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	345537	A. BUILDING _____ B. WING _____	C 08/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-WILMINGTON, INC	2305 SILVER STREAM LANE WILMINGTON, NC 28401

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E 000	Initial Comments An unannounced Recertification/Complaint investigation survey was conducted on 08/05/19 through 08/08/19. The facility was found in compliance with the requirment CFR 483.73, Emergency Preparedness. Event ID # FG5111.	E 000		
F 000	INITIAL COMMENTS A recertification/complaint investigation survey was conducted in the facility from 08/05/19 through 08/09/19. Event ID #FG5111. 1 of 5 complaint allegations was substantiteated with deficiency (F624).	F 000		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on home health interview, apartment manager interview, Department of Social Services social worker interview, facility staff interview, and record review the facility failed to complete a safe discharge for 1 of 1 sampled residents (Resident #178) reviewed for the discharge process. Findings included: A 05/15/19 hospital Discharge Summary documented Resident #178 was hospitalized from 04/17/19 until 05/15/19 after reports of back pain, chest pain, nausea, and generalized	F 624	F624: PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHARGE: A Facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. A. In relation to Resident # 178, and the Allegation of an Unsafe Discharge; To prevent this issue from happening in the	8/22/19

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

Electronically Signed | 08/22/2019

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 624	Continued From page 1 weakness. Her primary discharge diagnosis was generalized weakness most likely due to "anemia, atrial fibrillation (irregular heart beat), generalized deconditioned state and advanced age resulting in physical deconditioning." The summary documented, "Patient also reported bedbugs. EMS (emergency medical services) reports significant disheveled apartment and multiple pill bottles form multiple providers in her home." Record review reveal Resident #178 was admitted to the facility on 05/15/19. The resident's documented diagnoses included atrial fibrillation, obesity, anxiety disorder, depression, difficulty walking, gout, and chronic obstructive pulmonary disease. In a 05/17/19 progress note Social Worker (SW) #1 documented, "48-hour care conference-Team met with resident to review insurance, goals, and discharge plans. Here for short-term rehab. Resident hopes to discharge home when able. SW will continue to monitor and assist as needed." On 05/21/19 "Resident is to be discharged from the facility" was identified as problem in the resident's care plan. Interventions put in place to address the problem included arranging follow-up with the resident's physician, considering the resident's and family's preferences for care, defining roles and expectations with the resident and support person, ensuring access to services, exploring alternative care options with resident and family, discussing benefits and options to placement setting, obtaining needed equipment and supplies, planning for specific resident needs/continuing care after discharge, providing education, and providing written instructions for	F 624	future: We have a Discharge Plan outline in place that will be followed when patient is discharging from the facility. This form when completed has detailed information, to make sure the patient will have a safe discharge from the facility. B. To be assured deficient practice will not occur again: 1. Every resident who is scheduled for discharge, we will have a discharge meeting the week of discharge which includes the IDT Team consisting of Nursing, Social Worker, Therapy, Dietary and our Wound Care Nurse to review the discharge outline & look for any areas of concern. We will have a discussion with the resident and responsible party to see if our concerns can be alleviated before discharge. 2. Any resident for whom it is felt there is a question about safe discharge, we will contact Adult Protective Services for follow up. 3. All residents who have been discharged from February 1, 2019 through July 30, 2019 was completed to be assured that all discharges were appropriate. There were no residents found that we felt had an unsafe discharge. Who completed and when was this done? 4. The Nurse Liaison and/or the Social Workers will do a follow up call within the patient□s first 72 hours after discharge to make sure everything is going well for the resident and if there is a need for further assistance...We also do a follow up 3	

