STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555438	A. BUILDING _____ B. WING _____	12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEI-AI LOS ANGELES HEALTHCARE CENTER	2221 LINCOLN PARK AVE LOS ANGELES, CA 90031

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of two Complaints and six Facility Reported Incidents (FRI) during an annual Recertification Survey visit conducted on 12/28/2023. Complaint Numbers: CA00873791 and CA00873831 Facility Reported Incident Numbers: CA00865953, CA00872440, CA00872728, CA00873736, CA00873958 and CA00874555. Representing the Department of Public Health: Surveyor ID:38740 Surveyor ID:40994 Surveyor ID:43851 Surveyor ID:44253 Surveyor ID:44309 Surveyor ID:47883 Total Resident Census: 271 Total Resident Sample: 62 Highest Severity and Scope: J One deficiency was written for CA00873831 (Refer to FTag F804). One deficiency was written for CA00873958 (Refer to FTag F689), due to: On 12/27/2023 at 9:51 AM, an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause,	F 000	**F-554 (D)** **RIGHT SELF-ADMINISTER MEDS-CLINICALLY APPROP** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** RN Supervisor removed the bottle of Tamsulosin medication and an Albuterol inhaler from Resident 232's bedside immediately on 12/14/2023 and was given back to family. A Self-Administration Assessment was completed by RN Supervisor on 12/14/2023. Director of Nursing (DON)/ Designee conducted a series of in-service/ training and re-education to nursing staff (RNs/ LVNs) on 1/16/2024 thru 1/19/2024 and on-going, about medication administration process in accordance to facility's policy and standard scope of practice, emphasis on purpose and importance of ensuring that medication should not kept at bedside nor leaving them unattended in any circumstances, regardless whether the medication is from outside Pharmacy or owned by Resident. Director of Staff Development (DSD)/ Designee conducted a series of in-service/ training and re-education to nursing staff (CNAs) on 1/19/2024 and on-going, about identifying medication administration by residents and their duty to notify the Charge Nurse immediately. This in-service/ training will be conducted monthly x 3 then annually and as needed thereafter.	1/23/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin — (X6) DATE: 1/20/24

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 000	Continued From page 1 serious injury, harm, impairment, or death to a resident) was identified in the presence of the Administrator (ADM) and Director of Nursing (DON), Operation Resource regarding the facility's failure to identify and provide supervision for Resident 458, who had a diagnosis of dementia, required a 1:1 sitter as ordered, and care planned and failed to develop a care plan for Resident 458's non-compliance with the abduction pillow. An Extended Survey was also conducted with no additional deficiencies.	F 000	**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 1/17/2024 and 1/18/2024 all residents' rooms were checked by facility staff to see if there is/are medication left at bedside. Residents who have found to have medication(s) at bedside will be assessed for ability to self-administration. One other Resident was found with Medication at Bedside. Medication was removed and Resident was assessed for ability to self-administer on 1/19/2024. be affected by this deficient finding.	1/23/24
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one of two sampled residents (Resident 232) was not allowed to keep medications at the bedside without a physician's order and without assesing the resident's ability to self-administer medications. This deficient practice had a potential to result in the resident to self-medicate himself and for other residents to take unprescribed medication. Findings: A review of the admission record indicated the facility admitted Resident 232 on 8/8/2023, with diagnoses including dementia (loss of memory,	F 554	**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** Administrator/ Designee will schedule a room/ area rounds 5x a week for 2 weeks, then 3x a week for 2 weeks then randomly, at least 2x a week thereafter. Room Rounders will check room for any unattended medication(s). If unattended medication is found, then the Room Rounder will immediately notify the Charge Nurse and check PCC for a Self-Administration of Medication Assessment.	

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F 554	Continued From page 2 thinking and reasoning), chronic bronchitis (long term inflammation of the lungs) and benign prostatic hyperplasia (BPH- a condition that occurs when the prostate gland enlarges, potentially slowing or blocking the urine stream). A review of Resident 232's Care Plan related to altered thought process, initiated on 8/26/2023, indicated Resident 232 had periods of short and long-term memory problem and periods of forgetfulness. A further review of the care plan indicated interventions that included to explain all procedure and treatments to the resident, observe/report changes in cognitive status, increasing confusion, increase in forgetfulness and a change in communications skills. A review of Resident 232's history and physical (H&P), dated 8/9/2023, indicated Resident 232 had fluctuating capacity to understand and make decisions. A review of Resident 232's Quarterly Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 11/11/2023, indicated the resident had moderate cognitive (ability to acquire and understand knowledge) impairment and required substantial assistance with oral hygiene, toileting, dressing lower body and personal hygiene and required supervision with eating. A review of the Order Summary Report, dated 11/30/2023, indicated the physician ordered Resident 232 to receive the following medications: -Dulcolax suppository 10mg insert 1 dose rectally every 24 hours as needed for constipation on 8/8/2023	F 554	Director of Nursing (DON)/ Designee conducted a series of in-service/ training and re-education to nursing staff (RNs/ LVNs) on 1/16/24 thru 1/19/24 and on-going, about medication administration process in accordance to facility's policy and standard scope of practice, emphasis on purpose and importance of ensuring that medication should not kept at bedside nor leaving them unattended in any circumstances, regardless whether the medication is from outside Pharmacy or owned by Resident. This in-service/ training will be conducted monthly x 3 then annually and as needed thereafter. Director of Staff Development (DSD)/ Designee conducted a series of in-service/ training and re-education to nursing staff (CNAs) on 1/19/2024 and on-going, about identifying medication administration by residents and their duty to notify the Charge Nurse immediately. This in-service/ training will be conducted monthly x 3 then annually and as needed thereafter.	1/23/24

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F 554	Continued From page 3 -Dulcolax suppository 10mg insert 1 dose rectally every 24 hours as needed for constipation on 8/8/2023 -Albuterol sulfate inhalation aerosol solution two puffs orally every 6 hours as needed for shortness of breath or wheezing for three months on 11/21/2023 -Flomax 0.4mg orally by mouth at bedtime for BPH on 11/21/2023 -Colace 100mg take 2 capsules (for a total of 200mg) orally once a day for bowel management on 11/21/2023. A further review of the order summary report indicated there was no physician order that allowed for the resident to self administer medications. A review of Resident 232's clinical record indicated there was no documented evidence the resident was assessed for self-administration of any medications. During an observation on 12/11/2023 at 9:11 AM, Resident 232 placed a plastic disposable cup with pills in his bedside drawer. During a concurrent interview and observation on 12/14/2023 at 10:47 AM at Resident 232's bedside, a bottle of medication labeled Tamsulosin (brand name Flomax) was observed inside Resident 232's bedside drawer. The resident stated he received the medication from his doctor during a doctor's appointment and the medication was for his urination. Resident 232 stated he only takes medication from the nursing staff. During a concurrent interview and observation on	F 554	**How the facility will monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.** Findings from room rounds/ observation reports will be presented to QA Committee for further resolution and recommendations for the first 3 months, then quarterly thereafter if no negative trends are found. Huddle Report Form will be reviewed in the Daily Clinical Meeting. This correction will be monitored by the Administrator /Designee for continuous compliance. **Completion date: 1/23/2024**	1/23/24

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F 554	Continued From page 4	F 554		

12/14/2023 at 10:55 AM at Resident 232's bedside, Licensed Vocational Nurse 1 (LVN 1) stated the resident had a bottle of Tamsulosin, an albuterol inhaler and some unknown medication in his bedside drawer. LVN 1 stated the medications were not from the facility pharmacy and the resident had a current order to take Flomax and albuterol inhaler. LVN 1 stated the medications should not be at Resident 232's bedside. LVN 1 stated Resident 232 refused the inhaler at times and the possible danger from the resident having medication at his bedside was that he could take larger doses of his ordered medications.

During a concurrent interview and record review of Resident 232's medical record on 12/14/2023 at 11 AM, Registered Nurse Supervisor 2 (RN 2) stated Resident 232 told her the unknown medication in the blister pack in his drawer was a laxative. RN 2 further stated, Resident 232 stated he did not use the albuterol inhaler in his drawer, however his inhaler reads as having 80 inhalations left out of the 200 the inhaler holds. RN 2 further stated, "A self-administration medication assessment has to be completed prior to anyone keeping medication at their bedside and then there has to be a doctor's order for residents to have medications at the bedside." RN 2 further stated Resident 232 had not been assessed for keeping medications at his bedside and did not have a doctor's order to keep medications at his bedside.

During an interview on 12/15/2023 at 11:29 AM, the director of nursing (DON) stated, we have to do an assessment for self-administration of medication for residents to have medications at the bedside. The DON stated a possible adverse

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F 554	Continued From page 5 outcome from having medications at the bedside was the resident can take all the medication or another resident could take the medications. A review of the facility's policy and procedure titled, "Self-Administration of Medications," revised 11/2023, indicated as part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications were clinically appropriate for the resident. It also indicated self-administered medications must be stored in a safe and secure place, which was not accessible by other residents. If safe storage was not possible in the resident's room, the medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room. Nursing will transfer the unopened medication to the resident when the resident requests them.	F 554	**F-558 (D)** **REASONABLE ACCOMMODATIONS NEEDS/ PREFERENCES** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Resident 146's call light was immediately replaced to tap button call light by Maintenance Supervisor on 12/13/23. Resident 146 was evaluated by the Director of Rehab (DOR) to see if the tap button call light was appropriate on 12/29/23 and was able to return demonstrate the use the tap button call light to call for help effectively. In-service/ training and re-education was provided to nursing staff (LVNs / RNs) byDirector of Nursing (DON)/ Licensed Designee on 1/16/2024 thru 1/19/2024 about the purpose of the use of call light to call for help/ assistance and importance of evaluating resident's ability to call for help using the device and providing appropriate type of call light based on their physical and cognitive ability in accordance so the resident's individual needs and preferences will be accommodated to the extent possible.	1/23/24
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure one sampled resident (Resident 146) had an adaptive call light. This deficient practice placed the resident at risk of not receiving the necessary care and services. Findings:	F 558		

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F 558	Continued From page 6 A review of Resident 146's admission record indicated the facility admitted Resident 146 on 8/4/2020 and readmitted him on 10/4/2021 with diagnoses including disorder of the autonomic nervous system (a condition that disrupts automatic body processes such as blood pressure and heart rate), muscle weakness, and a history of falling. A review of Resident 146's Care Plan, created on 10/5/2021 and revised on 3/6/2023, indicated that because Resident 146 was at moderate risk for falls and injury related to limitation of mobility, all things needed by the resident should be within reach, including the call light. A review of Resident 146's History & Physical, dated 10/19/2023, indicated Resident 146 had the capacity to understand and make decisions. A review of Resident 146's Minimum Data Set (MDS - an assessment and care screening tool) dated 11/4/2023, indicated Resident 146 had intact cognition (the mental process that take place in the brain, including thinking, attention, language, learning, memory, and perception). The MDS also indicated Resident 146 required maximal assistance with bed mobility, transferring, locomotion on and off the unit, dressing, toilet use, and personal hygiene. A review of Resident 146's Fall Risk Assessment, dated 11/16/2023, indicated Resident 146 was at moderate risk for falls. During a concurrent observation and interview, on 12/12/2023 at 2:43 P.M., Resident 146 stated he could not press the call light because his fingers	F 558	**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 12/29/203, 1/2/2024 and 1/16/2024, Director of Rehab (DOR/ licensed designee (OTR) checked the call lights of all residents (in-house) identified with functional limitation or contracture on both arms/ hands see if type of call light they are currently using is appropriate based on their physical ability. physician. No other resident affected by this deficient finding. There are 7 Residents identified with functional limitation and need appropriate call light equipment accommodating their physical needs. 7 Residents were screened by OTR and Maintenance Supervisor provided appropriate call light device suitable for Resident physical needs. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** Administrator/ Designee will schedule a room/ area rounds 5x a week for 2 weeks, then 3x a week for 2 weeks then randomly, at least 2x a week thereafter. Room Rounders will check if call light is within resident's reach and if resident is able to use the device appropriately.	1/23/24

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F 558	Continued From page 7 were contracted. He stated he had to push the call light button against the bed rails. Resident 146's call light button was looped on the left side-rail at the head of the resident's bed. Licensed Vocational Nurse 8 (LVN 8) stated the resident should have an adaptive call light because the resident had a hard time pushing a regular call button. LVN 8 stated this deficient practice could also cause Resident 146 to fall. During an interview on 12/13/2023 at 11:43 A.M., the Minimum Data Set Coordinator (MDSC) stated the call light should always be within reach of the residents and an adaptive call light had to be provided to residents who had difficulty using the regular call light, otherwise residents would not be able to get help when they need something. The MDSC stated the resident can also fall if the resident tried to reach them. During an interview on 12/13/2023 at 10:28 A.M., the Director of Nursing (DON) stated the call light was the residents' tool to ask for assistance. The DON stated that to accommodate individual needs an adaptive device had to be provided to residents who had difficulty using the regular one. The DON stated there would be a delay in care and we would not know what the residents need if the call light was not within reach. The DON stated that this deficient practice had the potential to result in residents having accidents such as falls. A review of the facility's recent policy and procedure titled, "Answering the Call Light," last reviewed on 12/2023, indicated to "Place a call device within resident's reach before leaving room."	F 558	In-service/ training and re-education will be provided to nursing staff (RNs, LVNs/ CNAs) by Director of Rehab (DOR)/ Licensed Designee about the purpose of the use of call light to call for help/ assistance and importance of evaluating resident's ability to call for help using the device as well as providing appropriate type of call light based on their physical and cognitive ability in accordance so that resident's individual needs and preferences will be accommodated to the extent possible. In-service training/ re-education will be conducted monthly x 3 months, then annually and as needed thereafter. **How the facility will monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.** Findings from room rounds/ observation reports will be presented to QA Committee for further resolution and recommendations for the first 3 months, then quarterly thereafter if no negative trends are found. Huddle Report Form will be reviewed in the Daily Clinical Meeting. This correction will be monitored by the Administrator /Designee for continuous compliance. **Completion date: 1/23/2024**	1/23/24

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F 558	Continued From page 8 A review of the facility's recent policy and procedure titled, "Quality of Life- Accommodation of Needs," last reviewed on 11/2023, indicated "The resident's individual needs ... including the need for adaptive devices shall be evaluated upon admission and reviewed on an ongoing basis."	F 558		1/23/24
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is	F 582	**F582 – Medicaid / Medicare Coverage / Liability Notice** **How corrective action(s) will be accomplished for resident (s) found to have been affected by the deficient practice** Resident 169 is still in the facility as a custodial resident. SSD on 1/17/2024 contacted the responsible party for resident no 169 and provided information about the Expedited Review process using the Notice of Medicare Non-Coverage (NOMNC) letter and the Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN). SSD sent via certified mail the NOMNC. Director of Nursing conducted an assessment on resident 169 on 1/17/2024. The assessment yielded no negative impact observed during the resident's continued stay in the facility. An in-service was conducted by the MDS Resource Consultant on 1/16/2024 to the members of the Social Services / Discharge Planning Department on the use of the Beneficiary Notices – both NOMNC and SNF ABN.	

