POC Received 9/18/24
POC Accepted 9/19/24
BIC = 9/18/24 per ABallout

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055887	A. BUILDING _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BEND NURSING CENTER	2215 OAKMONT WAY WEST SACRAMENTO, CA 95691

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Federal Recertification Survey. The facility census was 89. The sample size was 30.	F 000	Preperation and/or execution of this Plan of Correction, inclusive of pages 1 through 67, does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by provisions of 42 CFR 483, et seq., and Health and Safety Code Section 1280. In response to the Department;s findings we submit the following Plan of Correction which shall constitute River Bend Nursing Center's credible allegation of compliance.	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550	**F 550** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** In-Services were done for the staff on Resident Rights and Homelike Environment. Staff were educated on the importance of knocking before entering room, for any reason. Staff were also educated on bathing and shower schedule in accordance with Resident Rights and Resident Dignity.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 9/18/2024

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 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure dignity and privacy were promoted for two of 30 sampled residents (Resident 52 and Resident 19), when: 1. Staff did not knock nor identify himself and entered Resident 52's room; and, 2. Resident 19 was left with a pungent, strong body odor and foul-smelling immediate environment. These failures resulted in negatively impacting Resident 52 and Resident 19's emotional, mental, and psychosocial well-being. Findings: 1. Resident 52 was admitted in early of 2024 with diagnoses which included post-traumatic stress disorder (PTSD), depression, and chronic pain. During a review of Resident 52's Minimum Data Set (MDS, an assessment tool), dated 7/25/24, the MDS indicated Resident 52 had no memory impairment and had episodes of feeling down,	F 550	**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;** All residents can be affected by this deficient practice. Department Heads will conducts daily room rounds. These room rounds will be discussed in daily stand up meetings. On daily room round audit form, department head will answer the question, Is resident clean, dry and free from any odor. Administrator will keep daily room round form to ensure residents are being taken care of. Room round form will also track if staff is knocking before entering the room.	

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F 550	Continued From page 2 depressed and hopeless. During a review of Resident 52's Nursing Care Plan (NCP), dated 8/1/24, the NCP indicated, "At risk for altered well-being & reduced sense of well-being related to: DX [diagnosis] of Depression, Post-traumatic disorder ..." During a concurrent observation and interview on 8/19/24 at 11:10 a.m. in Resident 52's room, Resident 52 was sitting on the edge of the bed, awake, alert and verbally responsive. In a very low tone voice, Resident 52 stated, "One time the maintenance man came in...He just walked into the room and didn't knock...he just walked right in and did not say anything...I thought I lost my dignity and my privacy was not respected during that time." During an interview on 8/20/24 at 8:38 a.m. with Maintenance (MAIN), when asked the process of repairing any broken equipment in the room, the MAIN stated, "I enter the room and go and fix what is broken or equipment not working...I just go in and do the work I am supposed to be doing, then leave...I don't knock and I don't talk to the resident." During an interview on 8/21/24 at 2:30 p.m. with Licensed Nurse 4 (LN 4), LN 4 stated, "[Resident 52] doesn't like any random person goes into her room. So, we have to introduce our names..." During an interview on 8/21/24 at 2:40 p.m. with LN 1, when asked what the process was when staff entered a resident's room, LN 1 stated, "We always knock first, you announce yourself, ask permission to come in...then they will know...I mean, just for respect and privacy and dignity if	F 550	**What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** Room round forms will be collected by Administrator. Room rounds will be discussed daily to ensure residents dignity and the rights of residents are being observed. If anything is reported during stand up, nursing will address them immediately. on the spot education will be given if knocking before entering the room is observed or reported. Any resident found to not be clean or free from odor will be reported to nursing and that will be addressed immediately.	

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F 550	Continued From page 3 they were sleeping or doing something." During an interview on 8/22/24 at 9:30 a.m. with the Director of Nursing (DON), the DON stated, "When staff goes in a room...knock on the door before going in...introduce yourself...I think that we should address them. It's their home...I believe that you should not come in if the resident does not want you to come in to respect their privacy and dignity." 2. Resident 19 was admitted in early of 2020 with diagnoses which included PTSD, blindness, and anxiety. During a review of Resident 19's MDS, dated 7/19/24, the MDS indicated Resident 19 had moderate memory impairment and did not reject ADL (activities of daily living) assistance. During a review of Resident 19's NCP, dated 5/9/23, the NCP indicated, "ADL SELF CARE DEFICIT: [Resident 19] is at risk for self-care deficit r/t [related to] decreased/impaired mobility." During a concurrent observation and interview on 8/19/24 at 2:33 p.m. in Resident 19's room, Resident 19 was in bed, awake, alert and verbally responsive, appeared disheveled, half naked and wearing a dirty incontinence brief. Resident 19's body had a very strong-smelling pungent odor and the immediate environment also had a foul-smelling strong odor, the sheets were disorganized, and the floor below the bed was dirty. When asked how he was doing, Resident 19 stated, "I live like a homeless. The nurses here, they don't attend to me and they leave me filthy...From an 82 year-old...this is what I get,	F 550	**How the facility plans to monitor its performance to make sure that solutions are sustained.** Daily room round forms will be collected and reviewed by Administrator. Daily discussion of findings from room rounds will be discussed in daily stand up. Anything that needs to be addressed or corrected will be noted and followed up on the next day in Stand Up by Administrator or designee. Room Rounds and compliance with Resident Rights and Resident Dignity will be discussed and followed up on in quarterly QA meeting to ensure compliance.	

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F 550	Continued From page 4 filthy and dirty...I wish they could tell me that someone will come and talk to me so I can prepare myself, not like this. These people don't know what they are doing." During an interview on 8/19/24 at 2:35 p.m. with LN 1, LN 1 entered Resident 19's room and verified Resident 19's filthy situation and strong odor with the immediate room environment's foul-smelling strong odor, and stated, "I can see he is dirty right now. It's very unhealthy leaving him like that..." During an interview on 8/22/24 at 9:30 a.m. with the DON, the DON stated, "It's all about what is needed for the resident...I'm on cleanliness and don't leave the resident filthy, smelly and dirty in order to promote their dignity." During a review of the facility's policy and procedure (P&P) titled, "Resident Rights," dated 12/16, the P&P indicated, "Employees shall treat all residents with kindness, respect, and dignity...Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to...a dignified existence...privacy and confidentiality."	F 550	**Date when corrective action will be completed;** 09/13/2024 QA - 10/2024 and ongoing.	
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits,	F 583	**F 583** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;**	

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F 583	Continued From page 5 and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents' right to personal privacy and confidentiality of his or her personal medical information when meal tray tickets were thrown into the general kitchen trash. This failure had the potential of compromising resident privacy for 54 residents receiving facility prepared meals. Findings:	F 583	On 8/26/24 a shredder was purchased and installed in the kitchen next to the Dietary Manager office. Staff have been educated and instructed that all tray tickets containing resident information need to be shredded. **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;** All residents have the possibility to be affected by the deficient practice. A shredder was purchased and installed in the kitchen by the Dietary Manager office on 8/26/24. All dietary staff have been instructed that each meal tray ticket is to be shredded in this shredder. **What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** Dietary Manager or designee will ensure that each meal tray ticket is collected after each meal service and shredded in the kitchen shredder. This will ensure compliance with policy on resident privacy.	

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F 583	Continued From page 6 During a concurrent observation and interview on 8/20/24 at 9:36 a.m. near the dish washing sink, with Dietary Aide 1 (DA 1), DA 1 was preparing the breakfast meal trays to be washed and, while doing so, threw the resident meal tray tickets into the kitchen's general trash. When asked what is done with the resident meal tray tickets, he pointed to the trash and stated, "I throw them in here." A review of the facility's meal tray tickets for 8/20/24 were noted to include the following information: resident name, room number, diet order, food allergies, food preferences, and special dietary needs. During an interview on 8/20/24 at 9:39 a.m. with the District Kitchen Supervisor (DKS), the DKS confirmed that meal tray tickets were being thrown in the trash and indicated that tray tickets needed to be shredded to maintain residents' privacy. During a review of the facility's policy and procedure (P&P) titled, "Resident Rights," dated 12/16, the P&P indicated, " ...Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to ...privacy and confidentiality ...The unauthorized release, access, or disclosure of resident information is prohibited."	F 583	**How the facility plans to monitor its performance to make sure that solutions are sustained.** Dietary Manager or designee will ensure that each meal ticket after each meal service is gathered and shredded in the kitchen shredder. Dietary manager will report compliance with this procedure in quarterly QAPI meeting to ensure compliance. **Date when corrective action will be completed;** 8/26/2024 QAPI - 10/2024	
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	F 656	**F 656**	

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F 656	Continued From page 7 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 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	F 656	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** The care plan for resident 52 was updated on 8/21/24 to correctly identify and address environmental concerns. Resident 52 was offered a room change, which was declined. That was documented by the Social Services Director. The care plan for resident 85 was initiated on 8/21/24 for activities.	

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F 656	Continued From page 8 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 ensure comprehensive care plans were developed and implemented for two out of 30 sampled residents (Resident 52 and Resident 85), when: 1. Resident 52's emotional issues and environmental concerns were not developed; and, 2. Resident 85 had no care plan developed and implemented for activities. These failures had the potential to result in residents not attaining their highest practicable physical, mental and psychosocial well-being. Findings: 1. Resident 52 was admitted in early 2024 with diagnoses which included post-traumatic stress disorder (PTSD), depression, and chronic pain. During a review of Resident 52's Minimum Data Set (MDS, an assessment tool), dated 7/25/24, the MDS indicated Resident 52 had no memory impairment and had episodes of feeling down, depressed, and hopeless. During a concurrent observation and interview on 8/19/24 at 11:10 a.m. in Resident 52's room, Resident 52 sat on the edge of the bed, awake, alert and verbally responsive. Resident 52 stated, "I have been here six months...People here don't respond to my problems. My main problem when	F 656	**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;** All residents have the possibility of being affected by the deficient practice. The Medical Records Director audited all care plans to coincide with proper diagnoses. All are up to date Care plan audit for all new admissions to the facility will be conducted by Medical Records Director and given to DON every Friday for review to ensure residents care plans are appropriate for diagnoses.	

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F 656	Continued From page 9 I called about three weeks was the doors slamming too loud when they close them...Every time they close the door, there is that loud noise. They slam the door so hard that I feel so scared. I have PTSD and I recall what happened to me whenever I hear that banging sound...I have already told the nurses about the doors being closed so loud, and they don't listen. The loud banging happens throughout the day, and especially at night...When I specifically said how can we fix the doors, they said nothing. No response at all. I cannot close my door because I am claustrophobic [fear of enclosed spaces] because of my PTSD...I am miserable with the...slamming doors." During an interview on 8/20/24 at 8:40 a.m. with Maintenance (MAIN), MAIN stated, "I am aware of the loud noise the door makes when closing, because that has been a long time problem near the [Resident 52's] room. It has been a problem by [Resident 52]...I brought the issue with the administrator but they have not done anything. There are three doors next to the room. The plan of the DON [Director of Nursing] was to move [Resident 52] to another room but it has not happened. That has been a while." During an interview on 8/20/24 at 2:30 p.m. with Licensed Nurse 4 (LN 4), LN 4 stated, "[Resident 52] wants to keep her door open but she doesn't like the noise and the slamming doors...She complained about this banging doors weeks ago...She wants to stay in her room...I also updated the maintenance guy about the doors." During an observation on 8/20/24 at 2:35 p.m. in the hallway near Resident 52's room, staff opened and closed the three doors, the exit door,	F 656	**What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** Upon admission, IDT will review diagnoses with care plans for new admissions to ensure they are appropriate. MRD will audit care plans weekly and report to DON on Friday. The care plan for resident 52 was updated on 8/21/24 to reflect proper diagnoses. Resident also given opportunity for room move due to alleged noise, which resident declined. The care plan for resident 85 was initiated on 8/21/24. Care plan is comprehensive to include 1v1 activities in room.	