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F 624	Continued From page 2 care and resources to use in case of emergency. The resident's 05/22/19 admission minimum data set (MD'S) documented her cognition was intact, she reported being depressed and tired, she exhibited no behaviors including resistance to care, she required limited assistance by a staff member with bed mobility/ transfers/dressing/hygiene, she required extensive assistance by a staff member with bathing, she required set-up assistance and supervision with toileting, she was independent with locomotion on the unit, she was independent with walking in a room after set-up assistance. she required set-up assistance and supervision with walking in a corridor and eating, and she was independent with locomotion off the unit after set-up assistance, her balance during transitions and walking was not steady but she was able to stabilize without staff assistance, she had no functional limitation to her upper and lower body range of motion, she used a wheelchair as a mobility device, the resident and the staff believed she was capable of increased independence in her activities of daily living (ADLs), she was occasionally incontinent of bladder and frequently incontinent of bowel, she was 67 inches tall and weighed 240 pounds, the resident participated in this assessment, the resident had no guardian or legally authorized representative, and it was expected that the resident would be discharged back to the community. SW #1 completed an Observation Detail List Report for Resident #178 on 05/24/19. The report documented the resident's expectation was to be discharged to the community, and active discharge planning had already been initiated in order for the resident to return to the community.	F 624	week call to check on the patient. 5. Inservice education about our discharge policy and follow up was completed with the IDT Team consisting of: Social Workers, Nurse Management, Unit Managers, Therapy on 8/13/2019. This was completed by the Administrator. 6. Monitoring of the discharge procedure will be completed by the Administrator and results taken to QAPI monthly meeting for review for 3 consecutive months to be assured of continued compliance. The Social Workers will bring the audit of how many residents were discharged and checking the discharge form to be sure every area was completed. They will check 10% of the discharges for 3 months. They will bring the results to the Administrator. The Administrator will present results to QAPI monthly for 3 months. This Facility alleges compliance of F692 by 8/21/2019. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal & State Law.	

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F 624	Continued From page 3	F 624		

During an interview with SW #1 on 08/07/19 at 12:03 PM she stated Resident #178 reported her expectation was to be discharged home when she was admitted into the facility, but the SW reported as the resident's stay in the facility continued the resident began to fluctuate between wanting to go home and wanting to stay in the nursing home because she enjoyed the socialization which the nursing home provided. However, the SW commented Resident #178 had insurance which would end when the insurance company felt the resident had made sufficient progress in therapy to warrant a better quality of life. According to SW #1, she could refer residents to sources that could help them complete the Medicaid application process, but the nursing home did not provide help with the application process itself.

During a follow-up interview with SW #1 on 08/07/19 at 2:12 PM she stated about two weeks into her nursing home stay Resident #178 began to express concerns about returning to her apartment because of bed bug infestation. The SW reported she made multiple attempts to reach the resident's apartment manager, but was unsuccessful. She also reported she did not complete a home visit to assess Resident #178's home environment.

A 05/30/2019 progress note documented SW #1 met with Resident #178, and "Resident expressed depression and anxiety related to discharge to her apartment."

SW #1 provided copies of texting between herself and a home health coordinator which took place on 05/31/19 in which SW #1 documented she

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F 624	Continued From page 4	F 624		

had a discharge on 06/03/19 which was "a little complex". The SW texted Resident #178 was "not happy" about going back to her apartment since it apparently had bed bug infestation. The home health coordinator replied she would have to have proof of extermination if the resident was returning to the same apartment unless the bed bug allegation was just hearsay. The SW indicated she had been unable to make contact with Resident #178's property manager.

During an interview with the Rehabilitation Manager (RM) on 08/07/19 at 12:14 PM she stated Resident #178 completed two weeks of speech therapy, and was in the process of completing occupational and physical therapy when her insurance company terminated the resident's therapy services. She said Resident #178 was not clinically appropriate for a home evaluation prior to facility discharge. She explained that therapy completed home assessments if residents or their family members requested them, the resident had cognitive issues with no legal representative, or the resident had safety or balance risks. She also commented the two therapists that had the most involvement with Resident #178 were on medical leave.