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F 582	Continued From page 9 reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide one of three sampled residents (Resident 169) the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN - provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility) and Notice of Medicare Non-Coverage (NOMNC - notification of termination of covered care) forms. For Resident 169, who did not have the capacity to understand or make decisions, the facility failed to mail the beneficiary forms by certified mail with return receipt to Resident 169's	F 582	**How facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** MDS Resource Consultant conducted a comprehensive review of all residents discharged from Medicare skilled coverage for the past six (6) months with remaining benefit days on 1/17/2024. The review focuses on the appropriateness of the issuance of the NOMNC and SNF ABN. No other residents were impacted by the deficient practice. **What measures will be put in place or systemic changes the facility will make to ensure that the deficient practice does not recur:** The Medical Records Director will conduct a review on the compliance on the issuance of beneficiary notices (NOMNC and SNF ABN) monthly for 3 months. The Medical Records Director will report and discuss the result of the monthly beneficiary notices compliance audit to the QA Committee during regularly scheduled meeting. The Medical Records Director will report the findings and implemented corrections during the facility's regularly scheduled QA Committee Meeting The Beneficiary notices audit will consist of the following measures • Evidence of appropriate and timely beneficiary notice notification • Evidence of appropriate communication to the resident and / or responsible party • Evidence appropriate alternate beneficiary notification, documentation and recording (direct phone contact, certified mail/ return receipt)	1/23/24

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	555438	A. BUILDING _____ B. WING _____	12/28/2023

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F 582	Continued From page 10 responsible party. This deficient practice had the potential to result in Resident 169's responsible party not receiving the information needed to decide if she would like to continue receiving or refuse specific skilled services for Resident 169 and have those options honored. Findings: A review of the admission record indicated the facility admitted Resident 169 on 5/31/2023 with diagnoses including schizophrenia (a serious mental disorder in which people interpret reality abnormally), bipolar disorder (a mental disorder that causes dramatic shifts in a person's mood or energy, and may affect the ability to think clearly) and Huntington's Disease (a genetic disease that damages the brain and affects one movement, cognition and mental health). A review of the history and physical dated 6/2/2023, indicated Resident 169 did not have the capacity to understand and make decisions. A review of Resident 169's SNF Beneficiary Protection Notification Review Form indicated the resident's last covered Medicare Part A Skilled Services was 6/16/2023 and the SNFABN and NOMNC forms were provided to the resident. A review of Resident 169's SNFABN form indicated the form was not signed by the resident or an authorized representative. A further review of the form indicated there was a handwritten note indicating, "SSD [Social Services Director] left a detailed voicemail to allow for follow up communication as contact information was also provided."	F 582	**How the facility plans to monitor its performance to make sure that solutions are sustained Compliance to be achieved with corrective action by:** Administrator will review and monitor facility's overall compliance on this measure every month for 3 months at the QA Committee Meeting or until compliance is sustained. The Administrator together with the QA Committee will conduct root cause analysis of any non-compliance during the regularly scheduled monthly meeting and develop and deploy improvement actions when necessary. **Completion date: 1/23/2024**	1/23/24

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F 582	Continued From page 11 A review of Resident 169's NOMNC indicated the resident's current skilled nursing services would end on 6/16/2023 and that on 6/14/2023, the facility's former Social Services Director (SSD 2) left a detailed voicemail providing information regarding last cover date. A further review of the form indicated it was not signed by the resident or patient representative. The NOMNC indicated Resident 169 had the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage. The NOMNC indicated the request for immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date of 6/16/2023. A review of the Quarterly Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 10/12/2023, indicated Resident 169 had severe cognitive impairment (ability to acquire and understand knowledge) impairment and required substantial assistance (staff provide more than half the effort) with dressing, eating, toileting, personal hygiene and bathing. During a concurrent interview and record review 12/14/2023 at 2:50 PM, Resident 169's beneficiary notices were reviewed. Social Services Director 1 (SSD 1) stated the forms were not signed by the resident or responsible party and that the beneficiary forms indicated, Resident 169's responsible party (RP) was not spoken to directly regarding the ending of services for Resident 169. SSD 1 also stated the facility should have sent a certified letter to Resident 169's RP once they were unable to speak with them by phone. SSD 1 stated she was unable to find any documentation indicating a	F 582	Continued at F 640	1/23/24

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F 582	Continued From page 12 certified letter was sent. During an interview on 12/15/2023 at 11:31 AM, the Director of Nursing (DON) stated the facility attempted to give residents a 3-day notice prior to the end of services. The DON stated the facility must call the responsible party and notify them about the end of services. The DON stated residents may lose their right to appeal. A review of the Form Instructions for the NOMNC CMS-10123 indicated the Center for Medicare and Medicaid Services (CMS) required that notification of changes in coverage for an institutionalized beneficiary/enrollee who was not competent be made to a representative. If the provider was unable to personally deliver a notice of noncoverage to a person acting on behalf of a beneficiary/enrollee, then the provider should telephone the representative to advise him or her when the beneficiary's services were no longer covered. The date of the conversation was the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. When direct phone contact cannot be made, send the notice to the representative by certified mail with a return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt. Place a dated copy of the notice in the beneficiary's/enrollee's medical file. A review of facility's policy and procedure titled, "Medicare Denial Process Beneficiary Notices," dated 11/27/2023, indicated in regards to the NOMNC, the beneficiary or representative will sign and date the applicable Generic Notice acknowledging that it was received. If the facility was unable to personally deliver the generic	F 582	Continued at F 640	1/23/24

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F 582	Continued From page 13 notice to a person legally acting on behalf of the beneficiary, then the facility must contact the representative via telephone and advise the representative when the beneficiary services were no longer covered. When direct phone contact cannot be made, send a copy of the generic notice to the representative by certified mail, return receipt requested. The date that someone at the representatives address signed or refuses to sign was the date of receipt. It further indicated the SNFABN provides information to the beneficiary so that they can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. The beneficiary or their authorized representative must sign the signature box to acknowledge that they read and understood the notice.	F 582	Continued at F 640	1/23/24
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment,	F 640	**F640 – Encoding / Transmitting Resident Assessment** **How corrective action(s) will be accomplished for resident (s) found to have been affected by the deficient practice** The completed assessment for residents 219 and 224 has been transmitted and accepted to the CMS IQES repository on 12/14/2023. On 1/18/2024, The MDS Resource Consultant conducted in-service to all the members of the facility MDS department. The educational in-service centered on the following topics (a) RAI Guidelines on assessment completion (b) RAI guidelines on assessment encoding (c) RAI guidelines on assessment submission (d) RAI guidelines on the review of validation reports, errors and correction guidelines.	

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F 640	Continued From page 14 a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure the Minimum Data Set (MDS - a standardized assessment and care screening tool) was transmitted timely to the Centers for Medicare and Medicaid Services (CMS) system for two out of two sampled residents (Residents 219 and 224). This deficient	F 640	**How facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** The Director of Nursing Service and the MDS Resource Consultant on 1/19/2024 conducted a comprehensive and thorough review of all other MDS assessments completed for the entire month of December 2023. The review yielded no other MDS assessment is impacted by this deficient practice. **What measures will be put in place or systemic changes the facility will make to ensure that the deficient practice does not recur:** MDS / Designee will conduct a review on timeliness of MDS assessment submission to the CMS – IQIES repository monthly for three (3) months. The MDS / Designee will report and discuss the result of the monthly MDS submission compliance audit to the QA Committee during regularly scheduled meeting. MDS / Designee will report the findings and implemented corrections during the facility's regularly scheduled QA Meeting. The audit will consist of the following measures • Evidence of timely submission of completed assessment to CMS - IQIES • Evidence that submitted / transmitted assessment has been marked as "accepted" in the facility EHR (PCC) system **How the facility plans to monitor its performance to make sure that solutions are sustained:** Administrator will review and monitor facility's overall compliance on this measure every month for 3 months or until compliance is sustained at the QA Meeting. MDS / Designee will bring to the QACommittee, reports of compliance of the performance measure (Timely Submission / Transmission of Completed MDS Assessment) and implemented corrections during the facility's regularly scheduled QA Meeting. **Completion date: 1/23/2024**	1/23/24

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F 640	Continued From page 15 practice had the potential to result in delayed services for the residents. Findings: a. A review of Resident 219's admission record (Face Sheet) indicated the facility admitted Resident 219 on 7/1/2023, with diagnoses including muscle weakness, and repeated falls. A review of Resident 219's MDS dated 7/5/2023, indicated the resident had moderately impaired cognition (decisions poor, cues/supervision required) and required extensive assistance with one-person physical assist for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. A review of Resident 219's MDS assessments since admission on 12/14/2023 at 11 AM, indicated that transmission of MDS assessment dated 7/5/2023, was accepted. However, the Quarterly MDS assessment transmission dated 10/5/2023, showed that it was exported but not accepted. b. A review of Resident 224's admission record indicated the facility admitted Resident 224 on 6/30/2023, with diagnoses including cellulitis (skin infection) of right lower limb and adult failure to thrive (a syndrome of weight loss, decreased appetite and poor nutrition, and inactivity). A review of Resident 224's MDS dated 7/4/2023, indicated the resident had moderately impaired cognition and required extensive assistance with one-person physical assist for bed mobility, dressing, toilet use, and personal hygiene.	F 640	Continued at F 656	1/23/24

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F 640	Continued From page 16 A review of Resident 224's MDS assessments since admission on 12/14/2023 at 11:05 AM, indicated the transmission of the Quarterly MDS assessment dated 10/4/2023, was not accepted, but was exported. During a concurrent interview and record review on 12/14/2023 at 12 PM, with the MDS Coordinator (MDSC), Resident 219 and Resident 224's MDS records were reviewed. The MDSC stated the Quarterly MDS assessment for Resident 219 was performed on 10/5/2023. However, Resident 219's MDS assessment was not transmitted to CMS. The MDSC further indicated on 10/4/2023, Resident 224's Quarterly MDS assessment was exported. However, the MDS was not transmitted. The MDSC stated staff were required to check and see if the data was transmitted to CMS. The MDSC further stated, "It is against regulations if the MDS assessments are not transmitted to CMS within 14 days of completion. CMS will not have the most updated information about the residents." During an interview on 12/14/2023 at 2:25 PM, the MDSC stated, "Effective as of 10/1/2023, there have been many changes regarding MDS and the submission of records. The MDS assessments that were due in October 2023, were all rejected once submitted. We had to repeatedly submit the MDS before it was finally accepted by the system. However, the staff failed to follow through and ensure that Resident 219 and 244's MDS assessment transmissions were successfully submitted." A review of the facility's Centers for Medicare and Medicaid Services (CMS) Long-Term Care	F 640	Continued at F 656	1/23/24

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F 640	Continued From page 17 Facility Resident Assessment Instrument (RAI) User's Manual, Version 3.0 dated October 2023, indicated all Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Internet Quality Improvement and Evaluation System (iQIES). Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS assessments must be submitted within 14 days of the MDS completion date.	F 640	Continued at F 656	1/23/24
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 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	F 656	**F-656 (D)** **DEVELOP/ IMPLEMENT COMPREHENSIVE CARE PLAN** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Resident 225 was placed on monitoring every shift for sign/symptom of infection associated with elevated WBC and adverse side effect of antibiotic therapy (Augmentin) from 12/10/2023 to 12/13/2023. A series of in-service/ training and re-education was provided to licensed nurses (RNs/LVNs) on 1/16/24 thru 1/19/24 by Director of Nursing/ Clinical Resource Nurse/ Director of Staff Development (DSD)/ Designee about purpose and importance of developing/ implementing person-centered, comprehensive care plan, particularly on administration of antibiotic therapy, so that necessary care and services will be provided and inadequate care will be prevented. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 1/16/24 MDS nurses checked all residents identified with ongoing antibiotic medication therapy to see if comprehensive care plan addressing prescribed antibiotic medication regimen has been developed and implemented. No other resident affected by this deficient finding.	

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F 656	Continued From page 18 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 interview and record review, the facility failed to develop a comprehensive person-centered care plan for the administration of antibiotics for one sampled resident (Resident 225). This deficient practice placed the resident at risk of not receiving the necessary care and services. Findings: A review of Resident 225's admission record indicated the facility admitted Resident 225 on 7/17/2023 and readmitted him on 10/21/2023 with diagnoses including gastrostomy (surgically made opening into the stomach from the abdominal wall for the introduction of food) malfunction, peripheral vascular disease (a systemic disorder	F 656	**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** A clinical review meeting 5x/week (Monday-Friday), excluding observed holidays, will be conducted by the Director of Nurses/ Designee with MDS Nurse(s) and other interdisciplinary team members, which comprises of Nursing staff and Social Service Designee, Case Manager to review new admission' clinical records, change-of-condition in the last 24-72H including but not limited to resident(s) identified with antibiotic therapy to see if comprehensive care plan addressing the prescribed antibiotic medication order has been developed and implemented. No other resident affected by this deficient finding. A Huddle Report Form was implemented on 1/15/24, and updated daily, and includes new orders for antibiotics with its corresponding care plan. **How the facility will monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.** Findings from clinical meeting minutes reports will be presented to QA Committee for further resolution and recommendations for the first 3 months, then quarterly thereafter if no negative trends are found. This correction will be monitored by the Lead MDS Nurse /Designee for continuous compliance. **Completion Date: 1/23/2024**	1/23/24

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F 656	Continued From page 19 that involves the narrowing of peripheral blood vessels [vessels situated away from the heart of the brain]), and dysphasia (swallowing difficulties). A review of Resident 225's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 10/25/2023, indicated Resident 225 had severely impaired cognition (the ability to make self-understood and understand other) and required maximum assistance from the staff for dressing, shower, transferring personal and oral hygiene. A review of Resident 225's history and physical (H&P), dated 10/28/2023, indicated Resident 225 did not have the capacity to understand and make decisions. A review of Resident 225's Physician's Order, dated 12/10/2023, indicated an order to administer Augmentin (antibiotic - medicines used to treat bacterial infection) 500-125 milligrams (mg - a unit of mass or weight) one tablet by mouth every eight hours for three days. During a concurrent interview and record review, on 12/12/2023 at 9:53 a.m., Licensed Vocational Nurse 5 (LVN 5) stated Resident 225 was receiving an antibiotic for elevated white blood cells (WBC - cells in the blood stream that protect against infection). During a concurrent interview and record review, on 12/13/2023 at 9:46 a.m., the Minimum Data Set Coordinator (MDSC) checked the point click care (PCC - a healthcare software) to check if Resident 225 had a care plan for the administration of antibiotics and stated the	F 656	Continued at F 689	1/23/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 20 resident did not. The MDSC stated that it was important to have a care plan for antibiotic administration because it ensured that the resident would be monitored for his response to antibiotic treatment. During an interview on 12/15/2023 at 11:30 a.m., the Director of Nursing (DON) stated that it was important to have a care plan for the antibiotic administration to ensure that the resident was receiving the appropriate treatment. A review of the facility's recent policy and procedure titled, "Care Planning (IDT) Policy," last reviewed on 11/16/2023, indicated all residents will have a comprehensive care plan to meet their individual needs.	F 656	Continued at F 689	1/23/24
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to provide supervision for one of three sampled residents (Resident 458), who had dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), psychosis (a mental disorder characterized by a disconnection from reality), Alzheimer's Disease (the most common type of	F 689	**F-689 (J)** **FREE OF ACCIDENT HAZARDS/ SUPERVISION/ DEVICES** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** Resident 458 was discharged to General Acute Care Hospital (GACH) on 12/6/2023 and had a procedure (Left hip closed reduction of dislocated hip prosthesis). Resident 458 was discharged home on 12/9/2023. Resident 458 was just admitted to the hospital from home on 12/24/23 for a repeat dislocation of the left hip. Clinical Resource Nurse(s) / Director of Staff Development/ Designee/Certified Physical Therapist conducted a series of in-service/training and re-education on 12/27/2023 to Nursing staff, Admission and Case Management Department about purpose and importance of provision of 1:1 sitter to Resident(s) and any status post hip surgery precautions pertaining to any devices, weight bearing status and any special precautions during care and transfers, as prescribed by the physician.	