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F 656	Continued From page 10 the laundry room door and the shower room door adjacent to the resident's room. The exit door on the main hallway closed with a loud banging sound. The laundry room door closed with a loud sound. The shower room door closed quietly when staff slowly closed the door. During an interview on 8/20/24 at 2:40 p.m. with LN 1, LN 1 stated, "The door stopper is not good on the exit door and the laundry room door... [Resident 52] mentioned to me...She's very alert and oriented...I heard that she's always mad about the doors and she already complained about them like two to three months ago." During an interview on 8/21/24 at 9:20 a.m. with the Social Services Director (SSD), when asked about Resident 52's emotional and environmental concerns, the SSD stated, "I am not aware of the issues on the loud noises and slamming doors ...there is no care plan for that. I am not aware of that situation...so it's not included in her care plan. I am aware that she has PTSD." During an interview on 8/21/24 at 10:45 a.m. with LN 1, LN 1 stated, "When there is a new problem for a resident, we develop a care plan right away. There should have always be a care plan for any issue or problem." 2. Resident 85 admitted to the facility in mid-2024 with diagnoses which included lumbar vertebral (lower back) fracture, difficulty in walking, Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills), and generalized anxiety disorder. During a concurrent observation and interview on 8/20/24 at 11:06 a.m. with Certified Nursing Assistant (CNA) 12, regarding Resident 85,	F 656	**How the facility plans to monitor its performance to make sure that solutions are sustained.** Audits for care plans for new admissions will be provided and reviewed weekly by DON. Updates will be provided in quarterly QA meetings to ensure compliance. Care plans will be reviewed and adjusted accordingly.	

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RIVER BEND NURSING CENTER	2215 OAKMONT WAY WEST SACRAMENTO, CA 95691

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F 656	Continued From page 11	F 656		

Resident 85 was lying in bed. When asked if Resident 85 attended activities, CNA 12 stated, "She does not go to activities...they do not get her up...she just stays in her bed."

During a review of Resident 85's, "ACTIVITIES-INITIAL REVIEW [assessment], dated 8/8/24, the assessment indicated, "Complete on admission. Use this data to design an activities program that meets the residents needs and preferences. Update the care plan on completion...will do in room visits 3x week..."

During a concurrent interview and record review on 8/21/24 at 2:18 p.m. with the Activities Director (AD), the AD reviewed the activities assessment and confirmed Resident 85 was to receive in room visits 3x week. The AD was asked if Resident 85 should have a care plan (CP) for activities, and stated, "Yes, there should be one." When asked to review the CP, the AD was unable to locate one and stated, "I have not done her care plan, there should be one." When asked why it was important to create a CP, the AD stated, "To make sure we are accommodating them. Not have them isolated so they don't fall into depression..."

During an interview on 8/22/24 at 9:30 a.m. with the DON, the DON stated, "If there is a new issue and we have a problem facing a resident...definitely the nurses within 24 hours should have a care plan developed and in place. I think the situation or whatever it is needed to be addressed is implemented and then you collaborate as a team to figure out what you're going to do...at least you've got a care plan developed at the start."

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F 656	Continued From page 12 During a review of the facility's policy and procedure (P&P) titled, "Care Plans, Comprehensive Person-Centered," dated 12/16, the P&P indicated, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident..."	F 656	**Date when corrective action will be completed;** 9/13/24 QA - 10/2024 and ongoing	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657	**F 657** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** Resident 18 care plan was revised to specify 2 handed sip cup with meals. The meal ticket did not coincide with the actual care plan. That has been corrected and revised again on 9/18/24. Adaptive devices will be highlighted by the dietary manager or designee at each meal tray line to ensure compliance. Resident 139s care plan was adjusted on 8/21/24 to state that medication should be given as ordered. This adjustment will ensure proper pain management to address resident needs.	

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F 657	Continued From page 13 assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to revise the comprehensive care plan for two of 30 sampled residents (Resident 18 and Resident 139), when: 1. Resident 18's nutrition care plan was not updated for an adaptive device; and, 2. Resident 139's pain care plan was not updated for a new pain medication. These failures had the potential to result in Resident 18 and Resident 139's not attaining their highest practicable well-being. Findings: 1. Resident 18 was admitted to the facility in late 2015 with diagnoses which included stroke, diabetes (uncontrolled blood sugar levels), left sided hemiplegia (paralysis on one side of the body), dysphagia (swallowing difficulty), and muscle weakness. During a review of Resident 18's Nursing Care Plan (NCP), dated 5/20/20, the NCP indicated, "Adaptive equipment: Sipper cups and Divided plate for all meals...No changes have been made since the last review." During a review of Resident 18's NCP, dated 8/19/20, the NCP indicated, "SELF CARE DEFICIT: due to: Need assistance IN ADL[activities of daily living]: Resident's ability to perform ADL at highest practicable level will be promoted with interventions...No changes have	F 657	**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;** Pain management care plan for each resident have be audited to assure proper interventions for pain medication administration. All care plans for new admissions will be audited by IDT to ensure proper pain interventions are in place at the time of admission. All residents that require adaptive equipment for meals have been audited to ensure care plan matches the diet ticket. Dietary Manager or designee will highlight, bold, underline, or italicize the proper adaptive equipment needed for residents, to ensure compliance at each meal.	

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F 657	Continued From page 14 been made since the last review." During a review of Resident 18's Clinical Physician Orders (CPO), dated 1/12/24, the CPO indicated, "Consistent Carbohydrate (CCD) diet, Dysphagia advance texture, Thin Liquids consistency...1:1 FEEDER. 2 handled cup, divided plate." During a review of Resident 18's Minimum Data Set (MDS, an assessment tool), dated 5/21/24, the MDS indicated, "Eating: The ability to use suitable eating utensils to bring food to the mouth...resident completes activity." During a review of Resident 18's NCP dated 5/28/24, the NCP indicated, "Nutrition risk: for weight loss related to poor meal intake." There was no documented evidence the NCP was revised or updated. During a concurrent observation and interview on 8/19/24 at 12:04 p.m. in the dining room with Licensed Nurse 2 (LN 2) and LN 3, Resident 18 started having her lunch meal. When asked what kind of cup did Resident 18 have in her meal tray, LN 2 stated, "That's a sippy cup. That's not a two handed cup." Resident 18's meal ticket indicated, "Divided Plate; Two Handled Cup." When asked if the cup was okay with her, Resident 18 shook head, and stated, "No." LN 3 verified the cup, and stated, "No. It's not a two handed cup. We are going to take another replacement from the kitchen." . During an interview on 8/21/24 at 11 a.m. with the MDS Coordinator (MDSC), the MDSC verified the care plan for Resident 18 included the use of adaptive devices ordered which included the two	F 657	**What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** IDT will audit new admission care plans for proper pain management interventions as well as the use of any needed adaptive equipment for meals. Audit will be run by MRD or designee and be given to DON weekly to ensure compliance. Dietary Manager or designee will ensure proper adaptive equipment is being used at each meal service.	

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F 657	Continued From page 15 handled cup, and stated, "The two handled cup was not included as an intervention in the nutrition care plan. The care plan was not revised and updated." 2. Resident 139 was admitted to the facility in the middle of 2022 with diagnoses which included stroke, decreased mobility, chronic obstructive pulmonary disease (CODP, lung disease), respiratory failure, stroke, and swallowing difficulty. During a review of Resident 139's NCP, dated 8/19/20, the NCP indicated, "[Resident 139] expressed alteration in Comfort and Daily Activity due to presence of pain." During a review of Resident 139's NCP, dated 4/27/23, the NCP indicated, "[Resident 139] is at risk for pain r/t [related to]: decreased mobility, COPD...low back pain." During a review of Resident 139's MDS, dated 8/12/24, the MDS indicated Resident 139 had no memory impairment and had verbalized pain. During a review of Resident 139's CPO, dated 8/14/24, the CPO indicated, "Tramadol...Give 1 tablet by mouth every 4 hours as needed for moderate to severe pain." During a review of Resident 139's Pain Interview Assessment (PIA), dated 8/16/24, the PIA indicated, "Pain Presence: Yes; Pain Intensity: Moderate; Pain Management: Tramadol... [Resident 139] did say she had some pain in her back..." During a concurrent observation and interview on	F 657	**How the facility plans to monitor its performance to make sure that solutions are sustained.** MRD will audit all care plans for new admissions weekly to focus on pain management and proper medication administration, and adaptive equipment needed for dining. This information will be given to the DON to review and make changes if necessary. Dietary Manager will audit tray tickets 2 times per week for 90 days. Each will report at quarterly QA meeting to ensure compliance.	

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F 657	Continued From page 16 8/19/24 at 9:44 a.m. in Resident 139's room, Resident 139 was in bed, awake and alert and verbally responsive, appeared restless and uncomfortable and grimacing. When asked how she was doing, Resident 139 stated, "...I also have pain but I don't know if I had pain medications. I have been here waiting for a long time." During a concurrent observation and interview on 8/19/24 at 9:50 a.m. in Resident 139's room, the Director of Staff Development (DSD) entered the room and stated, "I'm the DSD and I am not the nurse for the resident." When asked what to do with the Resident 139's pain, the DSD stated, "I will tell the nurse for her complaint of pain." Resident 139 stated, "She won't tell." During a concurrent observation and interview on 8/21/24 at 9:13 a.m. in Resident 139's room, Resident 139 was in bed, awake, alert and verbally responsive and grimacing. When asked how she was doing, Resident 139 frowned, and stated, "I still hurt. They never gave me my pain medication. They won't do anything with my pain." During an interview on 8/21/24 at 9:15 a.m. with CNA 14, when asked if she had seen Resident 139, CNA 14 stated, "[Resident 139] had told me about her pain. I already told the nurse and the nurse knows something about it." During an interview on 8/21/24 at 9:17 a.m. with LN 4, LN 4 stated, "[Resident 139] has PRN [as needed] medication for the pain...[CNA 14] told me about the patient with pain." During an interview on 8/21/24 at 9:28 a.m. with LN 1, when asked about Resident 139's pain, LN	F 657		

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1 stated, "Typically, when a resident complains of pain, absolutely, we address that right away. We do an assessment and we administer medication and follow the physician's orders. We don't wait."

During an interview on 8/21/24 at 9:59 a.m. with LN 4, LN 4 stated, "When a new medication order is received from the doctor...If the new medication is a new intervention, and there is already an old care plan for pain, we have to revise and update the care plan." LN 4 verified the care plan for Resident 139 on 5/24/22 which indicated no intervention for administration of medication as ordered and confirmed the Tramadol was ordered 8/14/24, and stated, "The care plan was not updated, It should be revised for the new medication ordered as an intervention."

During an interview on 8/21/24 at 2:25 p.m. with the MDSC, the MDSC verified there was no revision of the pain care plan after the order of tramadol was received, and stated, "There was no added intervention for the pain for medication as ordered."

During an interview on 8/22/24 at 9:30 a.m. with the Director of Nursing (DON), the DON stated, "Whatever it is needed to be addressed is implemented...then you can adjust it and you can revise it when a new intervention comes in...Every resident has the right to be provided with adequate care. We do not wait until we see their decline or their environment becomes unacceptable."

During a review of the facility's policy and procedure (P&P) titled, "Care Plans, Comprehensive Person-Centered," dated 12/16,

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F 657	Continued From page 18 the P&P indicated, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident...Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change."	F 657	**Date when corrective action will be completed;** 9/18/2024 QA - 10/2024	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure necessary services to maintain good grooming and personal hygiene were provided for two out of 30 sampled residents (Resident 19 and Resident 29), when: 1. Resident 19 was unkempt and the immediate environment had a strong foul-smelling odor; and, 2. Resident 29's fingernails were long and with jagged ends. These failures had the potential to result in the residents not attaining their highest practicable well-being. Findings: 1. Resident 19 was admitted in early 2020 with diagnoses which included post-traumatic stress	F 677	**F 677** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** Resident 19 was seen by the DON on 8/19/24. After several refusals, resident 19 agreed to a bed bath and also to a brief change. Resident 19 has a history of non-compliance with bathing and incontinence care. This is care planned. Resident 29 had nails cut by LN on 8/20/24. CNAs have been instructed to use new shower sheet with specific nail care documentation to ensure nail care is done.	