During an interview with Speech Therapist (ST) #1 on 08/07/19 at 12:21 PM she stated Resident #178 received therapy services from 05/16/19 through 05/29/19. She reported when services began she administered the Montreal Cognitive Test, version 7.2 to Resident #178 who scored 25 out of 30 with 26 - 30 being normal. She reported Resident #178 met all her goals, and upon completion of services she administered the Montreal Cognitive Test, version 7.1 to Resident #178 who scored 26 which was within normal

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F 624	Continued From page 5	F 624		

limits. Resident #178's 05/29/19 Speech Therapy Discharge Summary documented the resident was independent in problem solving, memory, auditory comprehension, verbal expression, and motor speech. This summary documented Resident #178's discharge location as assisted living, and ST #1 stated the resident requested a discharge to assisted living which she passed on the occupational and physical therapy.

During an interview with Physical Therapist (PT) #1 on 08/17/19 at 12:30 PM he stated he worked as needed (prn) and had only worked with Resident #178 three or four times. He reported the resident received physical therapy services from 05/16/19 through 06/02/19. He commented he was not involved in the resident's discharge, but the 06/02/19 Physical Therapy Discharge Summary documented, "Patient has made steady progress toward PT goals. Pain and swelling in her left ankle that had been causing pain and limiting activity tolerance/participation....Patient reports she may return to her apartment briefly but plan to go to ___ or ___ (names of community organizations) for assistance in housing placement....Patient scheduled for discharge from facility tomorrow, 06/03/19. Patient has personal rollator walker. Review of the resident's functional outcomes, documented in the Discharge Summary, revealed she was now independent with bed mobility, had modified independence with transfers, required supervision with ambulating level and uneven surfaces, and required supervision with stairs. PT #1 clarified Resident #178 was walking supervised 350 feet using a rollator walker, experiencing mild to moderate exertion.

A 06/01/19 Occupation Therapy Discharge

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F 624	Continued From page 6	F 624		

Summary documented Resident #178 received occupational therapy services from 05/16/19 through 06/01/19, and documented "Patient discharged to home w (with)/ support from others." Review of functional outcomes documented at discharge Resident #178 required set-up assistance with self-feeding/hygiene/grooming/upper body dressing, and required supervision with bathing/toileting/lower body dressing. The summary documented the resident received training in techniques to increase ADL safety in standing, reaching/bending, energy conservation, hygiene/grooming, and toileting/clothing management. The summary also documented the resident received therapeutic exercises and activities to improve her dynamic balance and strength.

During a 08/07/19 4:18 PM interview with Nurse #1, who cared for Resident #178, she stated Resident #178 was doing much better before discharge, and the resident's gout was under control using Prednisone and Allopurinol. She reported at first the resident wanted to go home, but as her stay continued she became apprehensive about bed bugs that were in her apartment. She commented the resident expressed the resident then decided she liked the nursing home so well that she wanted to stay. However, Nurse #1 reported she had heard the resident was told that this was not going to be possible financially. Then the nurse stated the resident was trying to weigh out whether it would be better to go home or to a shelter. According to Nurse #1, the last she heard from Resident #178 was that she had decided on the shelter because she had stayed their previously and was treated well and there was less risk of pest infestation

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F 624	Continued From page 7	F 624		

there.

During an interview with the Administrator on 08/07/19 at 1:56 PM she stated Resident #178 entered the nursing home stating she wanted to return home, but during the last week of her stay she began to experience some hesitation, mentioning her concerns about bed bugs in her apartment. She reported the resident had made great progress through therapy, was able to function on her own, and no longer had skilled needs. She stated the day before the resident's discharge she went and talked with the resident because she heard Resident #178 wanted to go to a shelter. According to the Administrator, she told Resident #178 that the nursing home did not usually discharge residents to a shelter, and encouraged the resident to return to her apartment where management would be obligated to provide sufficient pest control. The Administrator reported the resident changed her mind, and decided that she would go back to her apartment after all.

SW #1 completed a discharge Observation Detail List Report for Resident #178 on 06/03/19. The report documented Resident #178 was independent with dressing/grooming, transfers, and ambulation/mobility.

A 06/03/19 10:11 Discharge Summary Note documented, "...She (Resident #178) is due to be discharged to home today. She will have Home Health Care through ___ (name of agency) and will have SN/PT/OT/ ST (skilled nursing, physical therapy, occupational therapy, speech therapy) and an aide. She will be given all the medication that is left in her med cart and has a (follow-up appointment) with her primary physician on

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F 624	Continued From page 8	F 624		

06/12/19..."