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	555438	A. BUILDING _____ B. WING _____	12/28/2023

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F 689	Continued From page 21 dementia, a progressive disease beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment), and history of falls, with a history of hip fracture, status post hemiarthroplasty (partial hip replacement) on 11/27/2023, received care, treatment, and services in accordance with professional standards of practice by failing to: -Provide a 1:1 sitter as ordered, and care planned. -Develop a care plan for Resident 458's non-compliance with the abduction pillow (a pillow placed between the legs that helps prevent the hip from turning in or away from the body. It keeps the hip straight while in bed and while asleep. The abduction pillow holds the hip in one position to help it heal). As a result, on 12/5/2023 (eight days after original surgery) it was observed Resident 458's left foot was pointing inward. On 12/6/2023, the resident was transferred to the General Acute Care Hospital (GACH), for further evaluation and management of the left lower extremity abnormal position. Resident 458 developed a second dislocation of the left hip and required a closed reduction left hip surgery under anesthesia. On 12/27/2023 at 9:51 AM, an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the Administrator (ADM) and Director of Nursing (DON), Operation Resource regarding the	F 689	Clinical Resource Nurse(s) / Director of Staff Development/ Licensed Designee/Certified Physical Therapist conducted a series of in-service/training and re-education on 12/27/2023 to Licensed Nurses (RNs/ LVNs) and CNAs about purpose and importance of reviewing any status post hip surgery precautions pertaining to any devices, weight bearing status and any special precautions during care and transfers, as prescribed by the physician on admission to ensure that interventions are implemented and addressed in the care plan. This in-service/ training and re-education will continue until all 86 licensed nurses (RNs and LVNs) and 141 CNAs are captured. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Director of Nursing/ Licensed Designee/ Clinical Resource Nurses checked/ reviewed all residents identified with diagnosis of hip fracture S/P post-surgery care admitted in the facility in the last 30 days to see, if there was an order for 1:1 sitter and if specific post-surgery intervention(s), if any, was/ were implemented. No other Resident was found affected by this deficient finding. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** A clinical review meeting 5x/week (Monday-Friday), excluding observed holidays, will be conducted by the Director of Nurses/ Designee with MDS Nurse(s) and other interdisciplinary team members, which comprises of Nursing staff and Social Service Designee, Case Manager to review new admission' clinical records, change-of-condition in the last 24-72H including but not limited to resident(s) with diagnosis of hemiarthroplasty status-post surgery to see if there is an order for 1: 1 sitter and/ or other precautionary measures/ intervention prescribed by the physician to ensure that prescribed 1:1 sitter and/ or specific intervention(s) is/are implemented and addressed in the care plan.	1/23/24

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F 689	Continued From page 22 facility's failure to provide supervision for Resident 458, who had a diagnosis of dementia, required a 1:1 sitter as ordered, and care planned; and failed to develop a care plan for Resident 458's non-compliance with the abduction pillow. On 12/28/2023 at 3 PM, while onsite at the facility, the IJ was removed in the presence of the ADM and DON, after the ADM submitted an acceptable Removal Plan (interventions and implementation to correct the deficient practices) which was verified and confirmed through observation, interview, and record review. The acceptable removal plan was as follows: -Clinical Resource Nurse(s) / Director of Staff Development/ Designee/Certified Physical Therapist conducted a series of in-service/training and re-education on 12/27/2023 to Nursing staff, Admission and Case Management Department about purpose and importance of provision of 1:1 sitter to resident(s) and any status post-surgery precautions pertaining to any devices, weight bearing status and any special precautions during care and transfers, as prescribed by the physician. -Clinical Resource Nurse(s) / Director of Staff Development/ Licensed Designee/Certified Physical Therapist conducted a series of in-service/training and re-education on 12/27/2023 to Licensed Nurses (RNs/LVNs - Registered Nurses / Licensed Vocational Nurses) and Certified Nursing Assistants (CNAs) about purpose and importance of reviewing any status post-surgery precautions pertaining to any devices, weight bearing status and any special precautions during care and transfers, as prescribed by the physician on admission to	F 689	Initial provision of 1:1 supervision/ sitter and the reason for the service shall be documented on the resident's clinical records. Resident's clinical records will be reviewed by the IDT which comprises of Director of Nursing/ Designee, Case Managers, Social Service Designee, MDS Nurse(s), with Resident and/ or responsible party, within 24-72H after the 1:1 sitter was ordered to review the need of 1:1 sitter request while considering the resident's needs and medical condition, as well as to discuss the appropriate intervention(s) to prevent injury post-surgery. The approval or denial of the request or order of 1:1 sitter will be based on resident's rights, quality of life criteria and accepted standards of practice. If it is determined that 1:1 sitter is necessary for the resident, the assigned sitter completes the visual check observation form every 30 minutes to 60 minutes for the duration of the 1:1 sitter order. During the Shift-to-Shift Huddle, the RN Supervisor or Designee will populate the residents with 1:1 sitter order and discussed the residents and check the staff assignment sheet records to verify that scheduled sitter is in place for the shift and any status post hip surgery precautions pertaining to any devices, weight bearing status and any special precautions during care and transfers, as prescribed by the physician. In the event of non-compliance behavior with the devices on preventing a dislocation or fracture, the Primary MD will be notified of such behavior and a Change of Condition will be initiated by the Licensed Nurse. Medical Records Designee/ Licensed Nursing Designee will audit prescribed provision of 1:1 sitter to see if the intervention was implemented and Change of Condition for non-compliance behavior with MD notifications, as prescribed and addressed in the care plan within 72 hours then weekly x 4 weeks then 2x/week x 4 weeks then weekly thereafter.	1/23/24

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F 689	Continued From page 23 ensure that interventions are implemented and addressed in the care plan. This in-service/ training and reeducation will continue until current 71 licensed nurses (RNs and LVNs) and 132 CNAs are captured. At this time, the Facility has completed the in-service for 54 licensed nurses and 114 CNAs which is 86 percent. -Director of Nursing/ Licensed Designee/ Clinical Resource Nurses checked/ reviewed current residents identified with diagnosis of any post-surgery care admitted in the facility in the last 30 days to see, if there was an order for 1:1 sitter and if any specific post-surgery intervention(s), if any, was/ were implemented. -No other Residents were found affected by this deficient finding for 1:1 sitter. 6 Residents were identified who were admitted with status post-surgery. -A clinical review meeting 5x/week (Monday-Friday), excluding observed holidays, will be conducted by the Director of Nurses/ Designee with MDS Nurse(s) and other interdisciplinary team members, which comprises of Nursing staff and Social Service Designee, Case Manager to review new admission' clinical records, change-of-condition in the last 24-72H including but not limited to resident(s) with diagnosis of hemiarthroplasty status-post surgery to see if there was an order for 1: 1 sitter and/ or other precautionary measures/ intervention prescribed by the physician to ensure that prescribed 1:1 sitter and/ or specific intervention(s) is/are implemented and addressed in the care plan. -Initial provision of 1:1 supervision/ sitter and the	F 689	Orthopedic specialist/ educator will provide an in-service/training and re-education to Licensed Nurses (RNs/ LVNs) and CNAs about purpose and importance of reviewing any status post hip surgery precautions/ post-op care and rehab, pertaining to any devices, weight bearing status and any special precautions during care and transfers, as prescribed by the physician on admission to ensure that interventions are implemented and addressed in the care plan. This in-service/ training and re-education will be provided monthly x 4 months then annually and as needed thereafter. **How the facility will monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.** Findings from clinical meeting reports and audit reports will be presented to QA Committee for further resolution and recommendations for the first 4 months, then quarterly thereafter if no negative trends are found. This correction will be monitored by the Director of Staff Development /Designee for continuous compliance. **Completion Date: 1/23/2024**	1/23/24

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F 689	Continued From page 24 reason for the service shall be documented on the resident's clinical records. Resident's clinical records will be reviewed by the Interdisciplinary Team (IDT) which comprises of Director of Nursing / Designee, Case Managers, Social Service Designee, MDS Nurse(s), with Resident and/ or responsible party, within 24-72H after the 1:1 sitter was ordered to review the need of 1:1 sitter request while considering the resident's needs and medical condition, as well as to discuss the appropriate intervention(s) to prevent injury post-surgery. The approval or denial of the request or order of 1:1 sitter will be based on resident's rights, quality of life criteria and accepted standards of practice. -If it was determined that 1:1 sitter was necessary for the resident, the assigned sitter completes the continuous visual and behavioral monitoring form every 30 minutes to 60 minutes for the duration of the 1:1 sitter order. -During the Shift-to-Shift Huddle, the RN Supervisor or Designee will populate the residents with 1:1 sitter orders and discussed the residents and check the staff assignment sheet records to verify that scheduled sitters were in place for the shift and any status surgery precautions pertaining to any devices, weight bearing status, treatments, and any special precautions during care and transfers, as prescribed by the physician. -In the event of non-compliance behavior with the devices on preventing a dislocation or fracture, the Primary Medical Doctor (MD) will be notified of such behavior and a Change of Condition will be initiated by the Licensed Nurse.	F 689	Continued at F 693	1/23/24

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F 689	Continued From page 25 -Medical Records Designee/ Licensed Nursing Designee will audit prescribed provision of 1:1 sitter to see if the intervention was implemented and Change of Condition for non-compliance behavior with MD notifications, as prescribed and addressed in the care plan within 72 hours then weekly x 4 weeks then 2x/week x 4 weeks then weekly thereafter. Findings: A review of Resident 458's Admission Record indicated the facility admitted the resident on 11/30/2023 with diagnoses including fracture of the left femur (broken hip joint), repeated falls, lack of coordination, unsteadiness on the feet, Alzheimer's dementia, anxiety, and psychosis. A review of Resident 458's Physician's Order dated 11/30/2023, indicated to apply abductor pillow while in bed every shift. The Physician's Order indicated Resident 458 was to have no flexing post 90 degrees and no internal rotation. A review of Resident 458's Nurses Notes dated 12/1/2023, indicated the resident was non-compliant with safety measures, tried to get out of bed unassisted, and refused to be assisted during ambulation. The note indicated redirection was ineffective, and that Resident 458 was reminded to use the call light but was unable to put it to use due to her condition. The nurses note indicated Resident 458 removed the abductor pillow three times while in bed during the 7 AM to 3 PM shift. The nurses note indicated Resident 458 was explained the risk and benefits multiple times but continued to refuse. A review of Resident's 458's	F 689	Continued at F 693	1/23/24

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F 689	Continued From page 26 Orders-Administration Note dated 12/2/2023 indicated the resident was non-compliant with the abductor pillow and the risk and benefits were explained. According to a review of Resident 458's Skilled Services Documentation dated 12/2/2023, the resident was noted trying to get up from bed unassisted, safety reminders and frequent visual checks were provided to Resident 458. A review of Resident 458's Nurses Notes dated 12/2/2023 at 7:41 PM, indicated the resident had a 1:1 sitter noted at bedside. The note indicated Resident 458 was non-compliant with the use of the abductor pillow, the risk and benefits were explained, but Resident 458 continued to remove it. A review of Resident 458's Nurses Notes dated 12/2/2023 at 8:25 PM, indicated the resident got up from bed unassisted three times at the start of the PM shift, was non-compliant with safety measures and indicated the redirection was ineffective. The nurses note indicated Resident 458 was being monitored, was reminded to use the call light, but the resident was unable to put it to use due to her condition. The note further indicated Resident 458 was non-compliant to keep the abductor pillow on. A review of Resident 458's Orders-Administration Note dated 12/3/2023 at 2:59 AM, indicated the resident was trying to get out of bed without assistance. A review of Resident 458's Nurses Notes dated 12/3/2023 at 7:15 AM, indicated there was a 1:1 sitter at the resident's bedside, resident was non-compliant with the use of the abductor pillow	F 689	Continued at F 693	1/23/24

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F 689	Continued From page 27 and the risk and benefits were explained. According to a review of Resident 458's Skilled Services Documentation dated 12/3/2023 at 5:28 PM, the resident was trying to get up from bed unassisted, and safety reminders and visual checks were provided. A review of Resident 458's Case Manager Note dated 12/4/2023 at 11:20 PM, indicated an urgent request was sent to the resident's insurance for a 1:1 sitter. The note indicated the sitter was to be provided by Resident 458's insurance for diagnoses including Alzheimer's disease, dementia, psychotic disturbance, anxiety disorder, psychosis not due to a substance or known physiological condition. A review of Resident 458's Physician's Order dated 12/4/2023, indicated for a 1:1 sitter to be provided by the resident's insurance for diagnoses including Alzheimer's disease, dementia, psychotic disturbance, anxiety disorder, psychosis not due to a substance or known physiological condition. A review of the facility's Nursing Staff Assignment and Sign-In Sheet for the C-Wing Floor dated 12/4/2023 for the 7 AM- 3 PM shift, indicated Certified Nursing Assistant (CNA) 8 was assigned to be 1:1 sitter for Resident 458. A review of Resident 458's Altered Thought Care Plan initiated and revised on 12/4/2023, indicated this was related to Alzheimer's disease and dementia as evidenced by a short term and long-term memory problem, the resident could not recall after five minutes or of long past; unable to make decisions, a problem	F 689	Continued at F 693	1/23/24

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F 689	Continued From page 28	F 689	Continued at F 693	1/23/24

understanding others, and a problem making needs known. The care plan indicated interventions included to provide a 1:1 sitter as ordered, to anticipate and meet needs, observe/report change in cognitive status, increasing confusion, increased forgetfulness, and a change in communication skills. The care plan interventions further indicated to provide reality orientation, provide calm, therapeutic environment and structured routine, establish and maintain a consistent, routine, environment, use simple language, and to allow resident ample time to absorb and respond to information.