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F 677	Continued From page 19 disorder (PTSD), blindness, and anxiety. During a review of Resident 19's Minimum Data Set (MDS, an assessment tool), dated 7/19/24, the MDS indicated Resident 19 had moderate memory impairment and did not reject ADL (activities of daily living) assistance. During a review of Resident 19's Nursing Care Plan (NCP), dated 5/9/23, the NCP indicated, "ADL SELF CARE DEFICIT: [Resident 19] is at risk for self-care deficit r/t [related to] decreased/impaired mobility." During a concurrent observation and interview on 8/19/24 at 2:33 p.m. in Resident 19's room, Resident 19 was in bed, awake, alert and verbally responsive, appeared disheveled, half naked and wearing a dirty incontinence brief. Resident 19's body had a very strong-smelling pungent odor and the immediate environment had also a foul-smelling strong odor, sheets were disorganized, and the floor below the bed was dirty. When asked how he was doing, Resident 19 stated, "I live like a homeless. The nurses here, they don't attend to me and they leave me filthy...From an 82 year-old...this is what I get, filthy and dirty...I wish they could tell me that someone will come and talk to me so I can prepare myself, not like this. These people don't know what they are doing." During an interview on 8/19/24 at 2:35 p.m. with Licensed Nurse (LN 1), LN 1 entered Resident 19's room and verified Resident 19's filthy situation and strong odor and the immediate room environment's foul-smelling strong odor, and stated, "I can see he is dirty right now. It's very unhealthy leaving him like that..."	F 677	**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;** Department heads are assigned room rounds. Room rounds are done daily M-F. These room rounds are discussed at daily stand up. During room rounds, department heads check off the following. "Resident is clean, dry, and free from odor." " Resident is groomed, clean shaven, hair combed, oral and nail care provided." If anything has not been done, DON or designee will ensure the care has been given after stand up meeting. **What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** Room rounds will be done by department heads daily to ensure nail care and cleanliness of residents. If anything is missed, DON or designee will ensure the care has been given. For resident 19, DON or desginee will visit resident daily to encourage cleanliness, incontinence care, and bathing. Family members have been encouraged to participate in care if refusals continue.	

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F 677	Continued From page 20 During a concurrent observation and interview on 8/20/24 at 2:50 p.m. in Resident 19's room, Resident 19 in bed, awake and alert and verbally responsive. The room environment appeared cleaner and Resident 19 looked cleaner and much less odor compared to the day before. LN 1 stated, "Every now and then, he has different choices of staff...but they should not have left him smell like that to preserve his dignity." During an interview on 8/22/24 at 9:30 a.m. with the Director of Nursing (DON), the DON stated, "Every resident has the right to be provided with adequate care including medications, activities of daily living, adaptive devices and comfortable environment. We do not wait until we see their decline or their environment becomes unacceptable." 2. Resident 29 was admitted in late 2021 with diagnoses which included respiratory failure, traumatic brain injury, and seizure (abnormal body movements). During a concurrent observation and interview on 8/19/24 at 11:40 a.m. in Resident 29's room, Resident 29's fingernails were noticeably long and jagged. When asked if Resident 29 would like his nails trimmed, he nodded his head yes. During an interview on 8/19/24 at 11:45 a.m. with LN 6, LN 6 confirmed Resident 26's nails were long and stated, "They should be cut on his shower days, these [nails] could cut the skin." During an interview on 8/22/24 at 10:55 a.m. with the Director of Nursing (DON), the DON stated, "I expect the staff to care for the nails on shower days and as needed so they [residents] don't	F 677	**How the facility plans to monitor its performance to make sure that solutions are sustained.** Administrator will audit room round forms weekly to ensure nail care, as well as cleanliness of residents and ADLs are being completed. Shower sheets are monitored daily by DSD for compliance. Nail care is being done on Sunday for any resident that needs further assistance. Room rounds and compliance with ADL care will be dicussed by DON at quarterly QA meeting to ensure resident needs are being met.	

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F 677	Continued From page 21 scratch themselves." During a review of the facility's policy and procedure (P&P) titled, "Fingernails/Toenails, Care," dated 2/18, the P&P indicated, "The purpose of the procedure are to clean the nail beds, to keep nails trimmed, and prevent infections...Nail care includes daily cleaning and regular trimming." During a review of the facility's P&P titled, "Activities of Daily Living (ADLs), Supporting," dated 3/18, the P&P indicated, "Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable...Appropriate care and services will be provided for residents who are unable to carry out ADLs independently...in accordance with the plan of care, including...hygiene (bathing, dressing, grooming, and oral care)."	F 677	**Date when corrective action will be completed;** 9/9/2024 QA - 10/2024	
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced	F 679	**F 679**	

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F 679	Continued From page 22 by: Based on observation, interview, and record review, the facility failed to meet two of 30 sampled residents' (Resident 37 and Resident 85) activity needs when the residents did not receive in-room visits by staff. This failure increased the potential for residents to experience isolation and depression. Findings: Resident 37 admitted to the facility in late 2019 with diagnoses which included cerebral infarction (stroke, medical condition that occurs when blood flow to the brain is disrupted), aphasia (language disorder that makes it difficult for people to communicate), and quadriplegia (a form of paralysis that affects arms and legs). During a review of Resident 37's care plan (CP), initiated 5/10/22, the CP indicated, "...Will continue in room visits 3 x week..." During a review of Resident 37's, "Activities-Quarterly [assessment]...," dated 5/17/24, the assessment indicated, "Resident receives 1:1 in room visits with the activity staff...staff will continue to do in room visit." During a review of Resident 37's, "CUSTOM IDT [Interdisciplinary Team] CARE CONFERENCE FORM...ACTIVITIES," dated 8/13/24, the form indicated, "...1:1 visits...will offer reading and singing, encourage to participate with peers..." During a review of Resident 37's physician's orders (PO), dated 8/16/24, the PO indicated, "Patient has decision making capacity: Yes."	F 679	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** The care plan for resident 37 was revised on 8/22/24. Documentation requirements for Activities was entered into PCC to ensure proper charting of activities was initiated to ensure activities were being offered and completed by the activities staff. The care plan for resident 85 was initiated on 8/21/24. The same documentation requirements for charting the offering and completion of activities for resident 85 were also entered into PCC. **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;** All residents have the possibility of being affected by the deficient practice. Activities care plans were audited by MRD and days of in room visits for activities staff were adjusted to better serve the residents. Daily charting of resident in room as well as group activities was inputed into PCC. This will ensure that visits and activities have to be clicked off in PCC daily.	

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F 679	Continued From page 23 During a concurrent observation and interview on 8/20/24 at 2:12 p.m. with Resident 37, Resident 37 was lying in bed and with his laser pointer and alphabet board indicated, "I do not have enough to do." During a concurrent interview and record review on 8/21/24 at 2:21 p.m. with the Activities Director (AD) of Resident 37's electronic health record (EHR). The AD was asked about Resident 37's activities, and stated," He was coming into the activities room, he has started to decline..." The AD confirmed the care plan indicated in room visits. The AD confirmed the IDT indicated 1:1 visits. When asked to review the EHR for activities that were provided to Resident 37, the EHR did not indicate any activity visits had occurred. The AD confirmed there were not documented activity visits. When asked why activities were important, the AD stated, "They are important, he can fall into depression, he will be isolated." Resident 85 admitted to the facility in mid-2024 with diagnoses which included lumbar vertebral (lower back) fracture, difficulty in walking, Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills), and generalized anxiety disorder. During a review of Resident 85's, "ACTIVITIES-INITIAL REVIEW, [assessment]", dated 8/8/24, the assessment indicated, "...will do in room visits 3x week..." During an observation and interview on 8/20/24 at 11:06 a.m. with Certified Nursing Assistant (CNA) 12 of Resident 85. Resident 85 was lying in bed. When asked if Resident 85 attended activities,	F 679	**What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** Daily charting is being monitored by Activities Director under daily tasks. Activities Director has a daily schedule of residents that require in room visits on what days. Care plans and daily tasks for residents 85 and 37 have been adjusted and documented accordingly. Activities Director will monitor daily task charting of group and 1v1 activities daily for compliance. **How the facility plans to monitor its performance to make sure that solutions are sustained.** Medical Records Director or designee will audit daily activities task documentation weekly to ensure care plans are being followed and activity participation is logged in PCC. Activities Director will report on compliance of charting for activities in quarterly QA meetings the next 2 quarters.	

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F 679	Continued From page 24 CNA 12 stated, "She does not go to activities...they do not get her up...she just stays in her bed." During a concurrent interview and record review on 8/21/24 at 2:08 p.m. with the AD, the AD reviewed the activities assessment and confirmed it indicated Resident 85 was to receive in room visits 3x week. When asked to review the EHR for activities provided to Resident 85, the EHR indicated she had only received one activity in-room visit on 8/19/24. The EHR did not indicate any other visits had occurred. The AD confirmed there was only one documented activity visit since her admission. When asked why activities were important, the AD stated, "They need more 1:1 visits to make sure they know they are not here alone. [Resident 85] has been wanting companionship, she does not like to be alone." During a review of the facility's policy and procedure (P&P) titled, "Preparation for Activities," dated 6/18, the P&P indicated, "The Activity Director/Coordinator is responsible for the scheduling of activity functions and programs...Residents requiring assistance to and from scheduled activities are assisted..."	F 679	**Date when corrective action will be completed;** 9/13/2024 QA - 10/2024 and 01/2025	
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 700	**F 700**	

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F 700	Continued From page 25 §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to attempt appropriate alternatives, obtain physician's orders, and obtain an informed consent prior to using bed rails (adjustable metal or rigid plastic bars that attach to the side of the bed) for 1 of 30 residents (Resident 63). This failure had the potential to result in entrapment (resident caught, trapped, or entangled in the space in or about the bed and side rail), injury and/or negative physical outcomes to skin integrity or muscle function. Findings: Resident 63 was admitted on 7/29/24 with medical diagnoses including sequelae of cerebral infarction (occurs when blood flow to the brain is blocked or a blood vessel in the brain bursts), muscle wasting and atrophy (muscles weakening and shrinking), and dysphagia (difficulty swallowing).	F 700	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** On 8/21/24 the care plan, consent, and orders were updated for resident 63. MD signed order and an audit was done for all residents to ensure compliance. 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; An audit was conducted on 8/21/24 to ensure all residents using bed rails had a proper care plan, order, and consent in place. Facility is 100% compliant. All new admissions will be evaluated by therapy to see if bed rails would be appropriate for use. If therapy deems bed rails appropriate, IDT will audit to make sure the resident has a care plan, order, and proper consent for the bed rail usage.	