A 06/03/19 3:41 PM progress note documented, "Medications reviewed and sent with resident including tramadol. expressed understanding regarding her medications. Discharge plan of care also given to resident."

During a 08/08/19 12:14 PM phone interview with Resident #178's apartment manager she stated a pest control company had confirmed that there were bed bugs in the resident's apartment, but the resident never responded to pre-treatment notices that she needed to clean up her apartment before it could be treated for bed bugs. The manager reported the complex was unsure of the resident's whereabouts. The apartment manager stated Resident #178 showed up alone at the complex on 06/03/19. She reported there was an eviction notice on the resident's door because of delinquent payment of rent. She commented the resident reported she had money orders to pay the rent, but the apartment manager told her that she would have to clean her apartment before it could be treated for bed bugs. According to the manager, Resident #178 reported she could not clean her apartment alone, and asked for assistance. The manager commented she had to inform the resident that it was not the responsibility of the complex to provide cleaning assistance. According to the apartment manager, Resident #178 left the apartment complex, but she was unsure where she went.

During a 08/08/19 12:18 PM phone interview with the county coordinator of services for the home health agency that was contacted about providing services for Resident #178, she stated the

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F 624	Continued From page 9 agency could not accept the nursing home's referral for home health services because the nursing home never provided proof that the resident's apartment had been effectively treated for bed bugs. During a 08/07/19 12:30 PM interview with SW #2, who worked for the Department of Social Services, she stated Social Services received a call from a motel manager who reported Resident #178 had been living in his motel for about a week, and he had concerns about her safety because she was struggling to walk even with the aide of a walker. SW #2 commented Social Services helped Resident #178 with housing, and the resident was currently residing in an assisted living facility. During a 08/08/19 3:20 PM interview with the Administrator she stated she felt that Resident #178's discharge was a safe one because the resident was alert and oriented and could make her own decisions, and was cognitively and physically independent.	F 624		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte	F 692		8/22/19

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F 692	Continued From page 10 balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to follow physician approved recommendations from the Registered Dietician (RD) for 2 of 6 residents observed for nutrition. Resident #74 was admitted to the facility on 06/08/19 with diagnoses that included end stage renal disease, dependence on renal dialysis, and moderate protein-calorie malnutrition. Physician orders for August 2019 revealed Resident #74 was on a renal diet. No orders for protein replacement supplements were noted in the physician orders. A dietary care plan for Resident #74 dated 06/25/19 included an approach to provide and serve supplements as indicated. A quarterly Minimum Data Set (MDS) assessment dated 07/29/19 revealed Resident #74 had severely impaired cognition. He was on a therapeutic diet and required limited assistance for eating. Hepatic function panel laboratory test results dated 07/05/19 revealed Resident #74 had low	F 692	F692 NUTRITION/HYDRATION STATUS MAINTENANCE: Assisted nutrition & hydration. (Includes nasogastric & gastrostomy Tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy and internal fluids) Based on resident□s comprehensive assessment, the facility must ensure that a resident: Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range & electrolyte balance, unless the resident□s clinical condition demonstrates that this is not possible or resident preferences indicates otherwise. A. Patient # 74 had a nutritional recommendation made by the Registered Dietitian on this patient that had not been processed. The recommendation for Protein replacement was implemented. The patient now has this recommendation carried out as an order. There were no negative effects to the patient. B. Patient # 58 had a recommendation to be weighed because of gradual weight	