According to a review of Resident 458's Care Plans there was no care plan developed for the resident's non-compliance to use the abductor pillow or for the resident's attempts to get out of bed without assistance.

A review of the facility's Nursing Staff Assignment and Sign-In Sheet for the C-Wing Floor dated 12/4/2023 for the 3 PM- 11 PM shift, indicated CNA 8 was again assigned to be the 1:1 sitter for Resident 458, and the 11 PM- 7 AM shift, indicated Resident 458 was assigned a sitter.

A review of the facility's Nursing Staff Assignment and Sign-In Sheet for the C-Wing Floor dated 12/5/2023 for the 7 AM - 3 PM shift, did not indicate there was a 1:1 sitter for Resident 458. The Sign-In Sheet indicated Resident 458 was one of six residents assigned to CNA 6 that shift.

A review of the facility's Nursing Staff Assignment and Sign-In Sheet for the C-Wing Floor dated 12/5/2023 for the 3 PM - 11 PM shift, did not indicate there was a 1:1 sitter for Resident 458. The Sign-In Sheet indicated Resident 458 was

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F 689	Continued From page 29 one of the six residents assigned to CNA 9 that shift. During a concurrent interview and record review on 12/5/2023 at 11:50 AM, the Nursing Staffing Assignment and Sign-In Sheet for the C-Wing Floor dated 12/5/2023 for the 7 AM - 3 PM shift and Resident 458's care plan was reviewed with the Director of Nursing (DON). The DON stated Resident 458 had orders for a 1:1 sitter dated 12/4/2023 and indicated the resident's altered thought process care plan indicated interventions to provide a 1:1 sitter as ordered. The DON stated the Nursing Staff Schedule for C-Wing on 12/5/2023 for the 7 AM to 3 PM shift did not indicate there was a sitter for Resident 458 on that day and shift. The DON further stated Residents 458's non-compliance to use the abductor pillow was not care planned prior to the resident's change of condition on 12/5/2023. The DON stated the care plan for non-compliance should have been initiated when Resident 458 first started having these behaviors. The DON stated not providing a 1:1 sitter as ordered and not care planning for non-compliance behaviors could lead to the resident dislocating or fracturing the hip. A review of Resident 458's Change of Condition (COC) Evaluation form dated 12/5/2023 at 9:13 PM, indicated the resident had an abnormal appearance of the left leg that started on 12/5/2023 at night. The COC form indicated Resident 458's family visited and informed the charge nurse that the resident's leg looked different. The COC form indicated the charge nurse and Registered Nurse (RN) assessed the resident and noted the resident's the left foot was	F 689	Continued at F 693	1/23/24

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F 689	Continued From page 30 pointing inward. The COC form indicated Resident 458 had previous behavior of non-compliance and trying to get out of bed. The COC form indicated the wedge was in place, the primary care clinician was notified. According to a review of Resident 458's Physician's Order dated 12/5/2023, a STAT (immediate) x-ray (an imaging study that creates pictures of the inside of the body using radiation) of the left hip, knee, and ankle. A review of Resident 458's Nurses Notes dated 12/6/2023 at 1:58 PM, indicated radiology was checked to follow-up with the resident's x-ray, and indicated a tech was not yet assigned. A review of Resident 458's Nurses Notes dated 12/6/2023 at 4:30 PM, indicated a phone call was received from Medical Doctor (MD) 1 from the GACH. The note indicated MD 1 ordered to transfer Resident 458 to the GACH for further evaluation and management of the left lower extremity abnormal position / appearance related to status post left hip arthroplasty (hip replacement, a surgical procedure in which the hip joint is replaced by a prosthetic implant, that is, a hip prosthesis) per Family Member (FM) 1's request. A review of Resident 458's Emergency Department Physician's Notes from GACH dated 12/6/2023 at 8:43 PM, indicated the resident was brought in by ambulance complaining of the left foot turn inwards. The History and Physical indicated Resident 458 denied pain on arrival. A review of Resident 458's Imaging Report of the left hip dated 12/6/2023 at 10:39 PM, indicated the resident had posterior superior acetabular component dislocation (dislocated left hip).	F 689	Continued at F 693	1/23/24

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F 689	Continued From page 31 A review of the History and Physical Update from GACH dated 12/7/2023, indicated MD 1 was informed by FM 1 that Resident was noted to be without abduction pillow and the leg was noted to be shortened when she visited the resident on 12/5/2023. The H and P update further indicated the x-ray imaging showed dislocation of a left hemiarthroplasty and no evidence of a fracture. The H and P update indicated Resident 458 would need closed reduction under anesthesia that same day. According to a review of the Surgery and Procedure Reports from GACH dated 12/7/2023 at 5:06 PM, Resident 458 had an operation under anesthesia. The Surgery and Procedure Report indicated Resident 458 had a left hip closed reduction of dislocated hip prosthesis. During a telephone interview on 12/13/2023 at 10:40 AM, FM 1 stated she did not like the care the facility was giving Resident 458. FM 1 stated she went to visit Resident 458 on 12/5/2023 in the evening and found the resident's left leg twisted. FM 1 stated she then informed the nurse what she had seen. FM 1 stated Resident 458 had a 1:1 sitter at the GACH and she spoke to MD 1 from the GACH who stated the resident's leg did not look good. FM 1 stated MD 1 informed her that Resident 458 must have fell or got the injury when the resident was changed. FM 1 stated MD 1 told her Resident 458's leg got dislocated so he was going to try and snap the leg back in. FM 1 stated MD 1 informed her Resident 458 lost a lot of tissue from the injury. FM 1 stated facility staff said they couldn't be watching Resident 458, couldn't have a 1:1 sitter during the day to watch the resident. FM 1 stated the facility staff told her	F 689	Continued at F 693	1/23/24

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F 689	Continued From page 32 sorry and that they were going to try to do their best. During a concurrent interview and record review on 12/13/2023 at 1:47 PM, the Nursing Staff Assignment and Sign-In Sheet for the C-Wing Floor dated 12/5/2023 for the 7 AM - 3 PM shift was reviewed with Registered Nurse (RN) 4. RN 4 stated she was working on the C-wing on 12/5/2023 on the 7 AM to 3 PM shift. RN 4 stated Resident 458 was non-compliant with the abductor pillow and indicated the resident removed it and tried to get up out of bed. RN 4 stated Resident 458 required a 1:1 sitter and there were no reports from staff regarding abnormalities of the left leg that shift. RN 4 stated there were no reports that Resident 458 fell on that shift. RN 4 stated that the Sign In Sheet had no indication there was a sitter for Resident 458 on 12/5/2023 during the 7 AM to 3 PM shift. During an interview on 12/13/2023 at 2:34 PM, CNA 6 stated she was taking care of Resident 458 on 12/5/2023 during the 7 AM to 3 PM shift. CNA 6 stated on that shift Resident 458 would try to stand up and would throw away her abductor pillow. CNA 6 stated Resident 458 did not have a sitter on 12/5/2023 during her shift. CNA 6 stated she fed the resident breakfast and lunch, and indicated she had to stay with the resident a while because the resident would try to get out of bed. CNA 6 stated she went in and out of the room to see and help Resident 458. CNA 6 stated Resident 458 was confused and on occasions would see Resident 458 with her legs hanging off the side of the bed. On 12/13/2023 at 4:10 PM, during an interview, CNA 9 stated she was working 12/5/2023 on the	F 689	Continued at F 693	1/23/24

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F 689	Continued From page 33 3 PM to 11 PM shift and was assigned to take care of Resident 458. CNA 9 stated Resident 458 would try to stand up and try to remove the pillow between her legs. CNA 9 stated Resident 458 did not have a sitter at the change of the shift and indicated she told the charge nurse the resident needed a 1:1 sitter. CNA 9 stated FM 1 came to sit with the resident that night sometime after 4 PM. CNA 9 stated FM 1 saw how Resident 548's leg looked different and told the charge nurse. During a telephone interview on 12/14/2023 at 10:34 AM, MD 2 stated she saw Resident 458 on 12/4/2023. MD 2 stated she was not informed Resident 458 was declining the abductor pillow. MD 2 stated Resident 458 needed to use the abductor pillow at all times after her left hip surgery on 11/27/2023. MD 2 stated if Resident 458 was not compliant with the abductor pillow the left hip could get dislocated. During an interview on 12/14/2023 at 1:42 PM, Resident 458's care plans were reviewed with RN 4. RN 4 stated Resident 458 was confused and was non-compliant with the abductor pillow. RN 4 stated Resident 458 started refusing and removing the abductor pillow on 12/1/2023 and would regularly try to get out of bed. RN 4 stated Resident 458 did not have a care plan developed for the resident's non-compliance of the abductor pillow prior to the residents change of condition on 12/5/2023. RN 4 stated a care plan assisted in communication to staff and to identify concerns that needed attention. RN 4 stated not care planning for Resident 458's non-compliance could cause staff to not be aware of the resident's needs and affect the resident quality of care. On 12/15/2023 at 12:05 PM, during an interview,	F 689	Continued at F 693	1/23/24

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F 689	Continued From page 34	F 689	Continued at F 693	1/23/24

the Administrator stated the Nursing Staff Assignment and Sign-In Sheet dated 12/5/2023 did not indicate Resident 458 had a sitter on that day and shift. The Administrator stated he reviewed some video footage that indicated there was no sitter for Resident 458 between the hours of 7 AM and 10 AM on 12/5/2023.
During a telephone interview on 12/20/2023 at 12:21 PM, MD 2 stated she first saw Resident 458 on 12/4/2023. MD 2 stated a physician should see a resident within 48 hours of being admitted to the facility. MD 2 stated the initial visit was to see the overall status of the resident and their needs, and to reconcile the resident's medication. MD 2 stated not seeing the resident within 48 hours of admission to the facility could affect their over-all well-being.

During a telephone interview on 12/20/2023 at 2:25 PM, the DON stated a physician should see the resident within 72 hours of being admitted. The DON stated Resident 458 was admitted on 11/30/2023 and indicated MD 2 first saw the resident on 12/4/2023. The DON stated that MD 2 saw Resident 458 after 72 hours.

During a telephone interview on 12/20/2023 at 3:05 PM, the Medical Director (MED) stated physicians were required to see the residents within 72 hours from admission. The MED stated this was done to make sure and confirm the safety of the resident. The MED stated a physician visit done after 72 hours from the time of admission could cause complications from orders not being carried out, infection, bleeding, and inadequate pain control.

A review of the facility's policy and procedure titled, "Care Planning (IDT) Policy," effective

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F 689	Continued From page 35 11/16/2023, indicated all residents will have a comprehensive care plan to meet their individual needs that is prepared by the Interdisciplinary Team (IDT) within seven days after the completion of the comprehensive assessment and periodically reviewed and revised after subsequent assessments. Licensed Nurses and other IDT members would develop a care plan to meet the resident's immediate care needs at the time of admission. Preliminary care plans were used until the comprehensive care plan was completed. Care planning shall include review of clinical issues, discharge planning, coordination of care and management of resources. A review of the facility's policy and procedure titled, "Safety and Supervision of Residents Policy," effective 11/16/2023, indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risk for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Implementing interventions to reduce accident risks and hazards shall include the following: communicating specific interventions to all relevant staff; assigning responsibility for carrying out interventions, providing training as necessary, ensuring that interventions are implemented; and documenting interventions.	F 689	Continued at F 693	1/23/24

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F 689	Continued From page 36 Monitoring the effectiveness of interventions shall include the following: ensuring that interventions are implemented correctly and consistently; evaluating the effectiveness of interventions; modifying or replacing interventions as needed; and evaluating the effectiveness of new or revised interventions. The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual risk factors, and then adjusts interventions accordingly. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs. A review of the facility's policy and procedure titled, "Supervision/Sitter," released 11/2023, indicated the purpose of the policy and procedure was to assist residents who need additional supervision and/or companionship in obtaining sitters or companion care. The facility would assist residents and families in obtaining sitters for residents. Sitters may be appropriate when the resident would like or needs to have additional services outside of the services provided by the facility. 1:1 sitter providing supervision may be employed by the facility provide specific task indicated on their scheduled shift. Resident and/or legal representative may request for a sitter and the specific task to be performed by them. The need for sitters shall be documented on the resident's medical records as part nursing intervention. Initial provision of 1:1 supervision/sitter and the reason for service shall be documented on the resident's clinical records. The IDT would revise the resident's care plan to	F 689	Continued at F 693	1/23/24

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F 689	Continued From page 37 include specific care modalities which would be provided by the sitter. A sitter's responsibility was to provide companionship and/or supervision to a resident including, but not limited to: sitting at bedside, conversating with resident and/or supervising to resident's needs, setting up food trays Accompanying the resident to the bathroom, notify facility's staff of any resident's needs. Sitters must agree to comply with the facility sitter 1:1 supervision policy approved by the facility. Sitters who are CNAs may assist with feeding. The sitter will notify the facility staff when taking a break or when the sitter will be away from the resident during his/her work shift. Sitters must report to nurse supervision/charge nurse when coming on and going off duty. Sitters must report changes in a resident's condition to nurse supervisor/charge nurse immediately. Sitters may not serve for more than 12 hours during a 24H period.	F 689	Continued at F 693	1/23/24
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the	F 693	**F-693 (D)** **TUBE FEEDING MGMT/ RESTORE EATING SKILLS** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Resident 110 tube feeding and tubing was changed immediately on 12/11/2022 indicating the correct date/ time hung and initialed by RN Supervisor. A series of in-service/ training was conducted by Director of Nursing DON)/ Director of Staff Development/ Designee to licensed nursing staff (RNs/ LVNs) on 1/16/24 thru 1/19/24 about purpose and importance of accurately labeling the enteral feeding and its tubing with right Resident's name, prescribed feeding rate and date/ time hung to prevent feeding associated complication(s) such as infection, or diarrhea which may lead to serious illness, hospitalization and death.	