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F 700	Continued From page 26 During a review of Resident 63's Minimum Data Set (MDS, an assessment tool), dated 8/5/24, the MDS indicated Resident 63 had memory impairment. During an observation on 8/19/24 at 12:24 p.m. in Resident 63's room, Resident 63's left and right top bed rails were locked and in use in the upright position. During an observation on 8/21/24 at 9:06 a.m. in Resident 63's room, Resident 63's left and right top bed rails were locked and in use in the upright position. During a concurrent observation, interview, and record review on 8/21/24 at 9:14 a.m. with Licensed Nurse 5 (LN 5) in Resident 63's room, LN 5 verbally confirmed both of Resident 63's left and right top bed rails were locked and in use. LN 5 stated the normal process would be to get an order from the doctor and get a consent from the resident and/or responsible party before using bed rails. LN 5 also stated a care plan would be needed. Resident 63's medical record was reviewed with LN 5. LN 5 stated, "should be in the orders...but it's not there." LN 5 verbally confirmed no consent or care plan was found in Resident 63's medical record. LN 5 also checked the hard copy of the medical record at the nurse's station; LN 5 also could not find an informed consent for bed rails and stated, "it should be in the back with the consents, but it's not there." During a concurrent interview and record review on 8/21/24 at 9:21 a.m. with LN 1, Resident 63's medical record was reviewed. LN 1 verbally confirmed there was no informed consent,	F 700	**What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** All new admissions will be evaluated by therapy to see if bed rails would be appropriate for use. If therapy deems bed rails appropriate, IDT will audit to make sure the resident has a care plan, order, and proper consent for the bed rail usage. MRD or designee will audit for new admissions and usage of bed rails weekly to ensure compliance. DON will review. Arrows will be placed next to the name plate on the residents door. 1 arrow to indicate 1 rail, 2 arrows to indicate 2 rails. **How the facility plans to monitor its performance to make sure that solutions are sustained.** DON will receive an audit weekly from MRD or designee for any new admission that requires the use of bed rails. This will ensure that each resident has an order, care plan, and proper consent if bed rails are needed. DON will include the outcomes of these audits at quarterly QA meetings in Q4 and Q1 of 2024 and 2025 to ensure compliance.	

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F 700	Continued From page 27 physician's orders, or care plan for bed rails. During a review of the facility's policy and procedure (P&P) titled, "Bed Safety", dated December 2007, the P&P indicated, "The staff shall obtain consent for the use of side rails from the resident or the resident's legal representative prior to their use...Before using side rails for any reason, the staff shall inform the resident and family about the benefits and potential hazards associated with side rails...Side rails may be used if...and no other reasonable alternatives can be identified."	F 700	**Date when corrective action will be completed;** 8/21/24 QA - 10/2024 and 01/2025	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755	**F 755** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** Immediate Education was given to address the 2 residents indicated. In-Service was provided to Licensed Nurses on 8/21/24, 8/22/24, and 8/23/24, and another on 9/18/24. In-service covered medication administration and proper narcotic documentation in the PCC EMAR. Also covered pain assessment management and re-evalutation of pain levels.	

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F 755	Continued From page 28 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure an accurate inventory of narcotics (a medication that is used to relieve pain) for two of 30 sampled residents (Resident 66 and Resident 76) when six tablets of narcotics were not entered into the residents Medication Administration Record (MAR, document that serves as a legal record of the drugs administered to a resident). This failure had the increased potential for diversion and not being able to accurately monitor the amount or frequency of medications given to residents. Findings: Resident 66 was admitted to the facility in mid-2024 with diagnoses which included cancer of the head and neck. During a review of Resident 66's physician orders (PO) dated 8/1/24-8/31/24, the PO indicated, "Norco Oral Tablet 10-325 MG [mg, a unit of measurement] [Hydrocodone-Acetaminophen] Give 1 tablet ...every 6 hours as needed for ...pain."	F 755	**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;** All residents have the possibility to be affected by the deficient practice. Audits were done by the DON on 8/21/24 to ensure proper documentation of narcotics in the EMAR. In-services were given to Licensed Nurses on 8/21/24, 8/22/24, 8/23/24, and 9/18/24. All new hire Licensed Nurses will be given training on medication documentation prior to working on the floor.	

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F 755	Continued From page 29 During a review of Resident 66's "CONTROLLED DRUG RECORD [CDR], Individual Patient's Narcotic Record [a form that keeps count of the number of narcotics dispensed to a resident]," entries dated from 8/2/24-8/19/24, the CDR indicated one tablet of Norco was removed from the medication card (pre-packaged medications dispensed from a pharmacy) on 8/14/24 at 8:30 p.m. and one table of Norco was removed on 8/15/24 at 2:30 a.m. During a review of Resident 66's MAR dated 8/1/24-8/31/24, the MAR did not show documentation of Norco being administered on 8/14/24 at 8:30 p.m. or on 8/15/24 at 2:30 a.m. There was a total of two Norco's that were signed out from the narcotic medication card but were not documented as given to Resident 66. Resident 76 was admitted to the facility in early 2024 with diagnoses which included muscular dystrophy (a group of genetic diseases that cause progressive weakness and degeneration of skeletal muscles). During a review of Resident 76's PO, last reviewed 8/21/24, the PO indicated, "oxyCODONE (sic) ...Oral Tablet 5 MG ...Give 2 tablet ...every 4 hours as needed for severe pain ..." During a review of Resident 76's CDR, entries dated from 8/13/24-8/20/24, the CDR indicated two tablets of Oxycodone were removed from the medication card on 8/15/24 at 8:55 p.m. and two tablets were removed on 8/16/24 at 6:50 a.m. There was a total of four oxycodone tablets that were signed out from the narcotic medication card but were not documented as given to	F 755	**What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** DON or designee will audit EMAR weekly to ensure narcotics that are administered are properly documented in the EMAR and line up with the narcotic count sheets. On spot education will be given to licensed nurses if any discrepancies are found. **How the facility plans to monitor its performance to make sure that solutions are sustained.** Weekly audits of the EMAR done by DON or designee will be reviewed and any correction that are necessary will be made. DON will report this information and compliance with narcotic administration in quarterly QA meeting.	

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F 755	Continued From page 30 Resident 76. During a review of Resident 76's MAR, dated 8/1/24-8/31/24, the MAR did not show documentation of Oxycodone being administered on 8/15/24 at 8:55 p.m. or on 8/16/24 at 6:50 a.m. There was a total of two Norco's that were signed out from the narcotic medication card but were not documented as given to Resident 66. During an interview on 8/22/24 at 11:23 a.m. with the Director of Nursing (DON), the DON was asked the process for narcotic administration. The DON stated, " ...If it [pain level] meets the criteria of a narcotic you sign for it and then when they take it you document on the MAR." The DON confirmed the CDR documentation did not match the MAR documentation for Resident 66 and Resident 76 and stated, "There are no signatures on the MAR that match the narcotic sheet." When asked the importance behind accurately accounting for narcotic administration the DON stated, "They need to make sure the residents have been administered the medications." When asked if inaccurate documentation increased the risk for diversion of narcotics, the DON stated, "Absolutely." During a review of the facility's policy and procedure (P&P) titled, "Reconciliation of Medications on Admission," dated 7/17, the P&P indicated, "The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications ..."	F 755	**Date when corrective action will be completed;** 9/9/2024 QA - 10/2024	
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing	F 802	**F 802**	

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F 802	Continued From page 31 The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure kitchen staff had the knowledge and competencies to carry out dietary functions when: 1. A cook was unable to correctly read the temperature in one of the reach in freezers; 2. A Dietary Aide did not know how to check the temperature of a dishwashing machine; 3. A cook did not use a recipe when preparing pureed foods; and, 4. A cook used the wrong scoop size to measure out food quantities. These failures had the potential of leading to food borne illness or weight loss for 54 Residents receiving facility prepared food. Findings:	F 802	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** To address the potential 54 residents indicated, the Dietary Manager provided immediate education. Cook was in-serviced by the Dietary Manager on 8/23/24 on the freezer storage policy including reading the freezer thermometer. The dietary aide was in-serviced on dish washing machine procedure by the dietary manager on 8/23/24. The cook was in-serviced by the dietary manager on the policy and procedure for the preparation of pureed foods. The cook was in-serviced on 8/23/24 by the dietary manager on the correct portion control and scoop sizes needed.	

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F 802	Continued From page 32 1. During an interview on 8/19/24 at 10:23 a.m. near the kitchen's rear exit, with Cook 1 (CK 1), CK 1 was asked to check the temperature of the reach in freezer near the kitchen's rear exit. CK 1 was unable to differentiate between Fahrenheit (F, a unit of measurement for temperature) and Celsius (C, a unit of measurement for temperature) on the temperature probe used in the reach in freezer. CK 1 was also unable to state what temperature the reach in freezer should be. When asked about the importance of proper freezing temperatures, CK 1 stated, "Food can get bacteria if food is not freezing correctly, and it affects residents." During a review of the facility's policy and procedure (P&P) titled, "Food Storage: Cold Foods," dated 2/23, the P&P indicated, " ...Freezer temperatures will be maintained at a temperature of 0 F or below." 2. During a review of the facility's document title, "Low Temp Dish Machine," undated, the document indicated, "Step 2: Run the dish machine a few times with no dishes to meet required temperatures. Step 3: Check Temperatures: 1st Cycle 120 degrees or higher, 2nd Cycle 120 degrees or higher." During a concurrent observation and interview on 8/20/24 at 9:36 a.m. with the Dietary Aide (DA 1), DA 1 was using a chemical based dishwashing machine to clean dirty dishes from the breakfast meal. When asked about dishwashing temperatures, DA 1 was unable to state the desired temperatures for the dishwashing machine manifold (portion of the dishwashing machine where hot water is delivered to dirty	F 802	**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;** All residents have the potential to be affected by the deficient practice. In-services were given to dietary staff on 8/23/24 to address freezer storage, how to read freezer thermometer, dishwasher procedure, correct portion and scoop sizes, and following recipe for pureed food. All new hires will be given this information and will be documented by Dietary Manager.	

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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 802	Continued From page 33 dishes) and was unable to find the temperature gauge for the manifold. 3. During a concurrent observation and interview on 8/20/24 at 10:03 a.m. in the food preparation area, with Cook (CK 2), CK 2 was observed pureeing slices of bread in a blender. CK 2 added an unmeasured amount of milk, bread, and water to the blender container then blended the ingredients. CK 2 then poured the pureed bread into a metal food container and started adding an unmeasured amount of food thickener. CK 2 indicated that, when making purees, he makes them without a recipe and goes by "feel." During an interview on 8/20/24 at 1:52 p.m. with the Registered Dietitian (RD), the RD stated, "Cooks should follow recipes and measure out ingredients. Not following the pureed recipe could alter the nutrition that residents receive ...The bread puree recipe should be more specific and be followed. It can affect a resident's swallowing if they have a swallowing difficulty. Pureed foods should be made consistently and according to policy." During a review of the facility's P&P titled, "Trayline Accuracy/Menu Compliance," dated 2010, the P&P indicated, "Food preparation is important: standardized quantity recipes should be used to provide consistency of product. Recipes should be followed for the number of servings to be prepared so that seasoning, taste, and appearance are consistent throughout the month ...If the dietary staff does not follow the menu or recipe as written, then there is no assurance of adequacy or accuracy." 4. During a review of the facility's "[Facility name]	F 802	**What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** Dietary Manager or designee will perform freezer temperatures and documentation entries and accuracy checks 2 times daily. Dietary manager or designee will monitor and perform dish machine checks daily for dish machine usage compliance and documentation accuracy. The cook or designee will complete a Tray Line Service Checklist prior to each meal service to verify pureed food preparation and portion control scoop accuracy.	

