplasm of colon (cancer of the large intestines), diabetes mellitus (DM type 2, increase blood sugar) and essential hypertension (HTN, high blood pressure). A review of Resident 3 ' s Minimum Data Set (MDS - a standard assessment and care screening tool), dated 10/25/2023, indicated Resident 3 had moderately impaired cognition (ability to understand and make decisions), and able to eat with supervision. A review of Resident 3 ' s diet type report order by Physician, dated 8/8/2023 indicated Fortified	F 803	***Facility measures and systemic changes to ensure the deficient practice does not recur.*** On 11.28.23, an inservice was provided to all Food Service Staff by the RD&FSD on the following: 1. Recipe Compliance Adherence. 2. Liberalized Diets. 3. Mechanical Soft Textures. 4. Food Portion, Sizes; and 5. Resident Rights These inservices were provided to ensure menus are followed, prepared in advance and food servings are provided in appropriate size and portion to meet residents' nutritional needs in accordance with established national guidelines. ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process.*** FSD/DSS will conduct Weekly Test Tray and RD will conduct monthly Test Tray during her monthly visits and audit review x 3 months. Findings will be reported to the QA Committee. On 11-29-23 A New Qualified Dietary supervisor was hired and started on 12-04-23 to oversee and managed our food Service Dept. **Completion Date**: 12-07-23	11-28-23 12-07-23

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F 803	Continued From page 21 (adding high kcal, high protein food items to the tray such as butter, milk, margarine, etc.) consistent carbohydrate (CCHO, diet that contain consistent carbohydrate amounts in each meal), regular texture with thin liquid consistency. During an interview with Resident 1 on 10/31/2023 at 10:38 AM, Resident 1 stated the menu was not followed regularly, portion sizes were usually not followed when trays were served. A review of Resident 1 ' s Admission Record, dated 10/31/2023, indicated Resident 1 was initially admitted to the facility on 4/28/2021 and then readmitted on 12/27/2022 with diagnoses including malignant neoplasm of upper lobe, right bronchus or lung (a type of lung cancer that begins in the upper part of the right lung), chronic obstructive pulmonary disease (COPD, a lung disease characterized by persistent cough and progressive breathing) and unspecified protein-calorie malnutrition (a condition of insufficient intake of protein and calories resulting to weight loss, muscle loss and impaired growth and development). A review of Resident 1 ' s MDS, dated 8/8/2023, indicated Resident 1 was cognitively intact (able to understand and make decisions), able to eat with limited assistance, and needed one-person physical assist when eating. A review of Resident 1 ' s diet type report order by Physician, dated 7/18/2023, indicated Fortified soft mechanical chopped meat (a diet including foods that are chopped to help residents having chewing and swallowing issues), regular thin liquid consistency.	F 803		

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F 803	Continued From page 22 A review of facility ' s lunch menu (a list of available foods served for each resident), on 10/31/23, the following items will be served on regular diet: - Baked chicken 3 ounces (oz, a unit of measurement) - Rosemary Sauce 1-2 oz - Boiled red potatoes ½ cup (c) - Seasoned peas ½ c - Parsley garnish - Plain bread 1 piece (pc) - Margarine 1 teaspoon (1 tsp) - Ice Cream #12 scoops (3 oz) - Milk 4 oz A review of facility ' s lunch on 10/31/23, the following items will be served on soft mechanical chopped meats diet: - Chopped baked chicken 3 oz - Rosemary sauce 1-2 oz - Soft Boiled red potatoes 4 oz - Seasoned peas ½ c - Plain ice cream 3 oz	F 803		

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F 803	Continued From page 23	F 803		

During trayline (area used to plate food of the residents) observation, on 10/31/2023 at 12:18 AM, 10 trays received four (4) small pieces of boiled red potatoes, and one (1) small piece of chicken on regular diet trays.

During a concurrent observation of the weight of the chicken and potatoes using a weighing scale and interview with the Dietary Supervisor (DS) on 10/31/2023 at 12:30 PM, chicken with rosemary sauce weighed 2 oz and potatoes weighed 1 oz. DS stated the chicken should be weighing 3 oz, rosemary sauce 1-2 oz and potatoes 4 oz which was not the correct portion for the residents.