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F 693	Continued From page 38 resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility failed to label the tube feeding with the date, time, and initials for one of six sampled residents (Resident 110). This deficient practice had the potential for the residents to develop tube feeding associated complications such as infection or diarrhea, and lead to serious illness, hospitalization, and death. Findings: A review of the admission record indicated the facility initially admitted Resident 110 on 9/2/2023 with diagnoses including gastrostomy (a surgical procedure used to insert a tube, often referred to as a "G-tube", through the abdomen and into the stomach for feeding) and dysphagia (difficulty swallowing). A review of Resident 110's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 9/10/2023 indicated the resident had moderately impaired cognition (decisions poor; cues/supervision required), was totally dependent and required one-person physical assistance with toilet use. The MDS indicated Resident 110 required extensive assistance and one-person physical assistance	F 693	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** On 1/172024 and 1/18/2024 Room Rounders checked all Residents identified on continuous enteral feeding to see if enteral feeding and its tubing were accurately labeled with right name, feeding rate and date/time hung. On 1/18/2024 two Residents were found with deficient label (missing time on the label). The deficiency was corrected immediately. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** Huddle Report Form will be utilized on every unit and will be used during huddle (change of shift) indicating list of residents identified on continuous enteral feeding to monitor if enteral formula and tubing is labeled with right name, feeding rate and date/time hung. Administrator/ Designee will schedule a room/ area rounds 5x a week for 2 weeks, then 3x a week for 2 weeks then randomly, at least 2x a week thereafter. Room Rounders will conduct room rounds to check assigned Residents on continuous enteral feeding and check if it's labeled with right name, feeding rate and date/time hung. Director of Nursing DON)/ Director of Staff Development/ Designee will provide an in-service/ training to licensed nursing staff (RNs/ LVNs) about purpose and importance of accurately labeling the enteral feeding and its tubing with right Resident's name, prescribed feeding rate and date/ time hung to prevent feeding associated complication(s) such as infection, or diarrhea which may lead to serious illness, hospitalization and death. In-service training/ re-education will be conducted monthly x 3 months, then annually and as needed thereafter	1/23/24

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F 693	Continued From page 39 for bed mobility, dressing, and personal hygiene. The MDS further indicated Resident 110 had a feeding tube while he was a resident at the facility. A review of Resident 110's Physician's Order dated 10/31/2023, indicated the resident was to receive G-tube feedings of Nephro with Carb Steady at a rate of 40 milliliters per hour (ml/hr.) for 20 hours every shift. During an observation on 12/11/2023 at 3:10 PM, Resident 110's tube feeding Nephro Carb Steady 1.8 cal was observed infusing at 40 ml/hr. The tube feeding bottle was not labeled. During a concurrent observation and interview, on 12/11/2023 at 3:12 PM, Resident 110's tube feeding was observed in the presence of Licensed Vocational Nurse (LVN) 3. LVN 3 stated and confirmed Resident 110's tube feeding was not labeled or dated. LVN 3 stated the tube feeding should be dated and labeled when started. During an interview on 12/15/2023 at 11:44 AM, the Director of Nursing (DON) stated when changing a tube feeding, staff were required to label the bottle with the date and time the feeding was started. The DON stated this was done so staff knew when the tube feeding was started and to ensure the feeding was correct and had the correct rate. A review of the facility's policy and procedure titled, "Enteral Tube Feeding via Continuous Pump," revised 11/2023, indicated on the formula label document initials, date and time the formula was hung/administered, and initial that the label	F 693	**How the facility will monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.** Findings from room round reports and minutes of the meeting will be presented to the QA Committee for further resolutions and recommendations. This correction will be monitored by Assistant Director of Nursing (ADON/ Designee for continued compliance. **Completion Date: 1/23/2024**	1/23/24

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F 693	Continued From page 40 was checked against the order.	F 693	**F-695 (D)** **RESPIRATORY/ TRACHEOSTOMY CARE AND SUCTIONING**	1/23/24
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 observation, interview, and record review, the facility failed to follow the facility's Oxygen Administration policy and procedure for two of two sampled residents (Resident 210 and Resident 248). These deficient practices had the potential to cause complications associated with oxygen therapy. Findings: a. A review of Resident 248's admission record indicated the facility admitted the resident on 9/27/2023, with diagnoses including a displaced spiral fracture of the shaft of the humerus of the right arm (the parts of the bone in upper arm at the break no longer line up correctly), and a fracture of unspecified carpal bone (fracture of one of the bones of the wrist), multiple fractures of ribs (crack in the rib). A review of Resident 248's history and physical, dated 9/29/2023, indicated the resident had the capacity to understand and to make decisions.	F 695	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Resident 248 oxygen tubing and empty humidifier from the oxygen concentrator was discarded and replace with a new one and dated by RN Supervisor on 12/11/2023. A humidifier was provided to Resident 210 connecting to oxygen concentrator and nasal cannula and labeled with date/time it was replaced by RN Supervisor on 12/14/2023. A series of in-service/ training was conducted by Director of Nursing (DON)/ Director of Staff Development (DSD) / Designee to licensed Nurses (RNs/ LVNs) on 1/6/24 thru 1/19/24 about purpose and importance of providing necessary respiratory care and services to Residents on prescribed oxygen therapy including but not limited to accurately labeling the oxygen tubing (nasal cannula) and ensuring that humidifier is provided to dryness of nostrils, with date when it was changed/ replaced to prevent complication and infection associated with respiratory therapy tasks and equipment. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 1/17/24 and 1/18/24 Room Rounders checked all Residents identified on continuous oxygen therapy to see if there is a humidifier connecting to oxygen concentrator and oxygen tubing e.g., nasal cannula and to see if all were labeled and dated. No other Resident was affected by this deficient finding.	

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F 695	Continued From page 41 A review of Resident 248's Minimum Data Set (MDS - an standardized assessment and care screening tool), dated 10/11/2023, indicated the resident had intact cognition (mental action or process of acquiring knowledge and understanding) and required moderate assistance from staff for dressing, feeding, personal hygiene, and all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a concurrent observation and interview, on 12/11/2023 at 10:55 AM, with Licensed Vocational Nurse 5 (LVN 5), Resident 248 was observed in the bed receiving two liters per minute (LPM- unit of measurement for volume) of oxygen via a nasal canula (NC- a device used to deliver supplemental oxygen to a patient) from the oxygen concentrator with an empty humidifier. LVN 5 verified the humidifier was empty, and the date of the last oxygen tubing change was 12/3/2023. LVN 5 stated staff were required to change the humidifier and oxygen tubing every seven days. LVN 5 further stated Resident 248's oxygen tubing and the humidifier should have been changed on 12/10/2023. LVN 5 stated this deficient practice could result in Resident 248 developing a respiratory infection. During a concurrent interview and record review, on 12/13/2023 at 9:07 AM, with the MDS Coordinator (MDSC), Resident 248's physician's orders were reviewed. The MDSC stated there was no physician's order for administration of oxygen to Resident 248 and that "It is important to obtain a physician's order for oxygen administration after resident's admission to the	F 695	**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** Licensed Nurse will change Resident's oxygen tubing (nasal cannula) every week or as needed when oxygen tubing exposed to contamination and will keep the Resident's nasal cannula and tubing in a plastic bag labeled with Resident's name and date it was changed when nasal cannula and tubing are not in use. Licensed Nurse will provide a humidifier connected to oxygen concentrator and oxygen tubing for Resident on oxygen therapy and will replace the humidifier as needed when the humidifier is almost empty. Huddle Report Form will be utilized on every unit and will be used during huddle (change of shift) indicating list of residents identified on continuous oxygen therapy to monitor if their oxygen tubing (nasal cannula) and properly labeled with date it was replaced. Administrator/ Designee will schedule a room/ area rounds 5x a week for 2 weeks, then 3x a week for 2 weeks then randomly, at least 2x a week thereafter. Room Rounders will conduct room rounds to check assigned Residents receiving oxygen therapy if nasal cannula and tubing are labeled and dated. Director of Nursing (DON)/ Director of Staff Development (DSD)/ Designee will conduct an in-service/ training and re-education to licensed Nurses (RNs/ LVNs) on about purpose and importance of providing necessary respiratory care and services to Residents on prescribed oxygen therapy including but not limited to accurately labeling the oxygen tubing (nasal cannula) and ensuring that humidifier is provided to dryness of nostrils, with date when it was changed/ replaced to prevent complication and infection associated with respiratory therapy tasks and equipment. . In-service training/ re-education will be conducted monthly x 3 months, then annually and as needed thereafter.	1/23/24

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F 695	Continued From page 42 facility." During an interview on 10/5/2023, at 3:08 PM, the Director of Nursing (DON) stated the licensed staff were required to obtain a physician's order for oxygen administration. The DON stated oxygen tubing was required to be changed every seven days according to the facility's policy. The DON stated that missing the physician's order for oxygen could place resident at risk for not receiving correct amount of oxygen and the potential outcome of not changing the oxygen tubing and humidifier every seven days was cross contamination and infection. b. A review of Resident 210's admission record indicated the facility admitted the resident on 1/14/2023, with diagnoses including pulmonary fibrosis (a disease where there is scarring of the lungs which makes it difficult to breathe), and lack of coordination. A review of Resident 210's Order Summary Report dated 2/26/2023, indicated to administer oxygen at 2 liters per minute via nasal continuously during each shift for pulmonary fibrosis. The orders further indicated to change the humidifier bottle every week as needed when empty. A review of Resident 210's MDS dated 10/21/2023, indicated Resident 210 had moderately impaired cognition (decisions poor, cues/supervision required) and required moderate assistance for oral hygiene, showering/bathing, upper and lower body dressing, and personal hygiene. The MDS further indicated Resident 210 was receiving oxygen therapy while in the facility and within the last 14	F 695	**How the facility will monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.** Findings from room round reports and minutes of the meeting will be presented to the QA Committee for further resolutions and recommendations. This correction will be monitored by Assistant Director of Nursing (ADON/ Designee for continued compliance. **Completion Date: 1/23/2024**	1/23/24

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F 695	Continued From page 43 days. A review of Resident 210's Order Summary Report dated 11/28/2023 at 7 AM, indicated to administer oxygen at five liters per minute via nasal cannula (NC) continuously during each shift for pulmonary fibrosis. During an observation on 12/11/2023 at 9:04 AM, Resident 210 was observed sitting on her bed. Resident 210 was receiving oxygen infusing at five liters per minute via NC, but no humidifier was observed connected to the resident's oxygen. During a concurrent observation and interview, on 12/11/2023 at 9:05 AM, LVN 2 confirmed there was no humidifier connected to Resident 210's oxygen. LVN 2 stated a humidifier was required to be utilized to prevent dryness in the nostrils. LVN 2 further stated, "It must not have been replaced when the empty humidifier was changed." During an interview on 12/14/2023 at 3:34 PM, the DON stated when a resident was on five (5) liters per minute of oxygen via NC the humidifier was used to prevent dryness in the nostrils. The DON stated the staff were required to replace the empty humidifier and mark the date and time it was replaced. A review of the facility's policy and procedure titled, "Department (Respiratory Therapy)-Prevention of infection," reviewed November 2023, indicated to change the oxygen cannula and tubing every seven days and to change the refillable humidifier unit daily. A review of the facility's policy and procedure	F 695	Continued to F 697	1/23/24

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F 695	Continued From page 44 titled, "Oxygen administration," reviewed November 2023, indicated the purpose was to provide guidelines for safe oxygen administration. Verify that there was a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.	F 695	**F-697 (D)** **PAIN MANAGEMENT** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Resident 132 was evaluated for pain on 12/27/23 by Licensed nurse and was seen by Pain Specialist on 12/27/23 for effective pain management plan.	1/23/24
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record reviews, the facility failed to implement an effective pain management plan for one of three sampled residents (Resident 132). This deficient practice had the potential to negatively affect the resident's psychosocial wellbeing and quality of life. Findings: A review of the admission record (Face Sheet) indicated the facility admitted Resident 132 on 9/6/2023 with diagnoses including low back pain, and repeated falls. A review of Resident 132's Physician's Orders dated 9/6/2023, indicated to apply non-pharmacological interventions (do not involve drugs) for pain to include the following: 1. Repositioning 2. Back rub	F 697	A series of in-service/ training was conducted by Director of Nursing (DON)/ Director of Staff Development (DSD) / Designee to licensed Nurses (RNs/ LVNs) on 1/16/24 thru 1/19/24 about purpose and importance of providing and documenting non-pharmacological interventions or pain-relieving options such as repositioning, back rubs, relaxation, music and/or activities for pain-relief, consistent with the resident's goals and needs prior to administering pain medication, especially for Residents receiving "as needed" narcotic pain medication almost daily to help improve psychosocial well-being and quality of life, in accordance to facility's policy and procedure. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 1/05/24 thru 1/19/24 Director of Nursing/ Licensed Designee reviewed all Residents receiving "as needed" narcotic pain medication regimen almost daily in the last 14 days for pain- relief almost daily to see if non-pharmacological interventions have been provided prior to administering prescribed pain medication regimen. There are no other resident(s) who fund to have been affected by this deficient finding and was referred and seen/ evaluated by Pain Specialist for effective pain management plan.	

