STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345505	A. BUILDING _____ B. WING _____	C 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF CUMBERLAND	4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306

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E 000	Initial Comments The facility was found in compiance with the requirement CFR 483.73 Emergency Preparedness Event ID #6FP311	E 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		4/11/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/05/2019

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F 584	Continued From page 1 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interview the facility had wooden doors at the entrance to resident rooms that were chipped and splintered. This was evident in 2 of 3 resident care units (Independence Way and Dogwood Court). The findings included: Observation during the environment rounds on 3/12/19 at 4:48 PM revealed the door to the entrance of resident rooms were in disrepair as noted: a. The wooden door to Room #508 hole was chipped. b. The wooden door to Room #507 was chipped and splintered. c. The wooden door to Room #505 was chipped and splintered. d. The wooden door to Room #506 was chipped and splintered. e. The wooden door to Room #501 was chipped and splintered. Continued environmental rounds held on 3/13/19 from 4:50 PM to 5:15 PM revealed: a. The wooden door to Room #507 remained chipped and splintered. b. The wooden door to Room #711 was chipped and splintered. Observations on 3/14/19 at approximately 5:05 PM revealed the previous observations on the wooden doors on 3/12/19 and 3/13/19 remained	F 584	The statements included in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. F584 How corrective action will be accomplished for those residents found to have been affected: All identified resident room doors in rooms 501,505,506,507,508,711 were immediately repaired with putty and sanded down. F584 How the facility will identify other residents having the potential to be affected by the same deficient practice: All maintenance employees were in-serviced regarding ensuring resident	

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F 584	Continued From page 2 unchanged. The Director of Maintenance was interview at this time and date who indicated he was aware of the chipped and splintered wood doors. He stated he replaced a door near the kitchen. When an inquiry was made regarding the repair or replacement of the resident wood door the response at that time was the facility planned to replace the doors. There was no plan or date to indicate how or when the replacements would occur. Interview on 03/14/19 at 05:36 PM with the Administrator and corporate representative was held. The administrator stated she expected staff to make repairs as it is needed.	F 584	room doors are in safe working order on 3/14/2019. All resident room doors were audited to ensure they are in good working condition completed 4/11/2019. F8584 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The maintenance director or designee will conduct an audit of 5 resident room doors weekly x 4 weeks then 3 resident doors twice monthly x 1 month. Any doors found to not be in good working condition will be immediately repaired. F584 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Findings from audits will be reviewed at the Quarterly Quality Assurance meeting x1 for any further problem resolution if needed.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		4/11/19

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F 656	Continued From page 3 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to develop and implement a person-centered care plan for 1 of 6 residents (Resident #89) reviewed for unnecessary medications. Findings include:	F 656	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Care plan was updated for resident #89 during survey and is no longer a resident of the facility.	

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F 656	Continued From page 4 Resident #89 was admitted to the facility on 2/8/19 with diagnoses that included Non-Alzheimer's dementia, Alzheimer's disease, and depression. A review of Resident #89's most recent MDS (Minimum Data Set) dated 2/28/19 was coded as a 14-day assessment. The MDS coded the resident as cognitively impaired. Active diagnoses included Alzheimer's disease, Non-Alzheimer's dementia, depression, and Kawasaki disease. The MDS coded Resident #89 as having had an antidepressant 7 out of 7 days and an antipsychotic 7 out of 7 days during the look back period. A review of Resident #89's current care plan dated 2/25/19 revealed the resident was care planned for use of psychotropic medications, antipsychotic and antidepressant medications related to dementia and depression. The interventions were noted to be 'educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms at antipsychotic and antidepressant medications given and monitor for side effects and effectiveness.' An interview was conducted with Nurse #13 on 3/13/19 at 2:30pm. She reported when she had a new resident, she reviewed the care plan for interventions to know what was going on with the resident. Nurse #13 reported Resident #89 becomes agitated at times and wanted his family. An interview was conducted on 3/13/19 at 4:34 pm with MDS nurse #1. She reported it was the responsibility of the MDS nurses to complete the	F 656	How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of all residents with psychotropic drug use was completed on April 4, 2019 with immediate corrections to the care plan as indicated. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. The Nurse Consultant or designee provided education to the nurse administration team and MDS (Minimum Data Set) nurses on how to include non-pharmacological interventions on the comprehensive care plan for all psychotropic medications on April 8th 2019. Care plans will be reviewed for accuracy quarterly and on each annual assessment. Director of Nursing (DON) or designee will audit any newly admitted residents with psychotropic medications up to a random sample of 5 resident care plans. The audit will assess if non-pharmacologic interventions were added to the care plan for 1 time per week for 4 weeks, 2 times a month for 1 month, and monthly for 4 months to ensure deficient practice does not recur. How the facility plans to monitor its performance to make sure that solutions are sustained. Any issues identified on the audits will be immediately corrected with coaching/discipline as needed to the nursing administration team. Results of the audits will be presented in the quarterly QAPI (Quality Assurance and	