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F 802	Continued From page 34 Diet Guide Sheet (DGS)," undated, the DGS indicated that residents on the dysphagia (difficulty swallowing) mechanical (food texture modified in a way to help residents swallow easier) and dysphagia puree diets should receive a #8 (1/2 cup) serving of pureed potatoes and a #8 serving of pureed cream style corn. During a concurrent observation and interview on 8/20/24 at 12:02 p.m. in the food preparation area of the kitchen, with Cook 2 (CK 2) and District Kitchen Supervisor (DKS), CK 2 used a 3/8 scoop to measure the pureed potatoes and a ¼ scoop to measure out the pureed corn which caused residents on a pureed diet to receive the incorrect portion sizes for lunch. When asked about the different scoop sizes, CK 2 stated, "I didn't know that." DKS then stated, "The proper scoop size should be used. It's important so residents get their proper nutrition." During an interview on 8/20/24 at 1:52 p.m with the Registered Dietitian (RD), the RD stated, "Cooks should follow recipes and measure out ingredients." During an interview on 8/21/24 at 10:25 a.m. with the Dietary Supervisor (DS), the DS stated, "If the staff are unable to use the right scoops and don't know the temperature and dishwashing temperature, it can affect resident care and outcomes." During a review of the facility's P&P titled, "Trayline Accuracy/Menu Compliance," dated 2010, the P&P indicated, "If the dietary staff does not follow the menu or recipe as written, then there is no assurance of adequacy or accuracy ...Portion control: Foods should be served	F 802	**How the facility plans to monitor its performance to make sure that solutions are sustained.** Dietary Manager or designee will perform audits 4 times per week in month 1 of auditing. 3 times per week in month 2, and 2 times a week in month 3. These audits will be done on freezer temperature accuracy, dish machine procedure, pureed food preparation and recipe compliance, and tray line scoop size compliance. Findings will be reported to quarterly QAPI meeting. Administrator will identify any areas of deficiency, necessary changes or corrective action.	

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F 802	Continued From page 35 according to the portions noted on the menus and recipes. Care should be taken before each meal to make sure that the correct scoops, ladles, and spoodles are available and in the appropriate menu items ready for the meal to begin." During a review of the facility's P&P titled, "In-Service Training Program," dated 5/19, the P&P indicated, "...Annual in-services ...Ensure the continuing competence of staff and their appropriate discipline ...Include training that addresses the specific skills and knowledge related to their department and job function."	F 802	**Date when corrective action will be completed;** 9/6/24 QAPI - 10/2024 and 1/2025	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. 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	F 803	**F 803** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** To address the potential 3 of 20 residents on pureed diets indicated, the Dietary Manager provided immediate education. The cook was in-serviced on 8/23/24 by the dietary manager on the policy and procedure for the preparation of pureed foods. The cook was in-serviced on 8/20/24 by the dietary manager on portion control and scoop sizes.	

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F 803	Continued From page 36 §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow the recipe for pureed food for three out 20 residents (Resident 37, Resident 63 and Resident 85) receiving a pureed diet when a kitchen staff member used the wrong scoop size to measure out food quantities. This failure had the potential to place residents receiving a pureed diet at risk for malnutrition and weight loss. Findings: During a review of the facility's "[Facility Name Diet Guide Sheet] (DGS)," undated, the DGS indicated that residents on the dysphagia (difficulty swallowing) mechanical (food texture modified in a way to help residents swallow easier) and dysphagia puree diets should receive a #8 scoop (1/2 cup) serving of pureed potatoes and a #8 scoop serving of pureed cream style corn. During a concurrent observation and interview on 8/20/24 at 12:02 p.m. in the food preparation area of the kitchen, with Cook 2 (CK 2) and District Kitchen Supervisor (DKS), CK 2 used a 3/8 scoop to measure the pureed potatoes and a ¼ scoop to measure out the pureed corn which caused residents on a pureed diet to receive the incorrect portion sizes for lunch. When asked about the different scoop sizes, CK 2 stated, "I didn't know	F 803	**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 8/21/24 the Dietary Manager determined that 20 residents with pureed diets have the potential to be affected by the deficient practice. Education was given to staff on portion and scoop sizes, and the procedure for following pureed diet recipes. This education will be given to all new hire cooks in orientation to ensure compliance. **What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** The cook or designee will complete a Tray Line Service Checklist prior to each meal to verify pureed food preparation and portion control scoop accuracy. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The Dietary Manager or designee will perform test tray audits 2 times per week for 90 days. These audits will address pureed food preparation and recipe compliance. They will also address tray line scoop size compliance. Findings will be reported at quarterly QAPI meeting.	

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F 803	Continued From page 37 that." The DKS then stated, "The proper scoop size should be used. It's important so residents get their proper nutrition." During an interview on 8/20/24 at 1:52 p.m. with the Registered Dietitian (RD), the RD stated, "Cooks should follow recipes and measure out ingredients." During a review of the facility's Policy and Procedure (P&P) titled, "Trayline Accuracy/Menu Compliance," dated 2010, the P&P indicated, "If the dietary staff does not follow the menu or recipe as written, then there is no assurance of adequacy or accuracy ...Portion control: Foods should be served according to the portions noted on the menus and recipes. Care should be taken before each meal to make sure that the correct scoops, ladles, and spoodles are available and in the appropriate menu items ready for the meal to begin.	F 803	**Date when corrective action will be completed;** 9/6/24 QAPI - 10/2024 and 01/2025	
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 in a manner to conserve nutritive value	F 804	**F 804** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** To address the potential 20 residents on pureed diets indicated, the Dietary Manager provided immediate education. The cook was in-serviced on 8/20/24 by the Dietary Manager on the policy and procedure for the preparation of pureed foods.	

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F 804	Continued From page 38 and palatability for 20 residents receiving a pureed diet when the pureed bread was prepared without using a recipe. This failure had the potential of leading to poor intake and malnutrition for the 20 residents receiving pureed meals. Findings: During a concurrent observation and interview on 8/20/24 at 10:03 a.m. in the food preparation area, with the Cook (CK 2), CK 2 was observed pureeing slices of bread in a blender. CK 2 added an unmeasured amount of milk, bread, and water to the blender container then blended the ingredients. CK 2 then poured the pureed bread into a metal food container and started adding an unmeasured amount of food thickener. CK 2 indicated that, when making purees, he makes them without a recipe and goes by "feel." During a concurrent observation and interview on 8/20/24 at 12:35 p.m. near the kitchen entrance, with the Dietary Supervisor (DS), the DS brought two lunch test trays that contained one regular consistency meal and one pureed consistency meal. The pureed meal was sampled, and the pureed bread had a thick and sticky consistency indicating that too much thickener was used during preparation. When asked about the bread puree consistency, the DS stated, "The thickening [of pureed foods] should follow a recipe ..."	F 804	**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 8/20/24 the Dietary Manager determined that 20 residents receiving pureed diets have the potential to be affected by the deficient practice. Education was given to cook on 8/20/24 on policy and procedure for pureed food. This education will be included in new hire orientation for any new cook to ensure compliance. **What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** The cook or designee will complete and Tray Line Service Checklist prior to each meal to verify correct pureed food preparation. These checklists will be audited by the Dietary Manager or designee.	

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F 804	Continued From page 39 During an interview on 8/20/24 at 1:52 p.m. with the Registered Dietitian (RD), the RD stated, "Cooks should follow recipes and measure out ingredients. Not following the pureed recipe could alter the nutrition that residents receive ...The bread puree recipe should be more specific and be followed. It can affect a resident's swallowing if they have a swallowing difficulty. Pureed foods should be made consistently and according to policy." During a review of the facility's policy and procedure (P&P) titled, "Trayline Accuracy/Menu Compliance," dated 2010, the P&P indicated, "Food preparation is important: standardized quantity recipes should be used to provide consistency of product. Recipes should be followed for the number of servings to be prepared so that seasoning, taste, and appearance are consistent throughout the month ...If the dietary staff does not follow the menu or recipe as written, then there is no assurance of adequacy or accuracy." During a review of the facility's P&P titled, "Diet and Nutrition Care Manual," dated 2019, the P&P indicated, "All foods must be the consistency of moist mashed potatoes or pudding."	F 804	**How the facility plans to monitor its performance to make sure that solutions are sustained.** Dietary Manager or designee will perform test tray audits 2 times per week for 90 days. Audits will be done on pureed food preparation and pureed food recipe compliance. Findings will be reported at quarterly QAPI meeting. **Date when corrective action will be completed;** **9/6/24** **QAPI - 10/2024 and 01/2025**	
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;	F 806	**F 806** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;**	

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F 806	Continued From page 40 §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure food preferences were accommodated for one of 54 residents receiving facility prepared food (Resident 9) when Resident 9's request not to be served cream of wheat for breakfast was disregarded. This failure had the potential to negatively impact Resident 9's nutritional status. Findings: Resident 9 was admitted to the facility in the middle of 2024 with diagnoses which included acute and chronic respiratory failure with hypoxia (a lack of oxygen in the blood), pneumonia (infection of the lungs), and muscle wasting and atrophy (wasting away of a body part). During a review of Resident 9's Minimum Data Set (MDS, an assessment tool), dated 7/26/24, the MDS indicated Resident 9 had a Brief Interview for Mental Score (BIMS) of 13 indicating Resident 9 had no cognitive impairment. During a review of Resident 9's meal tray ticket	F 806	To address the potential 1 of 54 residents indicated, the Dietary Manager provided immediate education. Cooks and Dietary Aides were in-serviced by the Dietary Manager on 9/4/24 on resident dining and food preferences. **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 9/4/24 the Dietary Manager determined that all residents have the potential to be affected by the deficient practice. In-service was given to staff to address resident dining and food preferences. This training and education will be given to all dietary new hires upon orientation to ensure compliance with the stated policy and procedure. **What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** Dietary Manager or designee will either bold, highlight, underline, or italicize resident special requests or allergies on resident diet cards. This will ensure cook and dietary aides are aware of allergies and special requests.	

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F 806	Continued From page 41 for breakfast on 8/20/24, the tray ticket indicated, "No cream of wheat Oatmeal please 3 butter packets." During a concurrent observation and interview on 8/20/24 at 8:15 a.m. with Resident 9, Resident 9's breakfast tray had a bowl of cream of wheat. Resident 9 stated, "I wanted oatmeal, but I was given cream of wheat." During an interview on 8/21/24 at 10:25 a.m. with the Dietary Supervisor (DS), the DS confirmed that Resident 9 received cream of wheat instead of oatmeal for his breakfast on 8/20/24. The DS stated, " ...He should have gotten oatmeal." During a review of the facility's policy and procedure (P&P) titled, "Trayline Checklist," dated 2010, the P&P indicated, "Beverages and extra request items available Alternate meat, starch, and vegetable available."	F 806	**How the facility plans to monitor its performance to make sure that solutions are sustained.** Dietary Manager or designee will perform test tray audits 2 times per week for 90 days. These audits will be done to ensure allergies and special requests are highlighted for resident tray accuracy. Findings will be reported in quarterly QAPI meeting. **Date when corrective action will be completed;** 9/4/2024 QAPI - 10/2024 and 01/2025	
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure two of 30 sampled residents (Resident 18 and Resident 73)	F 810	**F 810**	

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F 810	Continued From page 42 were provided with necessary adaptive equipment for meals as ordered by the physician. This failure had the potential to negatively impact the resident's well-being and contribute to decreased meal intake. Findings: 1. Resident 18 was admitted to the facility in late 2015 with diagnoses which included stroke, diabetes (uncontrolled blood sugar levels), left sided hemiplegia (paralysis on one side of the body), dysphagia (swallowing difficulty), and muscle weakness. During a review of Resident 18's Nursing Care Plan (NCP), dated 8/19/20, the NCP indicated, "SELF CARE DEFICIT: due to: Need assistance IN ADL [activity of daily living]: Resident's ability to perform ADL at highest practicable level will be promoted with interventions." During a review of Resident 18's Clinical Physician Orders (CPO), dated 1/12/24, the CPO indicated, "Consistent Carbohydrate (CCD) diet, Dysphagia advance texture, Thin Liquids consistency...1:1 FEEDER. 2 handled cup, divided plate." During a review of Resident 18's Minimum Data Set (MDS, an assessment tool), dated 5/21/24, the MDS indicated, "Eating: The ability to use suitable eating utensils to bring food to the mouth...resident completes activity." During a concurrent observation and interview on 8/19/24 at 12:04 p.m. in the dining room with Licensed Nurse 2 (LN 2) and LN 3, Resident 18	F 810	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** To address the potential of 2 of 30 with necessary adaptive equipment, the Dietary Manager provided on spot education. The working cooks and dietary aides were in-serviced on 8/23/24 by the Dietary Manager on the policy for assisted devices. **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 8/21/24 the Dietary Manager determined that 30 residents receiving necessary adaptive equipment have the potential to be affected by the deficient practice. Education was provided to dietary staff on 8/23/24 on the policy for assisted devices. This education will be provided in new hire orientation to ensure compliance with the policy.	