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F 697	Continued From page 45 3. Relaxation 4. Give fluids 5 Redirection 6. Music 7. Activity 8. Adjusting room temperature 9. Quiet environment 10. Toilet 11. Breathing exercises 12. Distraction A review of Resident 132's Physician's Orders further indicated to use supplementary documentation and select corresponding numbers to indicate non-drug interventions as needed. A review of the Physician's Orders for Resident 132 dated 9/9/2023, indicated Resident 132 had an order to administer oxycodone-acetaminophen tablet (a controlled drug used to treat moderate to severe pain) 5-325 milligram (mg) one tablet by mouth every four hours as needed for moderate to severe pain (rating of 4-10 for moderate to severe pain using the pain rating scale of zero being no pain and 10 being the worst pain possible). A review of the Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 9/10/2023, indicated Resident 132 had intact cognition (decisions consistent / reasonable) and required extensive assistance with one-person physical assist for bed mobility, transfers, and toilet use. The MDS further indicated Resident 132 almost constantly had pain. The pain made it hard for her to sleep at nighttime and limited her day-to day activities.	F 697	**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** Licensed Nurse will offer non-pharmacological intervention(s) to include the following, but not limited to, repositioning, back rub, relaxation, give fluids, redirection, music, activity and will document non-pharmacological intervention(s) provided in the resident's clinical records in accordance with the numbers corresponding to each non-pharmacological interventions provided, prior to administering "as needed" prescribed pain medication therapy and every shift as supplemental intervention to relieve pain/ discomfort. Medical records will audit resident's Medication Administration Records (MAR) daily 5x/week to see if non-pharmacological intervention was offered or provided prior to administering prescribed "as needed" narcotic pain medication. Director of Nursing (DON)/ Director of Staff Development (DSD) / Designee will conduct an in-service/ training was conducted to licensed Nurses (RNs/ LVNs) about purpose and importance of providing and documenting non-pharmacological interventions or pain-relieving options such as repositioning, back rubs, relaxation, music and/or activities for pain-relief, consistent with the resident's goals and needs prior to administering pain medication, especially for Residents receiving "as needed" narcotic pain medication almost daily - to help improve psychosocial well-being and quality of life, in accordance to facility's policy and procedure. . In-service training/ re-education will be conducted monthly x 3 months, then annually and as needed thereafter.	1/23/24

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F 697	Continued From page 46 A review of Resident 132's Care Plan dated 9/13/2023 indicated, Resident 132 had an alteration (change) in comfort due to pain related to depression (a mood disorder that causes a persistent feeling of sadness), low back pain and presence of a pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure). The care plan goal indicated the resident will verbalize relief of pain within 60 minutes of administration of pain medication. The interventions listed indicated to anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Notify the physician if interventions were unsuccessful or if the current complaint was a significant change from the resident's past experience of pain and to provide non-pharmacological interventions for pain as ordered. A review of Resident 132's MAR for the month of November 2023 indicated the resident received non-pharmacological pain interventions on 11/7, 11/22, 11/28 and 11/30/2023 for the month of November. The MAR further indicated Resident 132 received oxycodone-acetaminophen at least one time a day from 11/1/ to 11/30/2023. A review of Resident 132's Medication Administration Record (MAR) for the month of December 2023, indicated Resident 132 received non-pharmacological pain interventions once on 12/10/2023, for the entire month. The MAR further indicated Resident 132 received oxycodone-acetaminophen at least one time a day from 12/1 to 12/13/2023. During an interview on 12/11/2023 at 10:31 AM, with Resident 132 in her room, Resident 132 stated that she was in pain. Resident 132 stated,	F 697	**How the facility will monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.** Findings from audit reports will be presented to the QA Committee monthly for further resolutions and recommendations. This correction will be monitored by Assistant Director of Nursing (ADON) for continued compliance. **Completion Date: 1/23/2024**	1/23/24

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F 697	Continued From page 47	F 697	Continued to F 726	1/23/24

"I took pain medication earlier, but I am still in pain, because I have chronic pain." Resident 132 stated the staff did not offer any pain-relieving options such as music, massage and heating or cooling to relieve her pain.

During a concurrent interview and record review, on 12/14/2023 at 10:04 AM with Licensed Vocational Nurse 4 (LVN 4), Resident 132's MAR was reviewed. LVN 4 stated she administered oxycodone to Resident 132 earlier today but did not offer or perform non-pharmacological interventions for Resident 132 before administering oxycodone. LVN 4 stated licensed nurses were required to perform non-pharmacological pain interventions before administering any as needed pain medications.

During an interview on 12/14/2023 at 3:50 PM, the Director of Nursing (DON) stated licensed nurses were required to offer non-pharmacological pain interventions for residents before administering any as needed pain medications. The DON confirmed that the staff did not provide non-drug methods to reduce Resident 132's pain as ordered by the physician and as indicated in her plan of care. The DON stated the potential outcome was unrelieved pain and discomfort.

A review of the facility's policy and procedures titled, "Pain Assessment and Management," revised November 2023, indicated the purpose of this procedure was to help the staff identify pain in the resident, and to develop interventions that were consistent with the resident's goals and needs and that address the underlying causes of pain. Non-pharmacological interventions may be appropriate alone or in conjunction with

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F 697	Continued From page 48 medications. Some non-pharmacological interventions include environmental, physical, exercise and cognitive and behavioral. A review of the facility's policy and procedure titled, "Administering Pain Medications," revised November 2023, indicated to evaluate and document the effectiveness of non-pharmacological interventions (e.g., repositioning, warm or cold compress, etc.).	F 697	**F-726 (E)** **COMPETENT NURSING STAFF** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** CNA 4 who has hired on 8/10/2021 was provided a skills competency check on 1/15/24 by Director of Staff Development. CNA 5 who has hired on 10/1/2022 was provided a skills competency check on 1/16/24 by Director of Staff Development.	1/23/24
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides.	F 726	CNA 6 who has hired on 12/3/2019 was provided a skills competency check on 1/16/24 by Director of Staff Development. CNA 7 who has hired on 2/6/2016 was provided a skills competency check on 1/17/24 by Director of Staff Development. 1:1 in-service/ training and re-education provided to Director(s) of Staff Development by Administrator/ Clinical Resource Nurse on 1/18/24 about purpose/ importance of conducting and completing staff (CNAs) facility and resident-specific skills competency evaluation upon hire, annually and as deemed necessary. A series of in-service/ training was conducted by Director of Nursing (DON)/ Clinical Resource Nurse/ Designee to licensed Nurses (RNs/ LVNs) on 1/16/24 thru 1/19/24 about purpose and importance of testing, measuring knowledge, skills, abilities behaviors of licensed nurses regularly based on their role and responsibilities necessary to care for resident's needs in accordance with the facility assessment so that Residents will receive appropriate nursing care services based on their needs to prevent potential injury or harm.	

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F 726	Continued From page 49 The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to perform annual staff competencies for four of five sampled staff (Certified Nursing Assistant [CNA] 4, CNA 5, CNA 6, and CNA 7. This deficient practice had the potential to result in residents to not receive the appropriate level of care needed affecting quality of care and potentially leading to resident harm. Findings: A review the employee files on 12/14/2023 at 3:12 PM for CNA 4, CNA 5, CNA 6, and CNA 7 indicated the following: -CNA 4 was hired on 8/10/2021. There was no competency for the year 2023 available for review in CNA 4's employee file. -CNA 5 was hired on 10/1/2022. There was no competency for the year 2023 available for review in CNA 5's employee file. -CNA 6 was hired on 12/3/2019. There was no competency for the year 2023 available for review in CNA 6's employee file. -CNA 7 was hired on 2/6/2016. There was no competency for the year 2023 available for review in CNA 7's employee file. During a concurrent interview and record review, on 12/14/2023 at 4 PM, the employee files for CNA 4 through 7 were reviewed with the Director of Staff Development (DSD) 1. The DSD 1 stated the annual competencies for the year 2023 for the	F 726	**How the facility will identify other employees having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 12/15/23 thru 1/19/24 Director(s) of Staff Development checked active employee files of all CNAs working in the facility to see if they have received competencies and skills Active employees are those that have worked at least one shift in the last 90 days. As of 1/20/24 there are 6 active CNAs who have not received their annual competencies and skills tests. Each of these will be completed by the Completion Date. If any are not completed by the Completion Date then the employee will be taken off the schedule until such can be completed. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** Director of Staff Development/ Designee will provide competencies and skills checks to CNA's within 7-14 days upon hiring or prior to providing direct-patient care then annually and as needed thereafter. Director of Staff Development/ Designee will use an excel tracking log to track competencies and skills of CNA employees. **How the facility will monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.** Findings from the CNA employee file tracking reports will be presented to the QA Committee for further resolutions and recommendations. **Completion Date: 1/23/2024**	1/23/24

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F 726	Continued From page 50 reviewed employee files were not completed. DSD 1 stated competencies were important to ensure staff were able to carry out tasks. The DSD 1 stated there was a potential for quality of care to be affected if staff competencies were not done annually. During an interview on 12/15/2023 at 11:40 AM, the Administrator stated the facility's policy indicated competencies were done annually. The Administrator stated if competencies were not done annually there was a potential for staff to have incompetent skills and wants to ensure staff were qualified to work. During an interview on 12/15/2023 at 11:42 AM, the Director of Nursing (DON) stated competencies were done once a year to review employee performance. The DON stated not performing competencies for staff annually could potentially affect resident quality of care. A review of the facility's policy and procedure titled, "Competency of Nursing Staff," revised 11/2023, indicated licensed nurses and nursing assistants employed (or contracted) by the facility will participate in a facility-specific, competency-based staff development and training program; and demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care. Facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment.	F 726	Continued to F 730	1/23/24
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7)	F 730		

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F 730	Continued From page 51 §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to perform annual performance evaluations for four of five sampled staff (Certified Nursing Assistant [CNA] 4, CNA 5, CNA 6, and CNA 7. This deficient practice had the potential for residents to not receive the appropriate level of care needed affecting quality of care and potentially leading to resident harm. Findings: A review of the employee files on 12/14/2023 at 3:12 PM for CNA 4, CNA 5, CNA 6, and CNA 7 were reviewed and indicated the following: -CNA 4 was hired on 8/10/2021. There was no performance evaluation for the year 2023 available for review in CNA 4's employee file. -CNA 5 was hired on 10/1/2022. There was no performance evaluation for the year 2023 available for review in CNA 5's employee file. -CNA 6 was hired on 12/3/2019. CNA 6's employee file indicated there was a performance evaluation dated 10/26/2021. There was no performance evaluation for the year 2023 available for review. -CNA 7 was hired on 2/6/2016. CNA 7's employee file indicated there was a performance evaluation dated 7/27/2020; there was no performance evaluation for the year 2023 available for review.	F 730	**F-730 (E)** **NURSE AIDE PERFORM REVIEW- 12 HR/ YR IN-SERVICE** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Performance Review Evaluation was provided to CNA 4 who has hired on 8/10/2021 on 1/15/24 by Director of Staff Development. Performance Review Evaluation was provided to CNA 5 who has hired on 10/1/2022 on 1/16/24 by Director of Staff Development. Performance Review Evaluation was provided to CNA 6 who has hired on 12/3/2019 on 1/16/24 by Director of Staff Development. Performance Review Evaluation was provided to CNA 7 who has hired on 2/6/2016 on 1/17/24 by Director of Staff Development. 1:1 in-service/ training and re-education provided to Director(s) of Staff Development by Administrator/ Clinical Resource Nurse on 1/18/24 about purpose/ importance of evaluating employee's job performance annually. to ensure if they are qualified to work and able to carry out the tasks assigned to them, in accordance with facility's policy. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 12/15/23 thru 1/19/24 Director(s) of Staff Development checked active employee files of all CNAs working in the facility to see if they have received Performance Evaluations. Active employees are those that have worked at least one shift in the last 90 days. As of 1/20/24 there are 6 active CNAs who have not received their annual Performance Evaluations. Each of these will be completed by the Completion Date. If any are not completed by the Completion Date then the employee will be taken off the schedule until such can be completed.	1/23/24

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F 730	Continued From page 52 During a concurrent interview and record review, on 12/14/2023 at 4 PM, the employee files for CNA 4 through 7 were reviewed with the Director of Staff Development (DSD) 1. The DSD 1 stated the annual performance evaluations for the year 2023 for the reviewed employee files were not completed. The DSD 1 stated performance evaluations were important to ensure staff were able to carry out tasks and there was a potential for quality of care to be affected if performance evaluations were not done annually. During an interview on 12/15/2023 at 11:40 AM, the Administrator stated the facility's policy indicated performance evaluations were done annually and if performance evaluations were not done annually there was a potential for staff to have incompetent skills. The Administrator stated we want to ensure staff were qualified to work. During an interview on 12/15/2023 at 11:42 AM, the Director of Nursing (DON), indicated the facility needed to catch up with performance evaluations of staff. The DON stated performance evaluations were done once a year and 90 days after hire and that performance evaluations were done to review employee performance. The DON stated not performing performance evaluations and competencies for staff annually could potentially affect resident quality of care. A review of the facility's policy and procedure titled, "Performance Evaluations," revised 11/2023 indicated the job performance of each employee shall be reviewed and evaluated at least annually. A performance evaluation will be completed on each employee at the conclusion of	F 730	**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** Director of Staff Development/ Designee will provide Performance Evaluations with CNA's annually and as needed thereafter. Director of Staff Development/ Designee will use an excel tracking log to track Performance Evaluation of CNA employees. Director of Staff Development/ Designee will create an excel tracking log to Performance Evaluation of CNA employees. **How the facility will monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.** Findings from the CNA employee file tracking reports will be presented to the QA Committee for further resolutions and recommendations. **Completion Date: 1/23/2024**	1/23/24

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F 730	Continued From page 53 his/her 90-day probationary period, and at least annually thereafter. The performance evaluation meeting will occur at the same time as the employee's compensation review."	F 730	**F-745 (D)** **PROVISION OF MEDICALLY RELATED SOCIAL SERVICE** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Resident 48 was discharged home on 12/20/2023. Clinical Resource Nurse/ Director of Nursing/ Designee provided an in-service/ training and re-education to Social Service Department staff members about purpose of assessing or evaluating Residents psychosocial well-being, addressing psychosocial issues, assisting the residents with their adjustment period in the facility and help identifying resident's personal and social needs and problems timely (within 14 days of admission) to attain the highest practicable physical, mental, and psychosocial well-being possible, in accordance to facility's policy. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 1/16/2024 Social Service Director/ Designee reviewed all Residents' clinical records (in-house) who are admitted to the facility within the last 90 days to check if Social Service Evaluation was completed timely in accordance to facility's policy. One Resident was affected and a 1:1 in service was provided to Social Service Designee on 1/18/2024.	1/23/24
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services 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 interview and record review, the facility failed to follow its "Social Assessment," policy and procedure for one of three sampled residents (Resident 48). This deficient practice had the potential for the resident not to attain the highest practicable physical, mental, and psychosocial well-being and delay in the delivery of care and services. Findings: A review of Resident 48's admission record (Face Sheet) indicated the facility originally admitted Resident 48 on 1/13/2023, and readmitted Resident 48 on 5/18/2023, with diagnoses including diabetes mellitus (a disease that result in too much sugar in the blood), and end stage renal disease (a condition when the kidneys permanently fail to work). A review of the Social Service Notes dated 1/17/2023 at 6:36 PM, indicated social service visited Resident 48 to assess her well-being upon admission.	F 745		