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F 656	Continued From page 5 care plans on the residents. She reported when she completed a care plan she usually "just clicked the boxes" in the computer. She reported Resident #89 should have had non-pharmalogical interventions for the psychotropic medications. An interview was conducted on 3/14/19 at 4:50pm with the Administrator. She reported it was the responsibility of the MDS nurses to complete all care plans for the residents. The Administrator reported it was her expectation that all care plans were individualized for each resident and non-pharmalogical interventions were included on the care plan.	F 656	Performance Improvement) meeting and reviewed for any need for systemic changes or further education.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to follow physician orders for 1 of 1 residents (Resident #7) reviewed for use of straws with liquids. Findings include: Resident #7 was admitted to the facility on 11/2/12 with diagnoses that included dementia, dysphasia, and glaucoma. A review of Resident #7's most recent MDS (Minimum Data Set) dated 3/5/19 was coded as a quarterly assessment. The resident was coded as	F 658	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #7 is care planned to allow for resident preference and behaviors related to not following physician orders on the use of straws. Resident #7 screened by speech therapy completed April 11th 2019 resident provided with a cup with lid due to vision issues. How the facility will identify other residents having the potential to be affected by the	4/11/19

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F 658	Continued From page 6 cognitively impaired. The MDS revealed Resident #7 required extensive one-person assistance with eating. Active diagnoses included non-Alzheimer's dementia, dysphasia, and glaucoma. A review of Resident #7's current care plan dated 3/5/19 revealed the resident was care planned for nutritional risk due to dementia disease progression, therapeutic diet restriction and use of diuretic which may cause weight fluctuations. The care plan stated Resident #7 was to have no straws. A review of Resident #7's medical record revealed a physician's order dated 1/28/19 that ordered the resident to not have straws with her liquids. A review of Resident #7's meal card on 3/14/19 at 12:40pm revealed the top of the meal card read 'no straws.' An observation was made on 3/13/19 at 5:20pm of Resident #7 sitting up in bed with 2 Styrofoam cups with lids on and straws inserted into each cup within reach of the resident. An observation was made on 3/14/19 at 11:20am of Resident #7 in bed with bedside table next to bed. On the bedside table within reach of Resident #7 was a Styrofoam cup with a straw placed in the cup. An observation of Resident #7 eating lunch was made on 3/14/19 at 12:20pm. Resident #7 had 3 cups of liquids on her tray with a straw placed in each one. Two of the cups were half empty when observed.	F 658	same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. Nursing staff was educated by the Director of Nursing or designee on checking tray cards for accuracy when providing trays to residents; completed April 8th 2019. The unit managers or designees will audit tray accuracy at least 3 times per week for 4 weeks, and 1 time per week for 4 weeks to ensure deficient practice does not recur. How the facility plans to monitor its performance to make sure that solutions are sustained. The findings of all audits will be shared with the QAPI committee for review of any further education or systemic changes needed. Staff found to be imprecise in tray accuracy will receive progressive discipline.	

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F 658	Continued From page 7 An interview was conducted on 3/14/19 at 12:40pm with NA #5 (Nursing Assistant). She reported she received instructions on caring for residents from the resident's Kardex. She reported if the resident had any special needs with meals such as no straws, it would be on the resident's Kardex and the meal card. She reported the NAs put the straws on the residents' trays as they served them. She reported she was not aware that Resident #7 was not to have straws. NA #5 reported she must have not looked at the meal card or Kardex for Resident #7. An interview was conducted on 3/14/19 at 12:49 pm with Nurse #14. She reported she knew Resident #7 was not supposed to use a straw with her drink but stated if she asked for one she would give her one. She reported she did not set up the residents' meal trays so she would not know if Resident #7 had a straw or not. An interview was conducted with the acting DON (Director of Nursing) on 3/14/19 at 1:10pm. She reported it was her expectation that the NAs follow the Kardex and the nurses follow physician orders. The DON reported it was her expectation that residents who have dietary equipment restrictions such as no straws, should have the restrictions followed by the staff.	F 658		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of	F 676		4/11/19

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F 676	Continued From page 8 daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide supervision to 1 of 3 residents (Resident #43) observed eating dinner unattended in the Dogwood dining room.	F 676	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #43 meal intake was reviewed. Physician was notified of intake patterns and resident has exhibited no	

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F 676	Continued From page 9 Findings include: Resident #43 was admitted to the facility on 6/24/18 with diagnoses that included Cerebral Vascular Accident, Amyotrophic Lateral Sclerosis, and Respiratory failure. A review of Resident #43's most recent MDS (Minimum Data Set) dated 1/23/19 and coded as a significant change assessment coded the resident as cognitively impaired. The MDS coded the resident as needing supervision and meal set up with eating. A review of Resident #43's current care plan dated 1/30/19 revealed the resident was care planned for having a deficit with Activity of Daily Living self-care performances related to weakness. Interventions included supervision of Resident #43 with eating. An observation was made on 3/13/19 at 5:25 pm of Resident #43 sitting in wheelchair at a table by himself in the Dogwood dining room. It was observed that Resident #43 received his dinner tray at 5:30 pm and the staff set up the silverware and drinks for the resident. It was observed that no staff returned to the dining room until 5:50 pm to ask Resident #43 if he needed anything. Between 5:30 pm and 5:50 pm, it was observed that Resident #43 ate very little on his plate. An interview was conducted with the acting DON (Director of Nursing) on 3/14/19 at 1:10 pm. The DON reported it was her expectation that a nurse be in the dining room throughout the meals to assist and oversee the residents. An interview was conducted with the administrator on 3/14/19 at 4:52 pm. The	F 676	adverse effects of meal being unsupervised on 3/13/19. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. Nursing staff were educated by the DON or designee on assisting residents with meal set up and supervision for all residents in the dining room during meals on April 8th 2019. Unit managers or designee will audit dining process and supervision 3 times per week for 4 weeks, and 1 time per week for 4 weeks to ensure deficient practice does not recur. How the facility plans to monitor its performance to make sure that solutions are sustained. The findings of all audits will be shared with the QAPI committee for review of any further education or systemic changes needed. Staff found to be non-compliant with dining process will receive progress discipline.	