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F 692	Continued From page 11 albumin (3.4) and low total protien (5.3) results. A progress note written by the RD on 07/08/19 at 3:38 PM read: "Edentulous resident with good intake of CCD, renal, regular texture diet, due to increased needs associated with dialysis will suggest use of prostat 30ml q day to provide an additional 15g of protein to his diet, will also suggest large protein portions with meals, will continue to monitor." Review of a facility Medical Nutritional Therapy Recommendation form dated 7/8/18 read, "(Resident #74)/provide prostat 30ml q day, start large protein portions". This recommendation was signed by the facility Nurse Practitioner (NP). In an interview with the Administrator on 08/07/19 at 10:30 AM she acknowledged the physician approved dietary recommendations for Resident #74 had not been processed. She had investigated the process that morning and discovered the RD had been laying the Medical Nutritional Therapy Recommendations forms on the desk at the nurse's station and not communicating with nursing in any other way that there were new dietary orders therefore the orders were not being carried out. She developed a plan the morning of 08/07/19 to correct the process which identified a need to change the process of capturing deitary recommendations. In an interview on 08/07/19 at 2:45 PM with the facility NP he explained dietary recommendations were presented to him by the RD. He stated if he agreed with the recommendation he initialed the form, otherwise he put a line through the recommendation to reject it. He gave the form	F 692	loss. The RD recommended the patient be weighed and this was completed w/surveyor present. There were no negative effects to the patient. Every Resident in the facility that we found may have a weight variance was reweighed. This was completed 8/9/2019. C. Every Recommendation that the RD made back to February 1, was reviewed to make sure the recommendation had been implemented if the Doctor or Nurse Practitioner approved. D. This issue identified the need for changing the process of capturing Dietary Recommendations: A. RD will give her recommendations to Nurse Practitioner or the physician on premises. If the Provider accepts the recommendations, the Provider will place an order into Matrix. RD will then place her recommendation into a notebook at each nurse□s station for follow up & monitoring by RD and Nursing. B. Discussion of RD recommendations will be made during the IDT weekly meeting. Weekly audits of the week□s recommendations are carried out at that meeting by the DON. The RD will be responsible for follow up of their recommendations and Nursing Management will do ongoing weekly Monitoring of the Registered Dietitian□s recommendations that are placed at each nurse□s station in a binder to be assured of her recommendations being carried out. It will be noted on the recommendation sheet that the Unit Manager has made sure the recommendation was followed	

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F 692	Continued From page 12 back to the RD to process the recommendations. He commented that once he approved a recommendation with his initials it became an order and was to be entered into the system. He said from now on if he signed off a dietay recommendation he was going to go ahead and put the order into the system himself to make sure it got done. In an interview with Nurse #5 on 08/07/19 at 3:25 PM he stated dietary recommendations initialed by the NP or physician were absolutely considered to be an order and entered into the computer system when received by nursing. In an interview with Nurse #6, RN Supervisior, on 08/07/19 at 3:29 PM she stated dietary recommendations signed by the NP or physician were considered by nursing to be an order and entered into the system as written on the Medical Nutritional Therapy Recommendations form. In an interview with the facility RD on 08/08/19 at 12:20 PM she commented she visited the facility three times a week. She normally attended meetings, monitored resident weights, reviewed wound care needs, reviewed charts for new admissions and residents who received tube feedings. She made recommendations, presented the recommendations to the physician or NP, and on approval forwarded the recommendations to nursing to process. She commented if a recommendation was not considered a medication she could put the order into the system herself. This included such things as house shakes, adjustments to tube feedings and diet changes. She stated she typically handed the approved recommendations to the administrative nurse, the charge nurse, the	F 692	and so noted in the chart. The Staff Development Coordinator completed the education for all the nurses/nurse managers. This was completed on 8/20/2019. The audits will be completed monthly and presented to QAPI monthly for 3 months for review and approval. The above measures outlined will be taken to QAPI Committee every month which will evaluate the effectiveness of the systems by monitoring the corrective action for 3 consecutive months for compliance. This facility alleges compliance of F692 on 8/22/2019. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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F 692	Continued From page 13	F 692		

Director of Nursing or the Staff Development nurse after making a copy for herself. She stated if a nurse was not available she would slip the recommendation under a nurse's door or lay it on the keyboard at the nurses station for a staff nurse to find. She concluded she did not go back and reveiw orders to ensure orders had been processed.

The findings included:

#2. Resident #58 was admitted to the facility on 07/21/17 with a cumulative diagnoses including: diabetes (DM), nausea, cerebral infarction, hypertension (HTN), coronary artery bypass grafting (CABG), anemia, dysphagia, gastro esophageal reflux disease (GERD), and pain.