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F 810	Continued From page 43 started having her lunch meal. When asked what kind of cup did Resident 18 have in her meal tray, LN 2 stated, "That's a sippy cup. That's not a two handed cup." Resident 18's meal ticket indicated, "Divided Plate; Two Handled Cup." When asked if the cup was okay with her, Resident 18 shook head, and stated, "No." LN 3 verified the cup, and stated, "No. It's not a two handed cup." During an interview on 8/21/24 at 11 a.m. with the MDS Coordinator (MDSC), the MDSC verified the care plan for Resident 18 included the use of adaptive devices ordered which included the two handled cup, and stated, "The two handled cup was not included as an intervention in the nutrition care plan." 2. Resident 73 was admitted to the facility in late 2023 with diagnoses which included encephalopathy (brain disease that alters brain function and structure), diabetes (uncontrolled blood sugar levels), dysphagia (swallowing difficulty), and reduced mobility. During a review of Resident 73's MDS, dated 6/19/24, the MDS indicated Resident 73 had moderate memory impairment and had complained of difficulty swallowing, and was dependent with eating. During a review of Resident 73's NCP, dated 7/23/24, the NCP indicated, "Plastic eating utensils." During a concurrent observation, interview, and record review on 8/19/24 at 12:07 p.m. in the facility dining room, Resident 73 was assisted by Restorative Nursing Aide 2 (RNA 2). Resident 73 tried to hold the silverware to eat her food, and	F 810	**What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** The dietary manager or designee will either bold, highlight, underline, or italicize resident adaptive equipment on resident diet cards to identify the residents needs. This will serve to draw attention to resident needs to adaptive equipment. **How the facility plans to monitor its performance to make sure that solutions are sustained.** Dietary Manager or designee will perform test tray audits 2 times per week for 90 days. This audit will be done to ensure accuracy and compliance for resident assisted devices. Findings will be reported in quarterly QAPI meeting.	

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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 810	Continued From page 44 prompted by RNA 2, had difficulty holding the silverware. Resident 73's meal ticket indicated, "Plastic Fork, Plastic Spoon." RNA 2 confirmed Resident 73 had metal silverware. During an interview on 8/21/24 at 11 a.m. with the MDSC, the MDSC verified the care plan for Resident 73, and stated, "[Resident 73] has care plan for the use of plastic utensils." During an interview on 8/22/24 at 9:30 a.m. with the Director of Nursing (DON), the DON stated, "Every resident has the right to be provided with adequate care including medications, activities of daily living, adaptive devices and comfortable environment. We do not wait until we see their decline or their environment becomes unacceptable." During a review of the facility's policy and procedure (P&P) titled, "Accommodation of Needs," dated 12/22, the P&P indicated, "Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity and well- being...The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis."	F 810	**Date when corrective action will be completed;** **9/6/2024** **QAPI - 10/2024 and 01/2025**	
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**	

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	055887	A. BUILDING _____ B. WING _____	08/22/2024

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F 812	Continued From page 45 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: F812 Based on observation, interview, and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety for a total of 54 residents who received facility prepared foods when: 1. Proper food labeling was not followed for items in the freezers, refrigerator, dry storage, and spice shelf; 2. Expired food items were found in the refrigerator, dry storage, and spice shelf; 3. Personal milk cartons were not stored at appropriate temperatures; 4. Kitchen reach in freezers contained multiple boxes of food items that were exposed and open to the freezer environment; a plastic container of brown sugar was not sealed properly; 5. Frozen foods were not stored at appropriate temperatures; 6. A steam table pan was found stored wet;	F 812	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** To address the potential 54 residents indicated, the Dietary Manager provided immediate education. The working cooks and dietary aides were in-serviced by the Dietary Manager on 8/19/24. The in-service covered food storage policy including sealing items, dating and labeling items, discarding expired food, freezer items, and milk storage temperatures. The cooks and dietary aides were in-serviced on food storage and dry goods policy by the Dietary Manager on 8/23/24. The cooks and dietary aides were in-serviced on 8/23/24 by the Dietary Manager on the policy and procedure for warewashing and drying of cookware. The can opener was removed and new one ordered on 9/3/24 and installed on 9/9/24. The dietary staff was in-serviced on 8/23/24 by the Dietary Manager on proper dietary work attire and the use of beard restraints.	

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F 812	Continued From page 46 7. No air gaps were found in the produce sink; 8. The kitchen can opener had a chipped blade; and 9. A kitchen staff member was not wearing a beard restraint. These failures had the potential to lead to food borne illness for the 54 residents receiving facility prepared meals. Findings: 1. During the initial kitchen tour on 8/19/24 beginning at 8:18 a.m. with the Dietary Supervisor (DS) present and confirmed findings, the following items were found stored un-labeled or undated: - In the reach in freezers: a box of tater tots, a box of corn, a box of pie crusts, a box of asparagus, two bags of frozen breaded meat, a box of sausage patties, three boxes of beef patties, and a box of turkey patties. - In the reach in refrigerator: a bag of cheddar cheese, a plastic container with sticks of butter, two containers of beef base, and a container of salad dressing. - In the dry storage area: three trays of prepared cereal in bowls, an opened bag of ranch dressing mix, an opened bag of tortillas, a box of cornbread mix, a container of brown sugar, five boxes of oatmeal cookies, and four cans of tuna. - In the spice shelf: two containers of black pepper, a container of rotisserie chicken seasoning, a container of ground cinnamon, a container of mustard, a container of basil leaves, a container of garlic powder, a container of paprika, a container of oregano, an opened bag of pasta, and an opened bag of chicken gravy	F 812	**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;** All residents have the potential to be affected by the deficient practice. Education was given to dietary staff on 8/19/24 and 8/23/24. New can opener was installed on 9/9/24. Education will be provided to all new hires in orientation to ensure compliance with all polices and procedures.	

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F 812	Continued From page 47 mix. During an interview on 8/20/24 at 1:52 p.m. with the Registered Dietitian (RD), the RD stated, "Expired food items and unlabeled food items can affect resident health." During a review of the facility's policy and procedure (P&P) titled, "Food: Preparation," dated 2/23, the P&P indicated, " ...All refrigerated, ready-to-eat TCS [temperature controlled for safety] prepared foods that are to be held for more than 24 hours at a temperature of 41F [Fahrenheit, a unit of measurement for temperature] or less, will be labeled and dated with a 'prepared date' (Day 1) and a 'use by date' (Day7)." During a review of the facility P&P titled, "Food Storage: Dry Goods," dated 2/23, the P&P indicated, " ...Storage areas will be neat, arranged for easy identification, and date marked as appropriate." During a review of the US (United States) FDA 2022 Food Code (FDA FC), section 3-501.17, titled, " Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking," dated 1/23, the FDA FC indicated, "Industry must implement a system of identifying the date or day by which the food must be consumed, sold, or discarded. Date marking requirements apply to containers of processed food that have been opened and to food prepared by a food establishment, in both cases if held for more than 24 hours, and while the food is under the control of the food establishment. This provision applies to both bulk and display containers."	F 812	**What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** AM and PM cooks or designee will conduct a daily opening and closing checklist which include dating and labeling of items in dry storage, refrigerators, and freezers. AM and PM cooks will check the can opener prior to use for any damage or defects. AM and PM cooks or designee will complete a service line checklist which includes hair and beard restraints usage prior to each meal service.	

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F 812	Continued From page 48 2. During the initial kitchen tour on 8/19/24 beginning at 8:18 a.m. with the DS present and confirmed findings, the following items were found expired: - In the reach in refrigerator: a container of potato salad, a container of diced tomatoes, a container of parmesan cheese, a container of mushrooms, a container of pickles, a container of mashed potatoes, a container of bacon, and a bottle of lemon juice. - In the dry storage: four bottles of lemon juice, a box of baking soda, a container of mustard, an opened bag of pasta, a container of sugar, a container of brown sugar, a container of powdered sugar, and a can of sliced peaches. - In the spice shelf: a container of baking powder, a container of salt, a container of sesame seeds, a container of ground nutmeg, and a container of ground cloves. During a review of the US FDA FC, section 3-501.17, titled, "Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking," dated 1/23, the FDA FC indicated, "Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date." 3. During the initial kitchen tour on 8/19/24 beginning at 8:18 a.m. with the DS, single use milk cartons were found on a cart with no cooling mechanism in place. The DS stated, "There should be an ice bucket to keep the milks cool." During a review of the facility's P&P titled, "Food Storage: Cold Foods," dated 2/23, the P&P indicated, " ...All perishable foods will be maintained at a temperature of 41 F or below,	F 812	**How the facility plans to monitor its performance to make sure that solutions are sustained.** The District Manager for Healthcare Services Group will complete a monthly unit inspection for 3 months. This inspection will specifically include labels and dating, correct hair net and beard guard usage, and can opener condition and sanitation. Registered Dietitian will complete monthly unit inspection for 3 months to specifically include checking on labels and dating, correct usage of hair net and beard guard, and can opener condition and sanitation. Findings of these inspections will be given in quarterly QAPI meetings. Administrator will identify results of inspections to identify any deficiencies or corrective actions that need to be taken.	

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F 812	Continued From page 49 except during necessary periods of preparation and service." 4. During the initial kitchen tour on 8/19/24 beginning at 8:18 a.m. with the DS present and confirmed findings, the following items were found unsealed and exposed: - In the reach in freezers: a box of cookie dough, a box of taco shells, and a box of corn. - In the dry storage: a container of brown sugar. The DS stated, "Bags [containing food] should be tied and sealed to prevent freezer burn ...Frost on food can affect quality and sanitation of food." During a review of the facility's P&P titled, "Food Storage: Dry Goods," dated 2/23, the P&P indicated, " ...All packaged and canned food items will be kept clean, dry, and properly sealed." During a review of the US FDA FC, section 3-202.15, titled, "Package Integrity," dated 1/23, the FDA FC indicated, "FOOD packages shall be in good condition and protect the integrity of the contents so that the FOOD is not exposed to ADULTERATION or potential contaminants...Damaged or incorrectly applied packaging may allow the entry of bacteria or other contaminants into the contained food." 5. During the initial kitchen tour on 8/19/24 beginning at 8:18 a.m. with the DS present and confirmed findings, a reach in freezer closest to the DS's office (freezer 1) had a temperature reading of 16 F and the reach in freezer adjacent to the first freezer (freezer 2) had a temperature reading of 8 F. The DS stated, "We want 0 F so	F 812		

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F 812	Continued From page 50	F 812		

they [kitchen staff] know it's actually frozen." The reach in freezer near the kitchen exit (freezer 3) had a temperature reading of 2 F.

During a concurrent observation and interview on 8/19/24 at 10:26 a.m. in the facility kitchen, with the DS and Cook 1 (CK 1), the freezer 1 had a temperature reading of 20 F. All ice cream, gelato, and orange sherbet containers being stored in the freezer were not frozen solid indicating the freezer was unable to maintain foods at freezing temperatures. When asked if foods stored in the freezer should be frozen solid, the DS stated, "We want them frozen." CK 1 also stated, "Food can get bacteria if food is not freezing correctly and affects residents."

During a review of the facility's P&P titled, "Food Storage: Cold Foods," dated 2/23, the P&P indicated, " ...Freezer temperatures will be maintained at a temperature of 0 F or below."

6. During a concurrent interview and observation on 8/19/24 at 9:34 a.m. in the kitchen, with the Dietary Aide (DA 2) and the DS, a steam table pan was found stored wet. DS and DA 2 confirmed the finding and DA 2 stated, "If not air-dried [pan], the container can grow bacteria."