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F 676	Continued From page 10 administrator reported it was her expectation that the nurses be in the dining room while the residents are eating their meals.	F 676		
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 by: Based on record review, observations and staff interviews, the facility failed to provide an ongoing structured activities program which met the individual interests and needs for 2 of 2 cognitively impaired residents reviewed for activities (Resident #26 and Resident #35). Findings included: Record review revealed 13 residents in the facility required 1:1 visits for activities. 1. Resident #26 was admitted to the facility on 11/12/18 with cumulative diagnoses which included stroke. Record review of the 11/19/2018 Admission Minimum Data Set (MDS) under Section F revealed a resident interview was attempted, however there was no response provided from the resident. Staff interview revealed responses	F 679	1. F679 How corrective action will be accomplished for those residents found to have been affected: Residents #26 and # 35 were seen during survey for one on one visitation and were added to the weekly schedule of one on one visitations. F679 How the facility will identify other residents having the potential to be affected by the same deficient practice: All activities staff were educated on following the established care plan goals on March 14th 2019. All residents requiring one on one activities were identified and a weekly schedule for their visits was established.	4/11/19

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F 679	Continued From page 11 of what was important for resident which was reading books, newspapers, or magazines, listening to music and participating in religious activities. Review of the care plan revised 2/20/19 revealed in part the following: The Focus: The resident is dependent on staff for meeting her emotional, intellectual, physical, and social needs due to cognitive deficits of an altered mental status. The Goal: The resident will maintain involvement in cognitive stimulation, social activities at least 2 times per week, The Interventions: The resident needs 1:1 bedside/in-room visits and activities such as music and sensory stimulation. The resident needs assistance/escort to activity functions. Record review of the Activity Calendars for the months October 2018 through March 2019 revealed no scheduled structured activities for 1:1 visits. Interview on 03/13/19 at 04:23 PM with the Activities Director (AD) stated Resident #26 had cognitive stimulation scheduled twice a week. Review of the computerized form used for documentation of 1:1 activities revealed no 1:1 activities had been conducted for the following dates: Week of 12/30/18-1/5/19 except one 1:1 visit on 1/4/19. Week of 1/6/19-1/12/19 except one 1:1 on 1/11/19. Week of 2/3-2/11/19. Week of 2/24 -3/2/19. Week of 3/3/19- 3/9/19. Observation on 03/11/19 at 1:51 PM revealed the resident was in bed asleep.	F 679	F679 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The activities director or designee will conduct an audit 5 residents requiring one on one activities for participation bi-monthly x 2 months than 3 residents monthly x 1 month. F584 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Findings from audits will be reviewed at the Quarterly Quality Assurance meeting x2 for any further problem resolution if needed.	

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Observation on 03/12/19 at 09:40 AM revealed the resident was in bed asleep. Continued observations during the survey revealed 1:1 activities were not being provided to the resident.
Interview on 3/13/19 at 5:50 PM with the Director of Activities (DA) was held and she provided a typed 1:1 schedule to be started March 2019 that indicated scheduled 1:1 visits on Mondays and Wednesdays. The DA indicated that this schedule was created so that all the residents would be able to be provided 1:1 activity as needed and that she and her assistant would not duplicate visits to the same residents and not miss others. Continued interview with the DA who stated she believed she had enough staff to provide 1:1 activities.
Interview on 3/13/19 at 6:30 PM with the Administrator stated her expectations for staff were to follow the care plan and goals established for activities.

2. Resident #35 was admitted to the facility with cumulative diagnoses which included a stroke and hypertension.
Record review 8/2018 Admission assessment MDS section F revealed resident unable to participate in interview, and staff interview performed. Staff interview revealed response of what was important for resident as follows: Family or significant other involvement in care discussions, reading books, newspapers, or magazines, listening to music keeping up with the news, participating in favorite activities, spending time outdoors
Review of the care plan updated 3/8/19 revealed a focus that resident was dependent on staff for meeting emotional, intellectual physical and social needs due to a cerebral infarction. The goal was to maintain involvement in cognitive stimulation,

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social activities at least 1-4 times per week. The interventions included 1:1 bedside/in room visit. Record review of the Activity Calendars for the months October 2018 through March 2019 revealed no scheduled structured activities for 1:1 visits.
Review of the documentation form used to demonstrate 1:1 visits had been completed revealed no indication that 1:1 visits had been conducted from 1/6/19 through 1/19/19, 2/17/19 through 3/2/19, 12/23/18 through 12/29/18, 2/3/19 through 2/9/19 and the week of 3/13/19.
Observation on 03/11/19 at 01:37 PM and 1:51 PM revealed the resident was in bed asleep. Observation on 03/12/19 at 09:32 AM revealed the resident was in bed asleep. Continued observations during the survey revealed 1:1 activities were not being provided to the resident.

Interview on 03/13/19 at 04:15 PM with the Director of Activities (DA)) stated 1:1 activity with resident was last done on 2/14/19 when a volunteer group came to the facility. The DA was not able to recall the volunteer group nor the time.