Review of weight records revealed the last weight obtained for Resident #58 was on 05/08/19 at 116.7 lbs.

Review of the most recent Minimum Data Set (MDS) dated 07/05/19 revealed Resident #58 had no cognitive impairments.

Review of the most recent care plan goals for Resident #58 revealed: resident had potential/actual nutritional impairment related to DM, dysphagia, with recent gradual weight loss.

Annual nutritional assessment dated 07/05/19 at 1:41 PM revealed Resident #58 on pureed diet, had good appetite with 50-75% of meals eaten, fed self, with a 5% weight loss.

Review of a dietary note dated 07/05/19 at 1:51 PM revealed Resident #58 presented with gradual weight loss based on weights of: 116.7

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F 692	Continued From page 14	F 692		

lbs. on (05/08/19), 121.1 lbs. on (04/17/19), and 127.5 lbs. on (02/15/19). Registered Dietitian (RD) suggested obtaining a current weight.

Review of a Medical Nutritional Therapy Recommendation dated 07/05/19 revealed to obtain a current weight for Resident #58, which was signed off by the Nurse Practitioner (NP).

An interview was conducted on 08/06/19 at 3:10 PM. The Registered Dietitian (RD) revealed she expected her recommendation for a current weight for Resident #58 to have been reviewed and signed off by the NP, entered into the facility's computer as an order, to be done within a week, and wasn't.

An interview was conducted on 08/06/19 at 3:47 PM. Nursing Aide (NA #6) revealed the weight assignments were put in by nurses, for her to do an immediate, daily, weekly, or monthly weights. NA #6 said she had not done a July/2019 weight for Resident #58, and nothing was in the electronic system, on paper, telling her that Resident #58 needed to have a current weight done.

An interview was conducted on 08/06/19 at 3:56 PM. NA #7 revealed a nurse would tell him if a resident needed a special weight. NA #7 said he never was asked to do a special weight on Resident #58, and that he had never done a July/2019 weight on her.

An interview was conducted with the Dietary Manager (DM) on 08/06/19 at 4:15 PM. The DM reviewed the Medical Nutritional Therapy Recommendations Form dated 07/05/19 for Resident #58 and confirmed the RD had an order

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F 692	Continued From page 15	F 692		

to obtain a current weight, which was signed off by the Nurse Practitioner (NP). The DM reported when she had an order for dietary, the RD or Nursing Unit Manager would put the order in the computer system. The DM said once the current weight order for Resident #58 was placed in the computer the nursing staff would know to obtain a current weight. The DM reviewed the computer system and found there to be no order for a current weight for Resident #58 dated 07/05/19. The DM was not sure why the order was not entered into the computer by either the RD or the Nursing Unit Manager. DM said, she would expect Resident #58's weight to have been obtained within a week of the RD's recommendation dated 07/05/19, and it wasn't.

An interview was conducted on 08/06/19 at 4:20 PM. The Director of Nursing (DON) revealed it was her expectation that the physician order was followed and that a current weight was obtained and recorded by the physician.

An interview conducted with Nurse #7 on 08/06/19 at 4:30 PM. Nurse #7 revealed it was her expectation that the RD's 07/05/19 recommended weight for Resident #58 to have been done within a week, and wasn't.

A weight of 114.5 lbs. for Resident #58 was observed on 08/06/19 at 5:06 PM with NA #6.