During a review of the US FDA FC, section 4-901.11, titled, "Equipment and Utensils, Air-Drying Required," dated 1/23, the food code indicated, "After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining ..."

7. During a concurrent interview and observation on 8/20/24 at 9:48 a.m. in the kitchen food preparation area, with the District Kitchen

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Supervisor (DKS), the sink used to wash produce did not have an air gap. DKS confirmed the finding and indicated wastewater could wash back up and affect produce being washed in a sink without an airgap.

During a review of the US FDA FC, section 5-202.13 titled "Backflow Prevention, Air Gap," dated 1/23, the FDA FC indicated, "During periods of extraordinary demand, drinking water systems may develop negative pressure in portions of the system. If a connection exists between the system and a source of contaminated water during times of negative pressure, contaminated water may be drawn into and foul the entire system."

During a review of the US FDA FC, section 5-203.14, titled, "Backflow Prevention Device, When Required," dated 1/23, the FDA FC indicated, "A PLUMBING SYSTEM shall be installed to preclude backflow of a solid, liquid, or gas contaminant into the water supply system at each point of use at the FOOD ESTABLISHMENT ..."

8. During an observation on 8/20/24 at 12:11p.m. in the kitchen food preparation area, the kitchen can opener blade was found to have a chipping metal coating.

During an interview on 8/21/24 at 10:10 a.m. with the DS, the DS confirmed the finding and stated, "Chipping [of the can opener blade] can be a physical contaminant of the food."

During a review of the US FDA FC, section 4-501.11, titled, "Good Repair and Proper Adjustment," dated 1/23, the FDA FC indicated,

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F 812	Continued From page 52 "The cutting or piercing parts of can openers may accumulate metal fragments that could lead to food containing foreign objects and, possibly, result in consumer injury." 9. During a concurrent observation and interview on 8/20/24 at 9:36 a.m. in the kitchen dishwashing area, with Dietary Aide 1 (DA 1) and DS, DA 1 was not wearing a beard restraint. DA 1 and DS both confirmed DA 1 was not wearing a beard restraint. DS indicated staff should wear a beard restraint when performing kitchen duties. During a review of the US FDA FC, section 2-402, titled, "Hair Restraints," dated 1/23, the FDA FC indicated, "(A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES."	F 812	**Date when corrective action will be completed;** 9/9/2024 QAPI - 10/2024 and 01/2025	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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	F 880	**F 880**	

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F 880	Continued From page 53 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 §483.71 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 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	F 880	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** In-Services were given to staff on 8/21/24, 8/22/24, and 8/23/24 on proper hand hygiene, enhanced barrier precautions, and contact precautions. On 8/21/24 all trash cans in rooms and dining room were replaced with trash cans that had functioning lids. Surveyors were made aware. Fan for resident 41 was cleaned on 8/21/24. Oxygen tubing and nebulizers were corrected with proper dats and labeled correctly on 8/21/24.	

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F 880	Continued From page 54 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 proper infection practices were followed when: 1. Respiratory Therapist (RT) did not perform hand hygiene during a breathing treatment for Resident 66; 2. The isolation trash can was not covered for Resident 66; 3. Oxygen tubing used by Resident 139 was not labeled and additional oxygen tubing and nebulizer facemasks were labeled with an expired date; 4. An air fan was found with black residue and lint in Resident 41's room; and 5. Three plastic trash containers were open and had no lid cover during lunch meal in the facility dining room. These failures had the potential to increase the transmission and spread of infection. Findings:	F 880	**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;** In-services were given to staff on 8/21,22,23/24 on barrier precautions, hand hygiene, oxygen tubing, correct labeling, changing of tubing, and enhanced precautions. Administrator did a sweep of the facility and replaced any trash cans that needed lids. Fan in the room of resident 41 was cleaned. Any other fan in use was checked to ensure cleanliness. Infection control policies and procedures will be taught to new hires in orientation. New labeling stickers were bought for oxygen tubing and cannisters to specific date changes.	

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F 880	Continued From page 55 1.Resident 66 was admitted to the facility in mid-2024 with diagnoses which included chronic obstructive pulmonary disease (lung disease), atrial fibrillation (an irregular heart rate), and heart failure. During a concurrent observation and interview on 8/19/24 at 8:35 a.m. at Resident 66's bedside the RT was observed putting tubing into the trash can with a gloved hand and pushed the contents down into the waste bin then returned to the resident and began organizing his tubing using the same gloves. The RT confirmed that he should not have used the same pair of gloves and stated, "We are supposed to hand sanitize and change our gloves. Yes, I should have done that." During an interview on 8/22/24 at 10:55 a.m. with the Director of Nursing (DON), the DON stated, "They [RT] should always change their gloves before proceeding to the next step in treatment." 2. During a concurrent observation and interview on 8/19/24 at 8:37 a.m. with Licensed Nurse 6 (LN 6), in Resident 66's room, the isolation trash can was overflowing, and the lid was in the open position exposing the personal protective equipment (PPE). LN 6 confirmed the open trash can and stated, "I believe it's broken and does not close...it should be covered." During an interview on 8/19/24 at 8:57 a.m. with the Infection Preventionist (IP), the IP stated, "All the trash cans should have working lids to protect the residents..." During an interview on 8/22/24 at 10:55 a.m. with the DON, the DON stated, "I expect all trash cans	F 880	**What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** A new system of labeling of oxygen equipment has been instituted. The new stickers specify the specific date that equipment needs to be changed. On spot education will be given by IP nurse if staff needs further education on hand hygiene and Infection Control protocol. Room rounds for department heads have questions that include the proper dating of oxygen tubing and nebulizers. If anything is found out of compliance, staff will correct immediately. Maintenance Director will audit the facility weekly to ensure cleanliness of any fan in use as well as checking to make sure trash cans in dining room and any in residents rooms for disposal of PPE have working lids.	

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F 880	Continued From page 56 to be in working order and closed, to prevent infection." 3. Resident 139 was admitted to the facility in the middle of 2022 with diagnoses which included stroke, decreased mobility, COPD, respiratory failure, and swallowing difficulty. During a review of Resident 139's Nursing Care Plan (NCP), dated 12/28/22, the NCP indicated, "Alteration in Respiratory status due to: DX of ACUTE AND CHRONIC RESPIRATORY FAILURE, CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)." During a review of Resident 139's Minimum Data Set (MDS, an assessment tool), dated 8/12/24, the MDS indicated Resident 139 had no memory impairment. During a review of Resident 139's Order Summary Report (OSR), dated 8/10/24, the OSR indicated, "ALBUTEROL SUL [sulfate, medication to prevent and treat wheezing and shortness of breath]...INHALE 1 VIAL VIA NEBULIZER THREE TIMES DAILY FOR COPD." During a concurrent observation and interview on 8/19/24 at 9:44 a.m. in Resident 139's room, Resident 139 was in bed, awake and alert and verbally responsive. Resident 139 had a nasal cannula (oxygen tubing) with no date or label, connected to an oxygen concentrator. Also, at the night stand were disconnected oxygen tubing and a nebulizer (turns liquid medicine into a mist that can be easily inhaled) facemask with labels and both dated 8/10/24. During a concurrent observation and interview on	F 880	**How the facility plans to monitor its performance to make sure that solutions are sustained.** Room rounds will be conducted daily by department heads to ensure labeling of oxygen tubing and nebulizers are correct. If any need to be corrected, that will be identified in stand up and followed up with immediately. Room rounds will be audited for compliance weekly by Administrator or designee. Maintenance Director will check for cleanliness of fans weekly and ensure that all fans are clean and in working condition. Administrator or designee will sweep the building weekly to ensure all trash cans in dining room are in working order with lids, and in resident rooms for PPE disposal. Quarterly QA meeting will be used to discuss compliance by Infection Control nurse.	

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F 880	Continued From page 57	F 880		

8/19/24 at 9:48 a.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 verified the oxygen tubing and nebulizer, and stated, "There is no label on the tubing. The other tubing and the breathing equipment have labels and the date is 8/10/24."

During a concurrent observation and interview on 8/19/24 at 9:50 a.m. with the Director of Staff Development (DSD), the DSD verified the oxygen tubing and nebulizer facemask, and stated, "The oxygen tubing should be changed every week...The oxygen tubing connected to [Resident 139] has no label or date and the other one and the nebulizer have labeled dates of 8/10/24." When asked what could result if the tubes and the nebulizer were not changed every week, the DSD stated, "If the tubes are not changed there is a potential for respiratory infection."

During an interview on 8/19/24 at 9:52 a.m. with the IP, the IP stated, "The oxygen tubing and the nebulizer are changed weekly and the reason is to prevent infection, especially respiratory infection."

During an interview on 8/19/24 at 11:02 a.m. with LN 1, LN 1 stated, "We change the tubing and other personal stuff weekly to prevent infections...because of bacteria, and we want to keep it down and keep it as clean as it should...it's a facility policy that we change them every week."

4. Resident 41 was admitted to the facility in early 2020 with diagnoses which included encephalopathy (brain disease that alters brain function), respiratory failure, reduced mobility, and swallowing difficulty.

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F 880	Continued From page 58 During a review of Resident 41's NCP, dated 3/13/24, the NCP indicated, "Alteration in Respiratory status due to ...ACUTE AND CHRONIC RESPIRATORY FAILURE...Promote adequate/effective respiration." During an observation on 8/19/24 at 2:21 p.m. in Resident 41's room, Resident 41 was in bed, awake and alert, but non-verbal. At the side of the bed was an electric air fan with black residue and gray lint on the front guard cover and the fan blades blowing directly towards Resident 41. During a concurrent observation and interview on 8/19/24 at 2:23 p.m. with CNA 10, CNA 10 verified the air fan, and stated, "The air fan is dirty. That should be cleaned...The resident can get sick and will end up with respiratory illness." During a concurrent observation and interview on 8/19/24 at 2:27 p.m. with LN 1, LN 1 confirmed the air fan was dirty, and stated, "If you see [air fans] dirty, we're always responsible to clean them ...If it is not clean, the dirty air will be going to the resident and can produce respiratory illnesses." During a review of the facility's P&P titled, "INFECTION PREVENTION AND CONTROL...RESPIRATORY POLICY AND PROCEDURE," undated, the P&P indicated, "Assure proper equipment cleaning and maintenance...Each resident shall be supplied with tubing and...or hand held nebulizer. These items shall be disposed of and replaced every week or sooner if soiled." 5. During a concurrent observation and interview	F 880		

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F 880	Continued From page 59 on 8/19/24 at 12:21 p.m. in the dining room, three plastic garbage/trash containers next to the entrance door of the dining room were opened with no lid cover while the residents were having lunch. During a concurrent observation and interview on 8/19/24 at 12:22 p.m. in the dining room, LN 1 verified the three containers were open and had no lid cover, and stated, "I can see that...the trash containers all have to be closed. It should be covered always...it's all about infection control."	F 880	**Date when corrective action will be completed;** 9/9/2024 QA - 10/2024	
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain one out of three reach-in freezers in safe operating condition when the freezer was found running at unsafe temperatures. This failure had the potential to lead to growth of bacteria and food borne illness for all 54 residents eating facility prepared meals. Findings: During a concurrent observation and interview on 8/19/24 at 8:18 a.m., in the facility kitchen, with the Dietary Supervisor (DS), the reach in freezer closest to the DS's office (freezer 1) had a temperature reading of 16 degrees Fahrenheit (F, a unit of measurement for temperature). The DM	F 908	**F 908** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** The freezer in question was reported to the Administrator on 8/19/2024 by the Lead Surveyor. Upon investigation the freezer and all it's contents were discarded. No food in question were served to residents. Administrator ordered a new freezer which was delivered and installed on 8/21/2024. Surveyor was made aware of the delivery and installation of new freezer. Other 2 freezers were in proper working order. **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;** All residents have the potential to be affected by the deficient practice. Dietary Manager has been instructed to inform Administrator if any freezer is not keeping the correct temperature. Freezer temperature checks will be done by staff and audited by Dietary Manager to ensure compliance. New freezer was purchased and is in working order.	