Interview on 3/13/19 at 5:50 PM with was held and she provided a typed 1:1 schedule starting March 2019 (no specific date) that indicated Resident #36 was scheduled on Fridays for 1-1. The DA indicated that this schedule was created so that all the residents would be able to be provided 1:1 activity and that she and her assistant would not duplicate visits to the same residents or miss residents. Continued interview with DA who stated she believed she had enough staff to provide 1:1 activities.
Interview on 3/13/19 at 6:30 PM with the Administrator who stated her expectation for staff to follow the care plan and goals established for

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F 679	Continued From page 14 activities.	F 679		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in	F 756		4/11/19

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F 756	Continued From page 15 the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff, physician assistant, and consultant pharmacist interviews, the consultant pharmacist failed to identify and recommend discontinuation of a prn psychotropic medication (Olanzapine) on 1 of 6 residents (Resident #3) reviewed for unnecessary medications. Findings include: Resident #3 was admitted to the facility on 2/19/19 with diagnoses that included dementia and Alzheimer's disease. A review of Resident #3's most recent MDS (Minimum Data Set) dated 2/26/19 and coded as an admission assessment coded the resident as cognitively impaired. The MDS coded Resident #3's medication look back for the past 7 days as the resident was on antipsychotic medication. Active diagnoses included Non-Alzheimer's dementia and Alzheimer's disease. A review of Resident #3's medical record revealed a physician's order dated 2/19/19 that read Olanzapine 5mg (milligram) every 8 hours as needed for agitation. A review of Resident #3's medical record revealed a consultant pharmacist note dated 2/26/19 that read 'Based upon the information available at the time of this review, and assuming the accuracy and completeness of such information, it is my professional judgment that at	F 756	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #3 has been reviewed by pharmacist/provider and stop date implemented as recommended. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with as needed psychotropic medications were referred to provider for stop date or justification with review date this was completed April 11th 2019. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. The Pharmacy Consultant was educated by the Director of Nursing (DON) or designee regarding the need for review of as needed psychotropic medications and recommendations for stop dates or justification by the providers on April 8th 2019. How the facility plans to monitor its performance to make sure that solutions are sustained. The DON or designee will run a list of all as needed psychotropic medications without a stop date monthly when the pharmacy consultant does his monthly review and ensure that he issues any needed recommendations regarding	

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F 756	Continued From page 16 such time, the resident's medication regimen contained no irregularities. Will continue to monitor psychotropics. Recommendations for discontinuing sliding scale insulin and Divalproex.' A review of Resident #3's Medication Administration Record for March 2019 revealed Olanzapine 5 mg was given on an as needed basis on 3/4/19. An interview was conducted on 3/13/19 at 12:40 pm with the consultant pharmacist. He reported if he had a resident on a prn (as needed) psychotropic medication, he would make a recommendation to the physician to discontinue the prn psychotropic medication. The consultant pharmacist reported he did not remember Resident #3 having an order for Olanzapine prn. An interview was conducted on 3/14/19 at 9:30 am with the facility PA (Physician Assistant). He reported the facility would give him a list of psychotropic medications that were prn and needed to be reevaluated each week. He reported not seeing a note regarding prn Olanzapine on Resident #3. The PA reported all prn psychotropic medications needed to be reevaluated every 14 days. He reported Resident #3 must have come from the hospital to the facility on the prn medication. An interview was conducted with the administrator on 3/14/19 at 4:50 pm. She reported it was her expectation that the consultant pharmacist and the physician work together and that all prn psychotropic medications be reevaluated every 14 days.	F 756	these medications for 6 months. The findings will be reviewed at quarterly QAPI meetings x 2 quarters.	
F 758	Free from Unnec Psychotropic Meds/PRN Use	F 758		4/11/19

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F 758 SS=D	Continued From page 17 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

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F 758	Continued From page 18 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure physician orders for as needed (PRN) psychotropic medications were time limited in duration for 1 of 6 residents (Resident #3) reviewed for unnecessary medications. Findings include: Resident #3 was admitted to the facility on 2/19/19 with diagnoses that included dementia and Alzheimer's disease. A review of Resident #3's most recent MDS (Minimum Data Set) dated 2/26/19 and coded as an admission assessment coded the resident as cognitively impaired. The MDS coded Resident #3's medication section for the past 7 days as the resident was on antipsychotic medication 7 out of 7 days. Active diagnoses included Non-Alzheimer's dementia and Alzheimer's disease. A review of Resident #3's medical record revealed a physician's order dated 2/19/19 that read Olanzapine 5mg (milligram) every 8 hours as needed for agitation.	F 758	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #3 had as needed psychotropic medication without stop date or justification with review date. Provider has reviewed medication and added stop date for resident March 14th 2019. How the facility will identify other residents having the potential to be affected by the same deficient practice. The DON reviewed all residents with as needed psychotropic medications and they were referred to provider for stop date or justification with review date on April 11th 2019. All were either discontinued or given dates. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. All licensed staff educated by the Director of Nursing (DON), Staff Development Coordinator (SDC), or designee on needing stop dates for as needed psychotropic medications on April 8th 2019.	