An interview conducted with Nurse #5 on 08/07/19 at 3:30 PM. Nurse #5 revealed process for obtain a current weight for Resident #58 would be for the RD to fill out the Nutritional Recommendation form, have it reviewed and signed-off by either by the MD or NP, and then it would be given to the nursing unit manager to

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F 692	Continued From page 16 enter into the computer as an order. Nurse #5 was not sure why the order was not entered into the computer by the Nursing Unit Manager. An interview conducted with Nurse #6, Unit Manager on 08/07/19 at 3:35 PM. Nurse #6 revealed she recognized the Nutritional Recommendation Form dated 07/05/19 for Resident #58. Nurse #6 said the facility's process of filling out the form, was for the RD to fill out the form, then the form would be given to the NP or MD to review the recommendations and sign off on them. The Unit Manager said the RD wrote the 07/05/19 recommendation, and the NP signed off on the recommendation. Nurse #6 was not sure why the order was not entered into the computer by her or the other Nursing Unit Manager.	F 692		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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	F 812		8/22/19

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F 812	Continued From page 17 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain a cold salad prepared with ranch dressing at 41 degrees Fahrenheit or below during the operation of the trayline. Findings included: At 5:34 PM on 08/07/19 a calibrated thermometer was used to check the temperature of a large tray pan of cucumber salad made with ranch dressing. The thermometer registered 52 to 50 degrees Fahrenheit, depending on where the thermometer was placed in the tray pan of salad. More than half of the ice, filling the steam table well under the tray pan of cucumber salad, had melted. At this time PM Cook #1 stated this salad contained cucumbers, onions, and bottled ranch dressing. She reported the salad was assembled the day before it was served, and was stored in a tray pan in the reach-in refrigerator. The cook also commented the trayline started operation at 5:00 PM, and two more carts were left to be filled with meal trays. During an interview with the Dietary Manager (DM) on 08/08/19 at 1:57 PM she stated her dietary staff was trained to prepare cold salads the day before they were served, to use chilled ingredients, to keep the salads in refrigerated storage after they were assembled, remove the chilled salads just before the trayline began operation, to remove from refrigerated storage in small batches, and to keep the small batches over steam table wells which were turned off and filled with ice. The DM reported the cucumber salad registered 35 degrees Fahrenheit when a	F 812	F812 FOOD PROCUREMENT, STORE/PREPARE/SERVE-SANITARY A facility must Store, prepare, distribute and serve food in accordance with professional standards for food in accordance with professional standards for food service safety. In relation to F812 and the cucumber salad was not at the appropriate temperature at the end of tray service for dinner. The salad should be at 41 degrees Fahrenheit or below. Cold foods will be prepared the night prior to serving. Chilled ingredients will be used for preparation and the food will be placed in refrigerated storage immediately after preparation. The chilled salads will be removed immediately prior to serving and will be placed in small batches over steam table wells which are turned off and filled with ice. To be assured this deficient practice does not happen again: All Dietary Staff have been educated on proper preparing, storage, serving and proper temperature of cold and hot foods. This education was completed on 8/9/2019 Dietary Manager. The Dietary Manager will do a daily temperature check of food being served. (Monday through Friday) This will continue for 4 weeks, then a weekly temperature check of food monthly for 3 months. Monitoring of the food temperature will be	

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F 812	Continued From page 18 calibrated thermometer was used to check the temperature right before the trayline began operation. She commented she thought because of poor air circulation in the kitchen the cucumber salad became warmer as the trayline operation progressed. According to the DM, there was a potential of making residents sick if cold salads could not be kept at or below 41 degrees Fahrenheit. During an interview with PM Cook #1 on 08/08/19 at 2:05 PM she stated the cucumber salad which was served on 08/07/19 had been assembled and placed into the reach-in refrigerator on 08/06/19. She reported the salad should have been removed from refrigeration in small batches. She commented she liked to get a temperature on cold salads as the trayline began operation and about mid-way through so she could make sure the salad temperatures remained no higher than 40 degrees Fahrenheit. PM Cook #1 stated the large pan of cucumber salad which was checked for temperature on 08/07/19 was the only pan of the cucumber salad that had been removed from refrigerated storage that day, and she thought because it had been on the trayline for a good while it had become too warm even though it was being kept over ice. She reported that cold salads which were kept above 40 degrees Fahrenheit had a greater chance of spoiling.	F 812	completed by the Dietary Manager and results taken to our Monthly QAPI meeting which will evaluate the effectiveness of the systems by monitoring the corrective action for 3 consecutive months for compliance. This facility alleges compliance of F812 by 8/21/2019. “Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal & State Law.	