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F 908	Continued From page 60 confirmed the temperature reading and stated, "It should be colder." The DS stated, "I think the freezer [freezer 1] was last serviced in July of this year [2024] but there is no scheduled maintenance ...it might be broken." During a concurrent observation and interview on 8/19/24 at 10:26 a.m., in the facility kitchen, with the DS, freezer 1 had a temperature reading of 20 F. All ice cream, gelato, and orange sherbet containers being stored in the freezer were not frozen solid indicating the freezer was unable to maintain foods at freezing temperatures. When asked if foods stored in the freezer should be frozen solid, the DS stated, "We want them frozen." During a review of the facility's policy and procedure (P&P) titled, "Food Storage: Cold Foods," dated 2/23, the P&P indicated, " ...Freezer temperatures will be maintained at a temperature of 0 F or below." During a review of the facility's P&P titled, "Equipment," dated 9/17, the P&P indicated, " ...All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials ...The Dining Services Director will submit requests for maintenance or repair to the Administrator and/or Maintenance Director as needed."	F 908	**What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** Dietary Manger or designee will perform freezer temperatures and documentation entries 2 times daily. Dietary Manager or designee will audit the freezer temperature logs 4 times per week in month 1, 3 times per week in month 2, and 2 times per week in month 3 to ensure temperature accuracy. **How the facility plans to monitor its performance to make sure that solutions are sustained.** Dietary Manager or designee will audit the freezer temperature logs 4 times per week in month 1, 3 times per week in month 2, and 2 times per week in month 3 to ensure temperature accuracy. Audits results will be reported in quarterly QAPI meetings. **Date when corrective action will be completed;** 9/9/2024 QAPI - 10/2024 and 01/2025	
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 921	**F 921**	

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F 921	Continued From page 61 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a safe, functional, sanitary, clean and comfortable environment was provided for a census of 89, when: 1. Several missing slats on the window blinds, three fluorescent bulbs not functioning, and three open trash containers without lids were found in the dining room; and 2. Resident 19 had a strong odor and foul-smelling room environment. These failures had the potential to result in the residents not attaining their highest practicable physical, mental and psychosocial well-being. Findings: 1. During a concurrent observation and interview on 8/19/24 at 11:42 a.m. in the facility dining room, Resident 12 stated, "The place could be much better." During a concurrent observation and interview on 8/19/24 at 12:15 p.m. in the dining room, the window blinds next to the table of Resident 12 had four missing slats. Restorative Nursing Aide 3 (RNA 3) verified the missing slats, and stated, "It has been a while those blinds had been missing some parts." During a concurrent observation and interview on 8/19/24 at 12:19 p.m. in the dining room, Licensed Nurse 1 (LN 1) verified the missing slats of the window blinds, and stated, "Everyone should have a dignity issue on that. I mean, some	F 921	**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** Immediate action was taken by the facility to address the condition of the blinds, light bulbs, and trash containers in the dining room. On 8/20/2024 all light bulbs, blind slats, and trash cans were replaced. On 8/19/24, DON spoke to resident 19 and after conversation resident 19 agreed to be changed and cleaned after refusing multiple times that day. Care plans for resident show non compliance with bathing and incontinence care. Efforts were made by DON and resident agreed to be changed.	

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F 921	Continued From page 62 people would just say like you know, if they don't want to be seen through the window..." During a concurrent observation and interview on 8/19/24 at 12:21 p.m. in the dining room, three plastic garbage/trash containers next to the entrance door of the dining room were opened with no lid cover while the residents were having lunch. During a concurrent observation and interview on 8/19/24 at 12:22 p.m. in the dining room, LN 1 verified the three containers were open and had no lid cover, and stated, "I can see that...the trash containers all have to be closed. It should be covered always...it's all about infection control. During a concurrent observation and interview on 8/19/24 at 12:23 p.m. in the dining room, when asked about the missing slats of the window blinds, the Activities Director (AD) stated, "I am aware there are blinds missing and it has been a long time ago. Well, they got the pieces to put it together but nothing has been done...It has been for a while that we have been missing the pieces." The AD verified there were at least 17 slats missing on the window blinds in the dining room. During a concurrent observation and interview on 8/19/24 at 12:25 p.m. in the dining room, three missing fluorescent bulbs in the dining room were not lit. The AD verified the missing bulbs, and stated, "I just didn't notice the bulbs are missing. The resident won't be able to see well during meals." During an interview on 8/20/24 at 8:35 a.m. with Maintenance (MAIN), MAIN verified the missing	F 921	**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;** All residents have the potential to be affected by the deficient practice. For any broken blind slat, light bulb, or open garbage with no lid, Administrator or designee will audit the dining room 1x per week to ensure blinds, lights, and garbage cans are in proper working condition. Activities Director has been educated to make Maintenance Director aware of anything that needs to be repaired in the Maintenance log. Care plan reviewed for Resident 19. Resident has history of refusing bathing and brief change. DON spoke with resident on 8/19/24 and resident agreed to be cleaned and changed. DON or designee will check in with Resident 19 daily to encourage bathing and incontinence care.	

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F 921	Continued From page 63 blinds in the dining room, and stated, "If there is a problem, I go and fix it...The [missing] blinds have been more than a year already...I talked with the previous administrator, but I guess they ignored the problem. I cannot fix it if there are no parts to use." MAIN checked and verified the fluorescent bulbs in the dining room, and stated, "Nobody told me about it. I am not aware of the missing bulbs. If the [bulbs] are not working, they should be replaced." 2. Resident 19 was admitted in early 2020 with diagnoses which included post-traumatic stress disorder (PTSD), blindness, and anxiety. During a review of Resident 19's Minimum Data Set (MDS, an assessment tool), dated 7/19/24, the MDS indicated Resident 19 had moderate memory impairment and did not reject ADL (activities of daily living) assistance. During a review of Resident 18's Nursing Care Plan (NCP), dated 5/9/23, the NCP indicated, "ADL SELF CARE DEFICIT: [Resident 19] is at risk for self-care deficit r/t [related to] decreased/impaired mobility." During a concurrent observation and interview on 8/19/24 at 2:33 p.m. in Resident 19's room, Resident 19 was in bed, awake, alert and verbally responsive, appeared disheveled, half naked and wearing a dirty incontinence brief. Resident 19's body had a very strong-smelling pungent odor and the immediate environment had also a foul-smelling strong odor, sheets were disorganized, and the floor below the bed was dirty. When asked how he was doing, Resident 19 stated, "I live like a homeless. The nurses here, they don't attend to me and they leave me	F 921	**What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** Activities Director or designee will report to Maintenance Director if anything needs to be repaired in dining room. Maintenance Director will report to Administrator weekly if any repairs are needed in the dining room. Administrator will perform a check of the dining room weekly to ensure lights, blinds, and garbage cans are in good working order. A department head will check on Resident 19 M-F in daily room rounds. The cleanliness of the resident and his surroundings will be reported in daily stand up. DON or designee will check in with Resident 19 daily to ensure residents is receiving incontinence care and bathing opportunities. Family has been encouraged to help with participation in bathing. Resident 19 has also been put on list by DON to be seen by a psychiatry, to assist with non-compliance with bathing.	

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F 921	Continued From page 64 filthy...From an 82 year-old ...this is what I get, filthy and dirty...I wish they could tell me that someone will come and talk to me so I can prepare myself, not like this. These people don't know what they are doing." During an interview on 8/19/24 at 2:35 p.m. with LN 1, LN 1 entered Resident 19's room and verified Resident 19's filthy situation and strong odor and the immediate room environment's foul-smelling strong odor, and stated, "I can see he is dirty right now. It's very unhealthy leaving him like that..." During an interview on 8/22/24 at 9:30 a.m. with the Director of Nursing (DON), the DON stated, "That is a given. The resident's immediate environment should be safe, clean and comfortable." During an interview on 8/22/24 at 12:28 p.m. with the Administrator (ADM), the ADM stated, "On resident safety and cleanliness of the environment, we're just reminding staff to keep their eyes open and be aware of their surroundings...in terms of maintaining their quality of life...on the residents' immediate environment." During a review of the facility's policy and procedure (P&P) titled, "Maintenance Service," dated 12/09, the P&P indicated, "Maintenance service shall be provided to all areas of the building, grounds, and equipment...maintaining the building in good repair...maintaining light levels that are comfortable ...follow established infection control precautions...inspection of building...follow established safety regulations to ensure the safety and well-being of all concerned."	F 921	**How the facility plans to monitor its performance to make sure that solutions are sustained.** Administrator will check the dining room 1x weekly to ensure blinds, garbage cans, and lights are in correct working order. Maintenance Director will notify Administrator if any materials are needed to fix anything that is not functioning properly. Room rounds will be done daily for Resident 19 and will be discussed in morning stand up meeting. Any refusal of bathing or incontinence care will be addressed. DON or designee will check on Resident 19 daily to encourage proper hygiene, bathing, and incontinence care. Results will be included in quarterly QA meeting. **Date when corrective action will be completed;** 9/9/2024	

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F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the required in-service training, competency skills and techniques were provided for two out of two sampled Contracted Certified Nursing Assistants (CCNA) CCNA 15 and CCNA 16, when the facility was unable to provide documentation to demonstrate the CCNAs received no less than 12 hours of annual in-services. This failure had the potential to significantly compromise the quality of services provided to the residents. Findings:	F 947	**F 947** **How corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** When using contracted CNAs, it is now required on the scheduling website for CNAs to include Dementia training and training on elder abuse. Since 12 hours of in-services are required over the span of 12 months, contracted CNAs are told if they are going to work at the facility they must keep track of their 12 hours and provide them if facility requests. **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;** All residents have the potential to be affected by the deficient practice. It is now required by our facility for any contracted CNA to upload proof of required Dementia training, and Elder Abuse training. DSD or designee will verify that this training is uploaded upon the CNA accepting a shift with our facility. **What measures will be put into place or what systematic changes will the facility make to ensure that the deficient practice does not recur;** DSD or designee will verify that Demntia training and Elder Abuse training are loaded to a contracted CNAs profile before they can work their shift at the facility. Facility has now required that all contracted CNAs who want to pick up a shift at the facility have this information loaded to their profile. If contracted CNA continues to work at the facility they will be reminded that over the course of the year their 12 hours of training need to be completed and provided to the facility upon request.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055887	A. BUILDING _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 947	Continued From page 66 During a concurrent interview and record review on 8/20/24 at 9:40 a.m. with the Director of Staff Development (DSD), the DSD confirmed she could not find the missing documentation to support dementia management training for CCNA 15. During a concurrent interview and record review on 8/20/24 at 10:25 a.m. with the Director of Nursing (DON), the DON stated, "The facility used contracted staff through a staffing agency, and the contracted nursing staffing agency is expected to provide CCNAs with mandatory training documentation." During an interview on 8/22/24 at 2:25 p.m. with the Administrator (ADM), the ADM stated, "After inquiring with the contracted agency, I found out they are a scheduling agency and, therefore, there was no way to verify if the in-service training was completed. I would have to check with the specific CCNAs [CCNA 15 and CCNA 16] and get back to you. The facility should ensure that proper training is provided for proper well-being of the residents." The ADM was unable to provide verification of the requested documents. During a review of the facility's policy and procedure (P&P) titled "In-Service Training Program," revised 5/19, the P&P indicated, "...Annual in-services...are no less than 12 hours per employment year...address the specific skills and knowledge related to their department and job function...including...dementia management and abuse prevention."	F 947	**How the facility plans to monitor its performance to make sure that solutions are sustained.** DSD or designee will verify contracted CNAs profile to ensure Dementia training and Elder Abuse training are loaded to their profile prior to working a shift at the facility. If this training is not provided for review, CNA will not be able to work at the facility. **Date when corrective action will be completed;** 9/9/2024	