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F 758	Continued From page 19 A review of Resident #3's medical record revealed a consultant pharmacist note dated 2/26/19 that read 'Based upon the information available at the time of this review, and assuming the accuracy and completeness of such information, it is my professional judgment that at such time, the resident's medication regimen contained no irregularities. Will continue to monitor psychotropics. Recommendations for discontinuing sliding scale insulin and Divalproex.' A review of Resident #3's Medication Administration Record for February 2019 and March 2019 revealed Olanzapine 5 mg was given on an as needed basis on 3/4/19 and no time in February. An interview was conducted on 3/13/19 at 12:40 pm with the consultant pharmacist. He reported if he had a resident on a prn psychotropic medication, he would make a recommendation to the physician to discontinue the PRN psychotropic medication. The consultant pharmacist reported he did not remember Resident #3 having an order for Olanzapine prn. An interview was conducted on 3/14/19 at 9:30 am with the facility PA (Physician Assistant). He reported the facility would give him a list of psychotropic medications that were PRN and needed to be reevaluated each week. He reported not seeing a note regarding PRN Olanzapine on Resident #3. The PA reported all PRN psychotropic medications needed to be reevaluated every 14 days and reordered if necessary. He reported Resident #3 must have come from the hospital to the facility on the PRN medication and he overlooked it.	F 758	How the facility plans to monitor its performance to make sure that solutions are sustained. The DON or designee will review all new admissions for as needed psychotropic medications weekly for 3 months for stop dates or justification with review date. If there are residents with as needed psychotropic medications, the DON or designee will refer them to the MD/NP for a stop date or justification for use. The findings will be reviewed at the quarterly QAPI meetings x 2 quarters.	

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F 758	Continued From page 20 An interview was conducted with the administrator on 3/14/19 at 4:50 pm. She reported it was her expectation that the all PRN psychotropic medications be reevaluated every 14 days to determine if the resident needed to stay on the medication.	F 758		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and review of manufacturer's recommendations for medication administration, the facility failed to have a medication error rate less than 5% as evidenced by 6 medication errors out of 28 opportunities, resulting in a medication error rate of 21.43% for 3 of 6 residents observed during medication pass. (Resident #300, Resident #25, and Resident #80) The findings included: 1. A review of Resident #300's March 2019 Physician Orders included a current medication order for Advair Discus Aerosol Powder Breath Activated 250-50 micrograms (mcg) 1 puff inhale orally two times a day. Advair discus is an inhaled medication used for the management of asthma or chronic obstructive pulmonary disease. A review of the manufacturer's information for Advair discus included the following instructions:	F 759	F759 How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The nurses providing the incorrect medication administration or procedures were immediately counseled and the physicians notified. " Resident #300 received an Advair discus administration without rinsing his mouth with water afterwards. Nurse #2 was advised of error on date of survey and rinse was provided to resident #300 upon notification of medication concern. " Resident #25 was given extended release medications that were crushed. Physician for resident #25 was notified at the time of the medication error. A	4/11/19

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F 759	Continued From page 21 "Rinse your mouth with water without swallowing after using ADVAIR to help reduce your chance of getting thrush." Thrush is fungal infection in your mouth or throat. On 03/12/19 at 5:15 PM, Nurse #2 was observed as she pulled an Advair discus (250/50 mcg) 1 dose meter from the medication cart for administration to Resident #300. Resident #300 was observed as he took the inhaler and self-administered the medication while in the presence of Nurse #2. The nurse did not offer the resident any water to rinse his mouth out after using the inhaler. An interview was conducted on 03/13/19 at 12:03 PM with Nurse #2. Upon inquiry, the nurse acknowledged she did not give or offer Resident #300 any water to rinse his mouth out after using the Advair but she should have done so. An interview was conducted on 03/13/19 at 12:18 PM with the facility's Staff Development Coordinator (SDC) who was the relief Director of Nursing during the survey. During the interview, concerns identified during the medication pass observations were discussed. Upon inquiry, the SDC stated she would expect a nurse to at least offer water for the resident to rinse and spit out after the Advair had been used. 2. A review of Resident #25's Physician Order Form for March 2019 included current medication orders for Nifedipine Extended release (ER) 60 mg milligrams (mg)by mouth (po) twice daily (a drug used to treat hypertension), Potassium Chloride ER(potassium supplement) 10 milliequivalent (meq)PO and Vitamin D (vitamin D supplement) 2000 Units (U) PO.	F 759	medication error report has been completed and there was no adverse effect to the resident. " Resident #80 did not receive the Esomeprazole on 3/13/19. The physician for resident #80 was notified at the time of the medication not being available with no adverse reactions. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the alleged deficient practice. The measures put into place or systemic changes made to ensure that the deficient practice will not recur: The Nurse Consultant and the Director of Nursing provided education to the licensed nursing staff on the five rights of medication administration, including verifying correct route of administration (do not crush extended release medications), following warning directions for medications (rinse after use for Advair), and ensuring medications are available for residents or physician notification for medications that are not in stock. Training will be completed by April 7, 2019. Nursing administration will conduct medication pass audits on licensed nursing staff monthly x 3 months and then quarterly to monitor for the accurate administration of medication. How the facility plans to monitor its	

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F 759	Continued From page 22 A review of the manufacturer's information for ER medications included the following instructions: Do not crush or chew ER medications. Doing so can release all the drug at the same time, increasing the risk of side effects. On 03/13/19 at 9:08 AM, Nurse #4 who was accompanied by Nurse #6 was observed as she crushed the medications, placed them in applesauce and administered medications to Resident # 25. The administered medications that were crushed included Nifedipine ER and Potassium Chloride ER. Vitamin D 1000 Units PO was poured and crushed instead of 2000 U. An interview was conducted on 03/13/19 at 11:24 AM with Nurse #4 and Nurse #6. During the interview, Nurse #4 stated she did not realize that the extended release medications could not be crushed. Nurse #6 stated she did not realize the extended release medications were crushed. Nurse #4 stated she thought 2 vitamin D 1000 U tablets were administered. An interview was conducted on 03/13/19 at 12:18 PM with the facility's Staff Development Coordinator (SDC) who was the relief Director of Nursing during the survey. During the interview, concerns identified during the medication pass observations were discussed. Upon inquiry, the SDC stated she would expect staff to follow policy and procedures for crushing medications and read the orders three times and compare the orders to the medications to be administered. 3. A review of Resident #80's Physician Order Form for March 2019 included a current medication order for Esomeprazole Magnesium	F 759	performance to make sure that solutions are sustained: The results of the medication pass audits will be reported to the QAPI committee for analysis of any patterns, trends, or need for further systemic changes. Any staff found to be non-compliant with the dispensing of accurate drugs will receive progressive discipline.	