During a concurrent observation of the soft mechanical chopped trays and concurrent interview with the DS, on 10/31/2023 at 12:50 PM, Cook 1 chopped the chicken and used the tong to portion it. Chopped chicken measured 1 ½" to 2" in size. DS stated the portion size for soft mechanical chopped chicken was 3 oz and that Cook 1 estimated what was served to the resident ' s tray was not accurate. DS stated resident won ' t be meeting the nutrients they needed and will result to weight loss due to lesser calorie and protein served. DS stated Cook 1 should be using a scoop for accuracy instead of tong.

During an observation of the resident ' s tray with soft mechanical chopped diet for Resident 4 on 10/31/2023 at 1:19 AM, Resident 4 tray was served 1.5" by 1.5" (1.5" x 1.5") cube chicken pieces.

During an observation of the resident ' s tray with soft mechanical chopped diet for Resident 5 on 10/31/2023 at 1:20 AM, Resident 5 tray was

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F 803	Continued From page 24 served 2" x 2" cube chicken pieces. During the same observation of the resident ' s tray with soft mechanical chopped diet for Resident 6, Resident 6 tray was served 1.5" x 2" of long strips sliced chicken. During an observation of the resident ' s tray with soft mechanical chopped diet for Resident 7 on 10/31/2023 at 1:25 AM, Resident 7 tray was served 1.5" x 1.5" pieces of chicken. During an observation of the resident ' s tray with soft mechanical chopped diet for Resident 8 on 10/31/2023 at 1:30 AM, Resident 8 tray was served 1.5" x 1.5" cube chicken pieces and 2"x2" long strips of sliced chicken. During the same observation of the resident ' s tray with soft mechanical chopped diet for Resident 9, Resident 9 was served 1.5"x 1.5" of chicken pieces. During an interview with Cook 1 on 10/31/2023 at 2:05 PM, Cook 1 stated regular diet received 3 oz of baked chicken but does not know the portion size for soft mechanical diet. Cook 1 stated mechanical soft diet was chopped and that it should be cut to a bite sized but doesn ' t follow a measurement. Cook 1 stated that it is important to chop the meat because residents on soft mechanical chopped meat were at risk of chocking. During a test tray observation for soft mechanical diet conducted with the DS on 10/31/2023 at 2:05 PM, soft mechanical tray contained 1.5" x 1.5" and 2" x 2" of chicken portions. DS stated soft mechanical diet are for resident with having difficulty using their hands when they have arthritis, hand fracture and dentition problems (difficulty chewing). DS stated the guidance of	F 803		

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F 803	Continued From page 25	F 803		

meat sizes for soft mechanical diet is 1" or less as it becomes a safety issue if it was served bigger. DS stated possible outcome was the risk of residents cocking and won ' t be able to eat the food if portions are bigger than 1".

During an interview with the DS on 11/1/2023 at 10:04 AM, DS stated soft mechanical diet was not properly chopped and portioned by Cook 1 yesterday.

During an interview with Cook 1 on 11/1/2023 at 2:53 PM, Cook 1 stated the portion size for soft mechanical chopped chicken for yesterday ' s lunch was 3 oz. Cook 1 stated the DS told her about the portion sizes as well as the size of the meat should be 1 inch or less for soft mechanical chopped diet. Cook 1 stated resident were at risk for chocking if they were given bigger sizes of chicken.

A review of facilities ' document titled, "Addition to the Spreadsheet Regarding the Diet Order Chopped Meat, not dated and signed by the facility Registered Dietitian on 4/14/2020, indicated, "Description: A diet may read regular with chopped meat or mechanical soft with chopped meat. In place of any whole meats the cook will chop the meat 1 inch or less in size unless otherwise specified for either diet.

A review of facility ' s document titled, "Regular Mechanical Soft Diet," dated 2020, indicated, "DESCRIPTION: The Mechanical Soft diet is designed for residents who experienced chewing or swallowing limitations. The regular diet is modified in texture to a soft, chopped or ground consistency as per foods below."