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F 745	Continued From page 54 A review of the Social Service Evaluation upon admission, indicated the resident's evaluation was performed on 2/6/2023. A review of Resident 48's history and physical dated 7/9/2023, indicated the resident had the capacity to understand and make decisions. A review of Resident 48's Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 10/20/2023, indicated Resident 48 had intact cognition (decisions consistent/reasonable) and required maximum assistance for oral hygiene, showering / bathing, and personal hygiene. During an interview on 12/13/2023 at 8:40 AM, Social Service Assistant 2 (SSA 2) stated the social workers were required to meet with the residents within 48 hours of their admission to the facility, as the initial social service assessment was required to be conducted within 14 days of residents admission. SSA 2 stated, "Seems like Resident 48's initial social service assessment was performed late," and the potential outcome was a delay in services. During an interview on 12/14/2023 at 3:27 PM, the Director of Nursing (DON) stated, "Social workers try to visit residents the day after their admission to the facility." The DON stated the initial social service assessment was required to be completed within 14 days of residents admission to the facility. The DON stated the potential outcome of a social worker not assessing residents timely was a delay in addressing psychosocial issues and assisting the residents with their adjustment period in the facility.	F 745	**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** Social Service Director/ Designee will evaluate Resident's psychosocial well-being using Social Service Evaluation and document information electronically within 14 days of admission in the facility. Medical Records Designee will audit Resident's admission records within 14 days. to see if Social Service Evaluation has been completed timely in accordance to facility's policy and procedure. **How the facility will monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.** Findings from audit reports will be presented to the QA Committee for further resolutions and recommendations. This correction will be monitored by Medical Records Director/ Designee for continued compliance. **Completion Date: 1/23/2024**	1/23/24

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F 745	Continued From page 55 A review of the facility's policy and procedure titled, "Social Assessment," revised November 2023, indicated a social assessment shall be completed within fourteen (14) days of the resident's admission to the facility. A social assessment will be done to help identify the resident's personal and social situation, needs, and problems.	F 745	**F-758 (D)** **FREE FROM UNNECESSARY PSYCHOTROPIC MEDS/PRN USE** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Resident 123's antipsychotic medication (Lorazepam 0.5 mg by mouth to given every 4 hours as needed) was discontinued on 12/27/2023, as ordered.	1/23/24
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 drugs;	F 758	Director of Nursing (DON) / Designee provided a series of in-service/ training and re-education to Licensed Nurses (RNs/ LVNs) on 1/16/24 thru 1/19/24 about purpose/ importance of indicating a stop date and/or duration of how long the resident was to receive an "as needed" psychotropic medication to prevent unnecessary psychotropic drug use that could lead to side effect and/or adverse consequence such as a decline in quality of life and functional capacity pursuant to State regulations, unless the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record and unless prescribing practitioner evaluates and document the rationale that extending beyond 14 days of therapy of "as needed" (PRN) orders is appropriate, pursuant to State regulations. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 1/16/24 Director of Nursing/ Licensed Designee checked all Residents with "as needed" (PRN) psychotropic medication order(s) to see if a stop date and/or duration of how long the resident was to receive an "as needed" psychotropic medication orders pursuant to State regulations. No other Resident was affected by this deficient finding.	

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F 758	Continued From page 56 §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 interview and record review, the facility failed to follow their "Antipsychotic Medication Use," policy and procedure for one of six sampled residents (Resident 123), as evidenced by failing to indicate a stop date and/or duration for how long the resident was to receive an as needed psychotropic medication (medication that affects the mind, emotions, and behavior). This deficient practice had the potential to result in administering unnecessary psychotropic drugs for Resident 123 that could lead to side effect and adverse consequence such as a decline in quality of life and functional capacity. Findings:	F 758	**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** Director of Nursing/ Designee will randomly check psychotropic medication ordered within the last 7 days daily 5x/week to ensure that a stop date and/or duration of how long the resident was to receive an “as needed” (PRN) psychotropic medication is indicated on the physician. PRN psychotropic medication order without a stop date will be called and clarified with ordering licensed practitioner immediately upon finding. Medical Records Designee will audit physician orders on the Order Listing Report populated electronically daily 5x/week to ensure that PRN or “as needed” psychotropic medication orders has a stop date indicated and documented. Director of Nursing (DON) / Designee will provide an in-service/ training and re-education to Licensed Nurses (RNs/ LVNs) about purpose/ importance of indicating a stop date and/or duration of how long the resident was to receive an “as needed” psychotropic medication to prevent unnecessary psychotropic drug use that could lead to side effect and/or adverse consequence such as a decline in quality of life and functional capacity pursuant to State regulations, unless the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record and unless prescribing practitioner evaluates and document the rationale that extending beyond 14 days of therapy of “as needed” (PRN) orders is appropriate, pursuant to State regulations. This in-service/ training and re-education will be provided monthly x 3 months then annually and as needed thereafter.	1/23/24

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F 758	Continued From page 57 A review of Resident 123's admission record (Face Sheet) indicated, the facility originally admitted Resident 123 on 12/12/2021, and readmitted the resident on 8/10/2023, with diagnoses including encounter for palliative care (specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness), and anxiety disorder (a condition in which you have anxiety that does not go away and can get worse over time). A review of the Order Summary Report dated 8/10/2023, indicated to administer lorazepam (a medication to treat anxiety) oral tablet 0.5 milligram, one tablet by mouth every four hours as needed for anxiety manifested by restlessness with agitation for Resident 123. The Physician's Order for lorazepam did not have a stop date. A review of Resident 123's Order Summary Report dated 9/5/2023, indicated to administer lorazepam oral tablet 0.5 milligram, one tablet by mouth every two hours as needed for anxiety manifested by restlessness with agitation. The Physician's Order for lorazepam did not indicate the duration of how long Resident 123 was to receive the medication. A review of Resident 123's Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 11/16/2023, indicated the resident had moderately impaired cognition (decisions poor, cues/supervision required) and required maximum assistance for eating, oral hygiene, toileting hygiene, showering/bathing, dressing upper and lower body, and personal hygiene. A review of Resident 123's Medication	F 758	**How the facility will monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.** Findings from audit reports will be presented to the QA Committee monthly for further resolutions and recommendations. This correction will be monitored by Medical Records Director/ Designee for continued compliance **Completion Date: 1/23/2024**	1/23/24

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F 758	Continued From page 58	F 758	Continued to F 803	1/23/24

Administration Record (MAR) for the mouth of December 2023, indicated lorazepam was not administered to the resident from 12/1/2023 to 12/13/2023.

A review of Resident 123's MAR for the month of November 2023, indicated lorazepam was administered to the resident on 11/4, 11/6, 11/11, 11/18, 11/22, and 11/27/2023.

During a concurrent interview, and record review, on 12/13/2023 at 9:20 AM, with Registered Nurse Supervisor 5 (RN 5), the Physician's Orders for Resident 123 were reviewed. RN 5 stated the Physician's Order dated 8/10/2023 and 9/5/2023 did not have a stop date for lorazepam. RN 5 stated 'as needed' psychotropic medications should have a stop date to monitor the resident's response to the medication.

During an interview on 12/14/2023 at 3:45 PM, the Director of Nursing (DON) stated and confirmed that Resident 123's Physician's Orders for lorazepam did not have a stop date. The DON stated as needed psychotropic medications should have a stop date so the physician can re-evaluate for the necessity of the medication.

A review of the facility's policy and procedure titled, "Antipsychotic (medication that works by altering brain chemistry to help reduce psychotic symptoms like hallucinations - where you hear, see, smell, taste or feel things that appear to be real but only exist in your mind, delusions - a belief that is clearly false and that indicates an abnormality in the affected person's content of thought, and disordered thinking) Medication Use," revised November 2023, indicated residents will only receive antipsychotic

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F 758	Continued From page 59 medications when necessary to treat specific conditions for which they are indicated and effective. Resident will not receive PRN (as needed) doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record. The need to continue PRN orders of psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order.	F 758	Continued to F 803	1/23/24
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. 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	F 803	**F-803 (E) VERSION 2.0** **Menus and nutritional adequacy** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** Resident 178 was evaluated by RD on 12/11/23. Ice cream was immediately offered to the Resident and the Resident accepted. An in service regarding fortified diet/items and tray card accuracy, including the importance of reading the entire diet to the cook when requesting food items, availability and substitutes was given on 1/18/24 by Dietary Manager. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 1/19/24 Director of Nursing reviewed all orders to verify that any fortified diet orders have been transitioned to a Dietary Order for each fortified item per meal (as opposed to a Dietary Supplement). No other Residents were affected by the practice. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** Licensed Nurses were in serviced by the Director of Nursing (DON) on 1/16/24 thru 1/19/24 to ensure that all dietary orders, including any orders for fortified diets, are input as a “Dietary Order” in PCC to ensure that the order arrives properly to the Dietary Dashboard and is added to the Diet Ticket. This allows the fortified items to be displayed on the meal ticket as a standing order.	

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F 803	Continued From page 60 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 ensure staff followed fortified diet (increase caloric intake) guidelines during lunch preparation and tray line observation for one of 35 sampled residents by failing to: -Ensure a fortified diet was prepared and served to Resident 178, who had requested food only from the Japanese menu and was on a fortified diet. This deficient practice had the potential to result in decreased caloric intake and lead to undesirable weight loss. Findings: During a tray line observation for lunch service on 12/11/2023 at 11:30 AM, Resident 178 was on a fortified diet but requesting Japanese soup from the alternative menu. Dietary Aide (DA) 1 did not communicate the fortified diet orders written on the meal tickets during the lunch service. During a concurrent interview, Cook 1 stated residents who were on a fortified diet received a fortified mashed potato for the lunch and dinner meal and fortified cereal for the breakfast meal. Cook 1 stated the fortified mashed potato adds extra calories for residents on a fortified diet. A review of Resident 178's tray or meal ticket, on the cart, indicated the order for a fortified diet, but requesting Japanese style soup. DA 1 did not read out loud the fortified diet and Cook 1 did not add any additional food items. During a tray line observation for lunch service on	F 803	Director of Nursing (DON) / Designee will review the Order Listing Report daily, 5x a week, to ensure that any order is input correctly as a Diet Order. Dietary Manager / Designee will check trays for Resident that has a fortified item on their meal ticket to ensure that the fortified item is actually served to the Resident. This check will occur daily, for each meal, and will include at least 5 resident trays with fortified items per meal. This audit will continue until the audit show that 100% accuracy is met for three consecutive weeks. If any trays are found to be inaccurate, they will be corrected and immediately addressed. It will also be noted in the Dietary Audit Form. **How the facility will monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.** Findings from the Daily Audit Form reports will be presented to the QA Committee for further resolutions and recommendations. This correction will be monitored by Dietary Manager/ Designee for continued compliance **Completion Date: 1/23/2024**	1/23/24

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	555438	A. BUILDING _____ B. WING _____	12/28/2023

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F 803	Continued From page 61 12/12/2023 at 12:45 PM, Resident 178 who was on a fortified diet and requested Japanese food and no fortified mashed potatoes received a bowl of soup from the Japanese menu and did not receive fortified food. During a concurrent observation and interview, Cook 1 stated there was nothing prepared for the resident on a fortified diet who asked for a Japanese soup. During an interview with the kitchen Team Leader (TL) on 12/12/2023 at 1 PM, the TL stated for the resident who received Japanese soup and was on a fortified diet, there was nothing prepared to fortify the diet. During an interview with the Registered Dietitian (RD) on 12/13/2023 at 9:30 AM, the RD stated fortified diets add an extra 300 to 600 calories to the meals. The RD stated the regular diet provided 2200 calories per day and the fortified diets provided 2800-3000 calories per day. The RD further said a fortified diet was recommended for residents who were at risk for weight loss and need extra to maintain or gain weight and the kitchen did not have fortified food options for residents who only requested Japanese food. The RD stated a resident who only asked for Japanese soup did not receive fortified food per menu and diet guidelines. A review of Resident 178's diet order for 12/11 and 12/12/23 indicated, a regular diet with no added salt, fortified diet with standing orders for Somen (Japanese soup) and no maidish on menu. A review of the facility policy titled, "Fortified Food Program," dated 11/16/2023 indicated a fortified diet was to provide nutrient dense foods for	F 803	Continued to F 804	1/23/24

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F 803	Continued From page 62 residents requiring extra protein and calories who were unable to consume adequate amounts of food.	F 803	**F-804 (E)** **Nutritive Value/Appear, Palatable/Prefer Temp** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** A new plate warmer with a larger capacity of 200 plates was ordered on 1/17/2023. An alternative plate warmer will be used until the new unit arrives. An in service including Nutritive Value/Appearance, Palatable/ Preference Temp was started on 1/18/24 and will continue, focusing on delivering food within the required temps and within resident preferences. Director of Nursing / Designee conducted in service with the licensend nurses re the food temperatures. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 1/17/24 and 1/18/24 all Residents were interviewed and asked how the food temperature was on that day. 13 out of 205 interviews reported that at least a portion of the food was cold. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** Dietary Manager/Designee will continue to conduct additional in service covering food temp preferences, regulation temps, and maintaining temps throughout tray line process, 2x week for 4 weeks and then 1x week for 4 week.	1/23/24
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 ensure food was prepared by methods that conserved flavor and served at appetizing temperatures for 259 out of 275 residents who received food from the kitchen and for one resident (Resident 170) who complained the food was cold. This deficient practice had the potential to result in meal dissatisfaction, decrease food intake and placed residents at risk for unplanned weight loss. Findings: A review of Resident 170's admission record indicated the facility admitted the resident on 8/15/2023 with diagnoses including hemiplegia (paralysis on one-side of the body) and hemiparesis (weakness on one side of the body), muscle weakness, congestive heart failure (a long-term condition in which the heart cannot pump blood well enough to meet the body's	F 804		

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F 804	Continued From page 63 needs), atrial fibrillation (irregular heart rhythm), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily activities). A review of Resident 170's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 11/19/2023, indicated Resident 170 was cognitively (ability to think, understand, and reason) intact and had impairment to both sides of the lower extremities. The MDS indicated Resident 170 required set up or clean-up assistance with eating. The MDS further indicated Resident 170 was dependent on helper assistance for oral hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. During the initial facility tour on 12/11/2023 at 8 AM, complaints about the temperature of the food were identified. Complaints about cold food were also discussed during a resident council meeting on 12/12/2023 at 11 AM. During an interview in the kitchen on 12/11/2023 at 11:30 AM, Cook 2 stated the plate warmer (an equipment that keeps plates warm during service) was broken, the lunch service takes more than an hour, and because of that they would check the temperature of the food on the holding table twice. During a concurrent observation, the tray carts were ready with residents' trays that included salads, desserts, beverages, and ice cream and was waiting for the main food to be added. During the same observation and interview the Dietary Supervisor (DS) stated the plate warmer	F 804	Dietary Manager/designee will conduct temperature checks throughout the tray line process during each meal and will record the temperatures of each hot food item on the Daily Test Tray Form. They will also conduct food temp checks on the last tray delivered to a patient room to ensure food is being delivered at adequate temps 5x week for 2 weeks. The Daily Test Tray Form will be kept in the Dietary Department's POC binder. Temp preference questions have been included in the facility room rounds and those questions will be recorded and shared with the dietary department. **How the facility will monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.** Dietary Manager/ Designee will present Findings from the Dietary Audit Form and room rounds to the QA Committee for further resolutions and recommendations. **Completion Date: 1/23/2024**	1/23/24