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F 759	Continued From page 23 Delayed Release 40 milligrams (mg) by mouth (po) two times a day. Esomeprazole magnesium is a proton pump inhibitor (PPI) that blocks acid production in the stomach. On 03/13/19 at 11:06 AM, Nurse # 4 was observed as she pulled medications from the medication cart for administration to Resident #80. Esomeprazole Magnesium Delayed Release capsule 40 mg was not available from the medication cart nor in the back-up medication system. Interview on 03/13/19 11:24 AM with Nurse #6 revealed the medication Esomeprazole magnesium capsule 40 mg was reordered and due to be delivered today (referring to 3/13/19). An interview was conducted on 03/13/19 at 12:18 PM with the facility's Staff Development Coordinator (SDC) who was the relief Director of Nursing during the survey. During the interview, concerns identified during the medication pass observations were discussed. Upon inquiry, the SDC stated she would expect staff on each shift to make sure that the medications are available.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, pharmacy consultant and physician assistant interviews, the facility failed to administer	F 760	F760 How corrective action will be accomplished for those residents found to	4/11/19

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F 760	Continued From page 24 admission medications as ordered for 1 of 6 residents reviewed for unnecessary medications. (Resident #100) The findings included: Resident #100 was admitted to the facility on 2/20/19 from a recent hospitalization with cumulative diagnoses which included a stroke, acute myocardial infarction involving the left main coronary artery, thrombosis of the atrium, automatic implanted cardiac defibrillator, chronic renal failure and atrial fibrillation. Due to the date of the facility admission there was no Minimum Data Set (MDS) assessment or care plan to review. Review of the hospital discharge summary medication list dated 2/20/19 revealed orders that included: Apixiban (Eliquis) 2.5 milligram (mg) two (2) times a day (BID) by mouth (po) until 2/25/19 then increase to 5 mg BID. A drug used to treat and prevent blood clots Torsemide 40 mg po daily. A drug used to reduce extra fluid in the body. Valsartan 40 mg po daily po. A drug used to treat high blood pressure. Metoprolol Tartrate 50 mg every 12 hours po. A drug used to treat high blood pressure. According to the discharge medication list these medications were last administered to Resident #100 on 2/20/19 at 8:05 AM. Review of the 2/20/19 admission medication orders included: Apixiban (Eliquis) 2.5 mg BID po until 2/25/19	F 760	have been affected by the deficient practice. Resident #100 is no longer a resident of the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. All pending medication deliveries were reviewed during the survey to ensure that all medications were available to residents at that time. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. The Nurse Consultant, Director of Nursing or designee provided education to the licensed nursing staff on the pharmacy process to obtain medications on newly admitted residents to include: using the Omnicell for medications that have not arrived from the pharmacy, notifying pharmacy of medication needs and using a backup pharmacy procedure if needed, and notification of medication issues to all physicians as required on April 8th, 2019. Nursing administration will conduct admission audits for a random sample of 5 admissions weekly x 4 weeks, twice monthly x 1 month, and monthly x 3months to ensure medications are obtained in a timely manner and administered as ordered.	

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F 760	Continued From page 25 then increase to 5 mg BID , Metoprolol Tartrate 50 mg every 12 hours po, Torsemide 40 mg po daily, and Valsartan 40 mg po daily po. Eliquis and Metoprolol Tartrate were scheduled to be administered at 9 AM and 5 PM. Torsemide 40 mg po daily and Valsartan 40 mg po daily were scheduled to be administered at 9 AM. Review of the computerized Medication Administration Record (MAR) revealed the above medications had not been administered to the resident since admission. Review of the computerized nurses' notes dated 2/20/2019 at 7:41 PM indicated Resident #100 arrived to the facility from the hospital due to left side hemiparesis. Further review of the computerized nurses notes dated 2/21/2019 at 12:04 PM indicated "Called to resident's room d/t [due to] resident having chest pain. Family present at bedside. Son was on phone with 911." Resident vital signs were blood pressure 133/69, pulse rate 88 and respirations 16 with an oxygen level of 98% on room air. Nitroglycerin 1 time was given sublingual with relief of chest pain. Report given to EMS with copy of medication list. Resident left the facility at 12noon. Record review revealed the resident was readmitted to the hospital Review of the hospital records dated 2/21/19 revealed the resident was admitted with diagnoses which included hyperkalemia (high potassium level) Interview on 03/13/19 at 02:48 PM with Nurse #16 (admitting nurse) revealed Resident #100 arrived via stretcher at 7:30 PM (not sure of exact time). Nurse #16 indicated the second medication pass for the evening was completed	F 760	How the facility plans to monitor its performance to make sure that solutions are sustained. The results of the audits will be reported to the QAPI committee quarterly x 2 for analysis of patterns, trends, or need for further systemic changes. Any staff found to be non-compliant with the pharmacy procedures will receive progressive discipline.	