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F 803	Continued From page 26 Foods Avoided for Meats, Poultry and Fish: Whole or chopped meat. Dry meat (chopped meat only allowed when ordered by Speech therapist). A review of the facilities ' document titled "Recipe: Chicken with Rosemary Sauce" not dated, indicated, "Special Diets: Mechanical Soft" Grind Chicken #10 scoop, serve with sauce." A review of the facilities ' Policies and Procedures (P&) titled "Menu Planning" dated 2020, indicated, "(4) The menus are planned to meet nutritional needs of the residents in accordance with established nutritional guidelines, physician ' s orders and, to the extent medically possible.	F 803		
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 temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved flavor and appearance. In addition, food portions were not correct. This deficient practice placed two hundred one (201) of two hundred forty-seven (247) facility residents at risk of unplanned weight loss, a consequence	F 804	**F 804: Nutritive Value/Appear, Palatable/Prefer temp** ***Immediate corrective action(s) for those Residents affected by the deficient practice.*** On 11-02-23 the FSD spoke with resident 1 regarding her food preferences, food seasoning, food size served one tray was prepared with recipe compliance. Resident 1 Diet was reviewed to ensure. Food serves met the resident's preferences with garnished compliance. ***Plan / Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken.*** As of 12.5.23, the DON or designees reviewed the residents receiving PO diets to ensure they did not have any significant weight loss for the month of November 2023. Currently, there are **215 residents** on **PO**	***Completion Date(s):*** **11-02-23** **12-05-23**

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F 804	Continued From page 27 of poor food intake. Findings: During an interview with Resident 1 on 10/31/2023 at 10:38 AM, Resident 1 stated the menu was not followed regularly, portion sizes were usually not followed when trays were served, and food lacked taste and seasoning. Resident 1 stated the menu sounds delicious in paper but it is not edible. Resident 1 stated, the kitchen served huge servings of starch like rice and pasta and fish was covered with large portions of breading. Vegetables such as green beans do not have any seasonings, zesty spinach was not zesty, and the tuna tasted like cardboard. Deli meats that they used in sandwiches were thin slices of meat and even the gasoline station sandwiches were better compared to what the kitchen served. Resident stated, "What I eat is important and I am losing weight in the last month." A review of Resident 1 ' s Admission Record, dated 10/31/2023, indicated Resident 1 was initially admitted to the facility on 4/28/2021 and then readmitted on 12/27/2022 with diagnoses including malignant neoplasm of upper lobe, right bronchus or lung (a type of lung cancer that begins in the upper part of the right lung), chronic obstructive pulmonary disease (COPD, a lung disease characterized by persistent cough and progressive breathing) and unspecified protein-calorie malnutrition (a condition of insufficient intake of protein and calories resulting to weight loss, muscle loss and impaired growth and development). A review of Resident 1 ' s Minimum Data Set	F 804	**diet.** (18= on Puree, 105 Mech. Soft Diet, and 92 Regular Diet) Findings were reported to their respective attending physician for appropriate intervention. ***Facility measures and systemic changes to ensure the deficient practice does not recur.*** On 11-28-23 an In-Service was provided to ALL Food Service Staff by RD<FSD/DSS regarding: 1. Food Garnishing & Tray Presentation 2. Food Portion Sizes 3. Tray line Accuracy All food Staff Members also completed the corresponding Quizzes with 100% pass rate to measure Staff Level of Competency ***Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process.*** The FSD/DSS and or Designee will monitor weekly for 3 months and report any Significant findings will be reported to Administrator and Q/A committee monthly X (3) months for analysis and recommendations. **A New Qualified Dietary Supervisor was hired on 11-29-23 and started 12-04-23 to Over the full operation and managed the Dietary Dept.** **Completion Date** : 12-07-23	11-28-23 12-07-23 12-04-23 12-07-23

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F 804	Continued From page 28 (MDS - a standard assessment and care screening tool), dated 8/8/2023, indicated Resident 1 was cognitively intact (able to understand and make decisions), able to eat with limited assistance, and needed one-person physical assist when eating. A review of Resident 1 ' s diet type report order by Physician, dated 7/18/23, indicated Fortified Regular (adding high kcal, high protein food items to the tray such as butter, milk, margarine, etc), soft mechanical chopped meat (a diet including foods that are chopped to help residents having chewing issues), regular thin liquid consistency. A review of the facility ' s fall menu spreadsheets dated 10/31/2023, indicated regular diet included the following food items on the tray: Baked chicken 3 ounces (oz, unit of measurement) Rosemary Sauce 1-2 oz Boiled Red Potatoes ½ cup (c) Seasoned Peas ½ c Parsley garnish Plain Bread 1 pc Margarine 1 teaspoon (tsp) Ice cream 3 oz Milk 4 oz During trayline (an area for food assembly)	F 804		