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F 804	Continued From page 64 was broken for a couple of weeks, and they were in the process to replace it. The DS also stated the tray carts were assembled prior to adding the main dishes. During the observation of lunch service on 12/11/2023 at 11:35 AM Cook 2 checked the temperature of the lunch items using the facility thermometer. The temperature of food checked at 11:30 AM was as follows; -Regular Swiss steak 170 degrees Fahrenheit (a unite of measure)(F) -Soft and bite Swiss steak 167.5F -Minced and moist Swiss steak 155F -Puree Swiss steak 165.2F -Alternative meal chicken Cordon blue 150F -Regular green beans 152F -Puree green bean 150.8F -Regular pasta 158.5F During the observation of lunch service on 12/11/2023 at 12:35 PM The second food temperature check was as follows: -Regular Swiss steak 151 degrees Fahrenheit (a unit of measurement) (F) -Soft and bite Swiss steak 143F -Minced and moist Swiss steak 170 F -Puree Swiss steak 158F -Alternative meal chicken Cordon blue 150F -Regular green beans 151F When Cook 1 and Cook 2 were asked about the temperature of the meat that had dropped from the initial measurement and now, Cook 1 and Cook 2 stated, "Yes it has dropped." No further action was taken, and they proceeded to continue serving.	F 804	Continued to F 812	1/23/24

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F 804	Continued From page 65 During an interview on 12/11/2023 at 3:36 PM, Resident 170 stated the food they received during meals was always cold and that they stopped asking for ice cream with meals because it would always be melted when they received the meal tray. During an observation in the kitchen on 12/12/2023 at 11:30 AM Cook 2 checked the temperatures of the lunch items using the facility's thermometer. The temperature of the food checked was as follows: -Regular Maple chicken 168F -Soft and Bite chicken 184F -Minced and moist chicken 184F -Chicken gravy 191F -Regular Dill Carrots 174F -Mashed Potato 183F During an observation in the kitchen on 12/12/2023 at 12:45 PM Cook 1 stated this was the second temperature check of the food after one hour. The temperature of the food checked was as follows: -Regular maple chicken 167F -Soft and Bite chicken 170F -Minced and moist chicken 171F -Chicken gravy 171F -Regular dill carrots 162F -Mashed potatoes 177F During an observation in the kitchen on 12/12/2023 at 1 PM, the plate warmer was not operational. The DS stated the machine was broken and they have ordered a new plate warmer.	F 804	Continued to F 812	1/23/24

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F 804	Continued From page 66 During the test tray on 12/12/2023 at 1:35 PM the food temperatures of the sampled food varied from warm to lukewarm. The kitchen team Leader (TL) took temperatures of the test tray items using the facility thermometer which recorded as follows: -Regular maple chicken 109F -Mashed potatoes with gravy 131F -Regular Dill Carrots 111F During the same test tray observation, the chicken and the carrots tasted lukewarm and not appetizing. The TL noted the temperature change in the chicken from 167.F from the last check in the kitchen to 109.F at serving time. The TL stated the temperature drop was because the plates were not warmed during service time to maintain the temperature of the food during delivery. During an interview with the RD and DS on 12/13/2023 at 9:30 AM, the DS stated the plate warmer was broken, and the maintenance staff was no longer working in the facility. The DS stated a new plate warmer was purchased and would be arriving soon. The RD agreed the temperature drop was significant and stated this has been a recent issue because of the broken plate warmer.	F 804	Continued to F 812	1/23/24
F 812 SS=E	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	F 812	**F-812 (E)** **Food Procurement, Store/Prepare/Serve-Sanitary** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** The 30 chocolate flavored nutritional supplements, 22 vanilla flavored supplements were discarded immediately on 12/12/2023. The “ready to eat” sliced ham was discarded immediately on 12/11/2023. All food in resident refrigerators that was not labeled or that was expired was discarded. A new ice machine was purchased on 12/13/2023 to replace the old ice machine. A new contract was signed with Chandler to clean the Facility Ice Machines on 12/15/23. Facility purchased bags of ice (10 pcs) for lunch on 12/13/2023 while the new ice machine was installed. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** A thorough walk thru in the Kitchen was conducted on 1/16/24 by Jennifer Byrd, an outside contracted RD. 2 items were found and immediately corrected during Ms. Byrd's rounds. No other items were affected.	

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F 812	Continued From page 67 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. (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 observation, interview and record review, the facility failed to ensure safe and sanitary food storage practices in the kitchen by failing to: -Ensure the 30 chocolate flavored nutritional supplements and 22 vanilla flavored supplements stored in the reach in refrigerator with no thaw date and labeled "Store frozen" with the manufactures instruction to use within 14 day of thawing, were monitored for the date they were thawed to ensure expired shakes were discarded after this time frame. This deficient practice had the potential to result in food borne illness in 80 residents who are on nutrition supplements at the facility. -Ensure the storage period of one large package of "Ready to Eat" sliced ham deli meat received on 12/2/2023 did not exceed the storage period for deli meat stored in the walk-in refrigerator. -Ensure food brought to residents from outside of	F 812	**What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** Dietary Manager/Designee will conduct rounds of freezers, refrigerators, and patient refrigerators 5x week for 2 weeks to ensure that all items are labeled, within their expiration dates, and are properly stored. Any items that are improperly stored will be discarded. After the 5x for 2 weeks then we will continue 1x week. The ice machines will be cleaned by dietary manager/designee/EVS supervisor monthly and professionally cleaned quarterly. Cleaning logs will be kept with EVS office and in the Dietary Office. **How the facility will monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.** Findings from refrigerator, freezer and patient refrigerators audits will be captured on the Monitoring Sheet and presented to the QA Committee monthly for further resolutions and recommendations. The Dietary department will also present the ice machine cleaning schedule to the QA Committee. The monthly RD inspection will be amended to include ALL ICE MACHINE cleaning review, review of labeling and dating audits with the results being submitted to the QA Committee monthly for further resolutions. This audit will verify and validate the results of the daily rounds of the Supervisor. **Completion Date: 1/23/2024**	1/23/24

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F 812	Continued From page 68	F 812	Continued to F 880	1/23/24

the facility, was stored in the resident's food refrigerator, and was monitored for an expiration date. One sandwich was stored in the refrigerator that was expired and apple and cranberry juice for residents had no open date.
-Ensure the ice machine was maintained in a sanitary manner and the inside compartment of ice machine was clean and not dirty.

These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 259 out of 275 residents who received food and ice from the facility and resident's who had food and juice stored in the resident refrigerator.

Findings:

a. During an observation in the kitchen on 12/11/2023 at 8:05 AM there were 30 single serve cartons of chocolate flavored nutrition supplements and 22 vanilla flavored nutrition supplements stored in the reach in refrigerator with no thaw date. During a concurrent interview, the Dietary Supervisor (DS) stated the single serve carton of nutritional supplements were frozen and were stored in the refrigerator. The DS stated once thawed we store and use them within 14 days. The DS agreed there should be a date on the supplements to monitor date of thaw and to discard them if expired. The DS was not sure when the chocolate and vanilla nutrition supplements were thawed.

A review of facility policy titled, "Labeling/Date Marking and safe storage of refrigerated and Frozen foods," revised 1/1/2018 indicated health

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F 812	Continued From page 69 shakes usually have a 14-day refrigerated shelf life once thawed. They must be individually labeled or kept together in a box or container that has a date mark for use by date. The day they are pulled from freezer is day 1. A review of the 2022 U.S. Food and Drug Administration Food Code titled, "Ready to Eat, Time/Temperature control for safety food, Date Marking," Code #3-501.17, indicated ready to eat, time temperature control for safety food prepared and packaged by food processing plant shall be clearly marked, at the time the original container was opened in a food establishment and if the food was held for more than 24 hours, to indicate the date or day by which the food shall be consumed, sold, or discarded. b. During an observation of the walk-in refrigerator on 12/11/2023 at 8:45 AM, there was a large bag of sliced ham stored in the refrigerator with a received date of 12/2/2023 which exceeded the storage period for ready to eat deli meats. During a concurrent interview with the DS stated ready to eat food was kept for 5-7 days in the refrigerator. The DS stated all items should have a use by date to discard before they were expired. The DS verified that the deli meat was frozen and placed in the refrigerator to thaw but did not know the date. The DS stated sliced ham would be discarded because it had been in the refrigerator more than seven days. A review of facility policy titled, "Labeling/Date Marking and safe storage of refrigerated and Frozen foods," revised 1/1/2018 indicated commercially processed food that were not PH adjusted, must be dated when open and were	F 812	Continued to F 880	1/23/24

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F 812	Continued From page 70 good for 7 days. A review of the facility food storage chart for refrigerated items, revised 1/1/2018, indicated recommended storage time for luncheon meats was 5-7 days in the refrigerator. c. During an observation in the resident refrigerator located in the nourishment station on the third floor on 12/11/2023 at 2:45 PM, there was a box of (spring rolls) stored in the freezer with no label. Two boxes of apple juice were open with no open date and one large bottle of cranberry juice for a resident with no open date. During a concurrent interview with the Desk Nurse (RN 3), she stated the apple juices were used by the nurses during the Medication Pass. RN 3 stated whoever opened the juice boxes had to label with the open date on the box. During an observation in the resident refrigerator located in the nourishment station on the first floor on 12/11/2023 at 3 PM, there was a large sandwich with a use by date of 12/10/2023 stored in the refrigerator. During a concurrent interview with LVN 9, she stated resident food brought from outside should be labeled with the resident's name and use by date. LVN 9 stated the sandwich was expired and should be discarded. d. During an observation of the facility ice machine on 12/12/2023 at 1:45 PM, located on the second floor in C wing, the Team Leader in the kitchen opened the ice machine upper compartment cover for inspection. There were black residue build up along the plastic cover	F 812	Continued to F 880	1/23/24

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F 812	Continued From page 71 around the water curtain and water distribution tube (area where water runs to form ice). The TL stated the Maintenance Supervisor cleaned the machine monthly, but he no longer worked in facility. During an interview with the Registered Dietitian (RD) and Dietary Supervisor (DS) on 12/13/2023 at 9:30 AM, the RD stated the maintenance supervisor was responsible for cleaning the ice machine. The RD and DS stated the inside of the ice machine's upper compartment was dirty and not safe for consumption. The RD stated the ice machine was disconnected and will not use the ice from the ice machine. During an interview with the administrator (ADM) on 12/13/2023 at 3 PM, the ADM said the ice machine was dirty and would be replaced. A review of the 2022 U.S. Food and Drug Administration Food Code titled, "Equipment Food-Contact Surfaces and Utensils," Code# 4-602.11, indicated surfaces of utensils and equipment contacting food that was not time/temperature control for safety food such as iced tea dispensers, carbonated beverage dispenser nozzles, beverage dispensing circuits or lines, water vending equipment, coffee bean grinders, ice makers, and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms.	F 812	Continued to F 880	1/23/24
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880	**F-880 (E)** **INFECTION PREVENTION AND CONTROL** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** A 1:1 in-service/ training and re-education provided to LVN 6 on 1/18/24 by Infection Preventionist about adherence on facility's infection control policy and procedure, emphasis on purpose and importance of performing proper hand washing/ hand hygiene prior to entering and after exiting resident's room, particularly before and after resident care, in between resident care, and after touching surfaces in the resident's room, to prevent spread of infection.	

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	555438	A. BUILDING _____ B. WING _____	12/28/2023

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F 880	Continued From page 72 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880	A competency skills test provided to LVN 6 by Infection Preventionist on 1/18/24about proper handwashing/ hand hygiene. LVN 6 demonstrated the process well. Infection Prevention (IP) Nurse/ Licensed Designee conducted a series of in-service/ training and re-education to nursing staff about infection prevention and control processes and program while providing care, emphasis on purpose and importance of performing proper hand washing/ hand hygiene prior to entering and after exiting resident's room, particularly before and after resident care, in between resident care, and after touching surfaces in the resident's room to prevent spread of infection, in accordance to facility's policy. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** On 1/16/24 Infection Prevention (IP) Nurse evaluated all Residents in the D-wing Unit for sign/ symptom of hospital acquired infection. No other Resident was found to be affected by this deficient finding. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur:** Infection Prevention (IP) Nurse/ Designee will conduct random handwashing/ hand hygiene adherence monitoring to at least 3-5 staff members/ day, including contracted vendors and registry workers 1x/week x 4 weeks then 5-10 staff members including contracted vendors and registry workers weekly x 2 weeks randomly and as needed thereafter.	1/23/24

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F 880	Continued From page 73 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff adhered to the facility's infection control policy and procedures by ensuring facility staff conducted hand hygiene prior to entering and after exiting a resident's room. This deficient practice had the potential to result in the spread of infection and placed facility residents and staff at risk to become infected and seriously ill, leading to hospitalization and/or death. Findings:	F 880	Infection Prevention (IP) Nurse/ Licensed Designee will provide an in-service/ training and re-education to nursing staff (CNAs/ LVNs/ RNs) about infection prevention and control processes and program while providing care, emphasis on purpose and importance of performing proper hand washing/ hand hygiene prior to entering and after exiting resident's room, particularly before and after resident care, in between resident care, and after touching surfaces in the resident's room to prevent spread of infection, in accordance to facility's policy. This in-service/ training will be provided monthly x 6 months then annually and as needed thereafter. **How the facility will monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system.** Findings from adherence monitoring process will be presented to the QA Committee monthly for further resolutions and recommendations. This correction will be monitored by Infection Preventionist for continued compliance. **Completion date: 1/23/2024**	1/23/24

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F 880	Continued From page 74	F 880		

During an observation on 12/11/2023 at 1:49 PM, Licensed Vocational Nurse (LVN) 6 was observed entering Room (A) without performing hand hygiene. LVN 6 was observed assisting the resident in Room (A) set up their lunch tray and moving their bedside table. LVN 6 was then observed exiting the resident's room without performing hand hygiene.

During an interview on 12/11/2023 at 1:53 PM, LVN 6 stated and acknowledged he did not perform hand hygiene prior to entering and exiting Room (A). LVN 6 indicated he was just helping the resident in Room (A) set up their lunch tray. LVN 6 stated he was "Supposed to perform hand hygiene before and after exiting a resident's room for infection control."

During an interview on 12/11/2023 at 11:47 AM, the Director of Nursing (DON) stated staff were to perform hand hygiene before and after resident care, in between resident care, and after touching surfaces in the resident's room. The DON stated there was a potential infection control issue if staff did not perform hand hygiene.

A review of the facility's policy and procedure titled, "Hand Washing/Hand Hygiene," revised 11/2023, indicated this facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations, before and after direct contact with residents, after contact with objects (e.g., medical

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F 880	Continued From page 75 equipment) in the immediate vicinity of the resident, before and after assisting a resident with meals.	F 880		