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F 760	Continued From page 26 and Resident #100 meds were not given due to being after the medication pass time. Continued interview with Nurse #16 indicated she did not contact the md and it was too late to call the pharmacy for the medications. An inquiry was made about the back-up pharmacy but there was no response. Interview on 03/13/19 03:01 PM with Unit Manager #3who stated if a newly admitted resident orders were not activated by 5 PM to the pharmacy, the facility would not receive any medications until the next day. The unit manager indicated the back-up pharmacy had not been utilized. Interview on 03/14/19 at 10:30 AM with the Physician Assistant who stated he expected ordered drugs be administered to the resident especially cardiac or blood thinning medications. Interview on 03/14/19 at 11:46 AM via the phone with the Consultant Pharmacist (CP) revealed after normal business hours for the pharmacy, the facility should call the pharmacy and request a stat (immediate) delivery. CP stated the pharmacy will either sent the medication or contact the back -up pharmacy for delivery. Interview on 03/14/19 at 05:46 PM with the Administrator revealed she expected the pharmacy to be contacted to obtain the medication and if necessary obtain the medications from the backup pharmacy.	F 760		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy.	F 803		4/11/19

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F 803	Continued From page 27 Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, review of the planned menu and staff interviews the facility failed to serve the menu as planned for 5 residents that received puree diets. Findings Included: Review of the diet guide sheet for Week 3, Day 17 Wednesday ' s lunch meal revealed the puree diets were to receive 3 ounces of pureed panko crusted tilapia, ½ cup of pureed yellow rice, ½ cup of pureed seasoned kale, 1 piece of pureed	F 803	1. F803 How corrective action will be accomplished for those residents found to have been affected: The facility failed to serve the menu as planned for 5 residents that received pureed diets. On 3/13/19, the facility failed to prepare and serve pureed cornbread as indicated on the menu ticket for 5 residents. Pureed cornbread was immediately prepared and brought to the 5 residents that did not receive cornbread upon meal delivery.	

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F 803	Continued From page 28 cornbread and a ½ cup of assorted pudding. An observation on 3/13/19 from 11:20 am through 12:10 pm of the serving line revealed there was no pureed cornbread available. 5 resident meal trays were prepared without the pureed cornbread and placed in a meal cart for delivery to the unit. The Registered Dietitian (RD #2) confirmed that the meals were complete and ready to be served to the residents. RD #2 was informed that the 5 puree meal trays were not served pureed cornbread. An interview on 3/13/19 at 11:45 am with Cook #1 revealed she had not prepared the pureed cornbread. An interview on 3/13/19 at 2:36 pm with RD #2 revealed the cook should have prepared the pureed cornbread and it was her expectation that menus were followed as planned. An interview on 3/14/19 at 4:49 pm with the Administrator revealed it was her expectation that the facility follow and serve the menus as planned.	F 803	F803 How the facility will identify other residents having the potential to be affected by the same deficient practice: The Corporate Dietitian or designee in-serviced/reeducated dietary staff on the requirement regarding serving all food that are listed on the menu ticket for all residents on. This was completed April 11th 2019. F803 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A tray accuracy evaluation will be completed by the Corporate Registered Dietician or designee weekly x 4 weeks, twice-monthly x 4 weeks, and monthly X 1 to ensure compliance with corrective actions, food preparation and tray accuracy. Any deficient practice identified through the tray accuracy evaluation will result in reeducation or disciplinary action as indicated. All new hires will receive in-service education by Dietary Services Manager on proper procedures for food preparation and menu adequacy. F803 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Findings from the tray accuracy evaluation will be reviewed at the Quarterly Quality Assurance meeting x2 for any further problem resolution if needed.	

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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; §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 observations, record review, family and staff interviews the facility failed to honor the food preferences for 1 of 1 resident reviewed for dining (Resident #23). Findings Included: Resident #23 was admitted to the facility on 12/9/08 and diagnoses included dysphagia, diabetes and Alzheimer ' s Disease. Review of a quarterly minimum data set (MDS) dated 12/28/18 for Resident #23 identified she received a mechanically altered diet, required extensive one-person assistance with eating and had severely impaired cognition. Review of the physician ' s orders for Resident #23 revealed she was on a puree diet with moderately thick consistency liquids. An interview on 3/13/19 at 5:35 pm with Resident #23 ' s family revealed she had filled out the menu for the resident and had requested the resident receive pureed chicken for dinner but	F 806	1. F806 How corrective action will be accomplished for those residents found to have been affected: The facility failed to honor the food preferences for 1 resident (resident #23). On 3/13/19, the facility failed to serve pureed chicken for dinner as was listed on the menu ticket and in residents' preferences. The same resident was served pureed bread that was in listed not to be served in patient's preferences. Pt was immediately brought pureed chicken by the dining services aide once discrepancy was identified. F806 How the facility will identify other residents having the potential to be affected by the same deficient practice: The Corporate Dietitian or designee in-serviced/reeducated dietary staff on the requirement regarding serving the foods listed on the menu ticket and honoring food preferences. This was completed April 11th 2019.	4/11/19