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F 804	Continued From page 29	F 804		

service in the kitchen observation on 10/31/2023 at 12:18 PM, kitchen staff started dishing resident food from the steam table (a kitchen equipment used to keep food hot at the proper temperature) to the resident plates. Boiled red potatoes looked mushy and portion sizes were 3 to 4 pcs small pieces of potatoes. Chicken portion size is 1 pc small chicken. Kitchen staff were using the following in portioning food items:

- Tong (an instrument with two movable arms that are joined together at one end, used to picking p and holding food) to portion chicken.

- 2 oz ladle to portion rosemary sauce,

- 4 oz perforated spoodle (a serving spoon to aid with draining excess liquid from food) to portion boiled red potatoes.

During a concurrent observation of weighting of the food on the tray and interview with the Dietary Supervisor (DS) on 10/31/2023 at 12: 30 PM, chicken with rosemary sauce weighed a total of 2 oz, boiled potatoes weighed 1 oz. DS sated the chicken was lacking 1 oz in portion or more and potatoes were missing 3 oz more.

During an interview with the DS on 10/31/2023 at 12:50 PM, DS stated that the cool was not using a scoop to portion the chicken and was estimating the amount to put on the tray. DSS stated some trays received small portions of chicken than 3oz which means residents got less protein on their tray. DS stated the resident would not be meeting the nutrients they needed and may cause weight loss.

During a test tray conducted with on 10/31/2023

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F 804	Continued From page 30	F 804		

at 2:05 PM for regular diet, DS stated that the presentation of the food does not look appetizing because the sliced bread was on top of the food touching all the main food such as chicken, rosemary sauce, potatoes, and seasoned peas. DS stated the chicken breast was tough, dry and boiled potatoes were bland and needed a little bit seasoning. DS stated bread should be individually packed and served on the side and food should be garnished. DS stated when chicken was dry and tough, it will be hard to chew causing resident not to eat the food causing unintentional weight loss.

During an interview with Cook 1 on 11/1/2023 at 2:53 PM, Cook 1 stated that she got training about scoops sizes, portions, diets and always following standardized recipes. Cook 1 stated she followed the recipe for boiled potatoes and seasoned it however she did not season it with parsley and used a little bit of margarine instead. Cook 1 stated not following the recipes will result in a different taste and resident wont like it as it wont taste the same and wont be tasty. Cook 1 stated, residents might lose weight if they don ' t like the food. Cook 1 also stated that using a tong is not appropriate in measuring the chicken and it was hard to gauge if residents were getting what they are supposed to be getting. Cook 1 stated if residents received more chicken, it could cause unplanned weight gain and if residents received less chicken, it could cause unplanned weight loss. Cook 1 stated, she needed to use the right scoop sizes in trayline.

A record review of the facility ' s recipe titled, "Recipe: Boiled or Steamed Potatoes" not dated, indicated "Portion size: ½ cup ingredients: red or white potatoes, boiling water, margarine, parsley,

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F 804	Continued From page 31 minced." A record review of the facility ' s policies and procedures (P&P) titled, "Food Preparation," dated 2018, indicated, "Policy: Food shall be prepared by methods that conserve nutritive value, flavor and appearance. Procedure: (1) The facility will use approved recipes, standardized to meet the resident census. This count is to be kept current so that an accurate amount of food is prepared. (2) Recipes are specific to portion yield, method of preparation, amounts of ingredients, and time and temperature guide. (4) Poorly prepared food will not be served. Such food is to either be improved, prepared again, or replaced with an appropriate substitution. May add increased amounts of herbs and spices (not salt) since potency of products may vary." A record review of the facility ' s policies and procedures titled, "Recipe: Menu Planning," dated 2018, indicated, "To meet recommended daily dietary allowances. Protein Group: serve two or more servings everyday to equal at least 6 oz of cooked meat or the equivalent. One serving is three (3) ounces of cooked meat, fish, or poultry without bone or fat. All kinds of meat, fish, and poultry, eggs, dried beans or peas, lentils, and peanut butter are included in this group."	F 804		