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F 806	Continued From page 30 was served the pureed beef. The family member stated she didn ' t want the resident to receive beef. The family member added the resident had been served pureed bread and she had requested that the resident not receive bread. An observation on 3/13/19 at 5:35 pm of Resident #23 ' s meal card revealed pureed herb baked chicken had been circled and pureed bread was not listed to be served. Review of the resident ' s meal tray revealed she had been served pureed beef and pureed bread. An interview on 3/14/19 at 3:52 pm with Registered Dietitian #1 (RD #1) revealed she wasn ' t sure why Resident #23 received the pureed beef instead of the pureed chicken that was circled on her meal card. She stated the resident didn ' t like bread and it should not have been served. RD #1 explained the resident ' s family would fill out the select menu for the resident. She added residents ' meals should be served according to the food preferences identified on their meal card. An interview on 3/14/19 at 4:50 pm with the Administrator revealed it was her expectation that resident ' s meal preferences were followed.	F 806	F806 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A tray accuracy evaluation will be completed by the Corporate Registered Dietitian or designee weekly x 4 weeks, twice-monthly x 4 weeks, and monthly X 1 to ensure compliance with corrective actions, food preparation and tray accuracy. Any deficient practice identified through the tray accuracy evaluation will result in reeducation or disciplinary action as indicated. All new hires will receive in-service education by Dietary Services Manager on proper procedures for food preparation and menu adequacy to honor food preferences. F806 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Findings from the tray accuracy evaluation will be reviewed at the Quarterly Quality Assurance meeting x2 for any further problem resolution if needed.	
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 approved or considered satisfactory by federal, state or local authorities.	F 812		4/11/19

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F 812	Continued From page 31 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard foods by the expiration date, allow dishware to air dry before being stored, remove chipped glass dishware from service and maintain clean hood filters. This was evident in 1 of 1 kitchen observation and 1 of 2 nourishment room observations. Findings Included: 1. An observation of the kitchen on 3/11/19 at 11:00 am with the kitchen supervisor and Registered Dietitian #1 (RD #1) revealed the following: a. The dry storage room contained 48 - 4-ounce (oz) containers of nectar thickened water with an expiration date of 1/8/19 and 23 - 4 oz containers of nectar thickened water with an expiration date of 2/26/19. b. 30 - 8 oz coffee mugs were stored wet on a solid tray near the tray line available for use for the lunch meal service. c. 5 - 5 oz glass bowls and 2 - 6" glass plates	F 812	1. F812 How corrective action will be accomplished for those residents found to have been affected: The facility staff failed to discard foods by the expiration date, allow dishware to air dry before being stored, remove chipped glass dishware from service and maintain clean hood filters. On 3/11/19, the 48 4oz containers of nectar thickened water with an expiration date of 1/18/19 and 23 4oz containers of nectar thickened water with an expiration date of 2/26/19 were found expired and not discarded in the dry storage room. On 3/11/19, 30 8 oz coffee mugs were stored wet on a solid tray line available for use for the lunch meal service. On 3/11/19, 5 5oz glass bowls and 2 6 glass plated were found chipped and stored for use during meal service. On 3/11/19, 6 hood filters found over cooking equipment were dirty with built up grease and dust. On 3/13/19, an open container of no sugar added med pass was found in the independence	

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F 812	Continued From page 32 with chipped, sharp edges were stored on a shelf available for use for the lunch meal service. d. 6 hood filters located above the cooking equipment were noted with a build-up of dust and grease. An interview on 3/11/19 at 11:30 am with RD #1 revealed the expired thickened water should have been used or discarded by the expiration date. She stated chipped dishware should have been discarded and not available for the staff to use. The RD added the coffee mugs should be air dried before being stored and the hood filters should be clean. 2. An observation on 3/13/19 at 12:00 pm of the independent hall nourishment room revealed an open container of no sugar added med pass supplement that was dated 3/5/19. An interview on 3/13/19 at 12:05 pm with Nurse #15 revealed the date on the container of med pass was the date it was opened. Nurse #15 stated she believed they could use the med pass for 3 days after the open date and then it needed to be discarded. She added she would need to verify that was correct. An interview on 3/13/19 at 12:15 pm with RD #1 revealed opened containers of med pass should be discarded by the third day after opening. An interview on 3/14/19 at 4:47 pm with the Administrator revealed it was her expectation the facility followed policies and procedures regarding kitchen sanitation and food storage.	F 812	nourishment room was expired dated 3/5/19. The containers of expired nectar and honey water were immediately discarded upon observation. The coffee mugs stored wet were immediately taken to the dish room and re-cleaned. The glass bowls and glass plates found chipped were immediately discarded. The hood filters found dirty were immediately taken down and cleaned. The med pass found expired in the independent hall nourishment room was immediately discarded. F812 How the facility will identify other residents having the potential to be affected by the same deficient practice: All Dining Services employees were in-serviced regarding proper procedures for discarding expired food, allowing dishware to air dry before being stored, removing and discarding all chipped glass dishware and maintaining clean hood filters. All Nursing staff were in-serviced on labeling and discarding all med pass products left in the nourishment room refrigerator. These were completed April 11th 2019. F812 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur A sanitation inspection will be conducted by Corporate Registered Dietician or designee weekly x 4 weeks, twice-monthly x 4 weeks, and monthly X 1 to ensure	

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F 812	Continued From page 33	F 812	compliance with corrective actions and sanitation standards. Any deficient practice identified through the sanitation inspections will result in reeducation or disciplinary action as indicated. All new hires will receive in-service education by Dietary Services Manager and Nursing Manager on proper procedures for storing, preparing and distributing food safely F812 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Findings from sanitation inspections will be reviewed at the Quarterly Quality Assurance meeting x2 for any further problem resolution if needed.	