STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345096	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE OAKS	12019 VERHOEFF DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification and complaint survey was conducted 09/22/19 through 09/27/19. The facility was found to be in complinace with CFR 483.73, Emergency Preparedness. Event ID HXZZ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted 09/22/19 through 09/27/19. A total of 56 allegations were investigated with 27 allegations substantiated. Event ID: HXZZ11.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to	F 561		10/25/19

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

Electronically Signed | 10/21/2019

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F 561	Continued From page 1 participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to honor a resident wish to be out of bed by 10:30 AM for 1 of 3 resident reviewed for choices (Resident #125). The Findings included: Resident #125 was admitted to the facility on 04/18/18 with diagnoses that included embolic stroke, hemiparesis, diabetes, depression, and osteoarthritis. Review of the quarterly Minimum Data Set (MDS) dated 06/10/19 revealed that Resident #125 was cognitively intact and required extensive to total assistance with activities of daily living including transfers. An observation and interview were conducted with Resident #125 on 09/23/19 at 11:49 AM. There was a sign on the wall behind the bed that read, plan of care: Resident #125 wants to be up no later than 10:30 AM. Resident #125 stated that this morning it was after 11:00 AM when the staff got her out of bed. She stated that the staff were aware of her wish to be up by 10:30 AM but a lot of times that did not happen because they did not have enough staff to help. An observation and interview were conducted with Resident #125 on 09/24/19 at 11:00 AM. Resident #125 was sitting in a shower chair in her	F 561	DISCLAIMER: 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 and State law. The following Plan of Correction is Date Certain for 10/25/2019 F561 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #125 was interviewed on 10/2/19 by the Social Worker to review resident□s time preference to get up in time for morning activities. Resident□s preferences were updated in the resident□s plan of care. "¿Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Nursing and Social Services will conduct	

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F 561	Continued From page 2 room and had just finished her shower. She stated that the staff just got her up about 10 minutes ago and gave her a shower. Nurse Aide (NA) #1 and Nurse #2 were observed to transfer Resident #125 from the shower chair to her bed to dry her off and then get her up for the day to her wheelchair. An observation of Resident #125 was made on 09/25/19 at 11:15 AM. Resident #125 remained in bed at this time and was alert and verbal. She stated she was waiting on the staff to come and get her washed and dressed and then put her in her wheelchair for the day. An observation and interview were conducted with Nurse Aide (NA) #1 on 09/25/19 at 11:19 AM. NA #1 entered Resident #125's room and apologized for not coming to her room sooner and stated she had been busy. NA #1 confirmed that this was the first time she had been able to provide any care to Resident #125 that day because there was no staff on the other unit, and she had to go and assist with serving breakfast and then assist residents that needed help with eating. She added that she had just returned to her unit and was just getting started on providing care to her residents. NA #1 proceeded to wash Resident #125 and provide incontinent care and get her dressed. NA #1 stated that once she was dressed, she would get some help to transfer her to her wheelchair. NA #1 stated that she was aware that Resident #125 preffered to be out of bed by 10:30 AM but stated this morning she had to assist the residents on the other unit with breakfast because there was no staff to do so. NA #1 added that the previous Administrator had placed the care plan on the wall behind Resident #125's bed but stated sometimes she was not	F 561	resident interviews and will update preferences and establish updated resident care plan and resident profile to reflect preferences "¿Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Facility Educator to inservice nurses and nurse aides on utilizing Electronic Medical Record (EMR) for information regarding resident□s preferences. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. "¿ Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility. To ensure compliance with honoring resident□s out of bed preferences, Social Workers or designee will conduct 5 resident interviews weekly. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI	

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F 561	Continued From page 3 able to do that because there was not enough help. An interview was conducted with Nurse #1 on 09/26/19 at 10:10 AM. Nurse #1 confirmed that she was caring for and was familiar with Resident #125. She stated that she was aware Resident #125 preferred to be out of by 10:30 AM and they staff tried but with the lack of staff on the unit that did not always happen. She stated that a lot of time there was only 1 NA on the unit and that left the nurse to assist with the mechanical lift transfers and pass medications. A lot of times she was not out of bed by 10:30 AM because it was just not possible due to the lack of available staff. Nurse #1 stated that if Resident #125 wanted to be out of bed by 10:30 AM than the staff was expected to honor her choice. An interview was conducted with the Director of Nursing (DON) on 09/26/19 at 4:28 PM. The DON stated that she expected the staff to get Resident #125 out of by 10:30 AM per her choice and if they were not able to do so that they communicate that to her. She added however that should not be on a daily basis but on rare occasion when they were not able to get her up like she preferred. The DON stated she has told the staff numerous times that if things got busy and they got behind to communicate that to her, and she would do whatever they needed.	F 561	monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		10/25/19

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F 578	Continued From page 4 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Medical Doctor interview the facility failed to have an	F 578	DISCLAIMER: Preparation and/or execution of this Plan	

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F 578	Continued From page 5 advance directive available and in the medical record for 1 of 1 resident reviewed for advance directives (Resident #129). The findings included: Resident #129 was admitted to the facility on 07/10/19 with diagnoses that included atrial fibrillation, chest pain, coronary artery disease, diabetes, dyspnea, and others. Review of a physician order dated 07/10/19 read, Do Not Resuscitate (DNR). Review of the quarterly Minimum Data Set (MDS) dated 09/04/19 revealed that Resident #129 was moderately impaired for daily decision making and required extensive assistance with activities of daily living. Review of Resident #129's medical record including the electronic record and the hard chart record on 09/23/19 and again on 09/26/19 revealed no advance directives that indicated if Resident #129 was a full code or a DNR. An interview was conducted with the Interim Administrator on 09/25/19 at 4:44 PM. The Interim Administrator stated that "the ball got dropped" and no DNR had been issued for Resident #129. He added if something happened the nurse would pull up the record and verify the code status. An interview was conducted with the Social Worker (SW) on 09/25/19 at 5:11 PM. The SW stated she had been at the facility for 8 weeks and she had not had to deal with the advance directives. She stated that the Medical Director	F 578	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 and State law. The following Plan of Correction is Date Certain for 10/25/2019 F 578 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #129 was readmitted to the facility on 10/10/19. The MOST (Medical Orders for Scope of Treatment) form was completed on 10/10/19 with Resident Representative. Resident□s Cardiopulmonary Resuscitation (CPR) was defined as Do Not Resuscitation (DNR) and a Goldenrod was in place and located in the resident□s medical record. "¿Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Social Workers to conduct 100% audit of code status, verifying in Electronic Medical Record (EMR) resident□s code status and validating corresponding Advance Directives documentation.	

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F 578	Continued From page 6 (MD) usually went over the advance directives with the resident and/or families when she visited them for the first time and then they were scanned into the electronic medical record. An interview was conducted with Nurse #1 on 09/26/19 at 10:30 AM. Nurse #1 stated that she admitted Resident #129 to the facility on 07/10/19. She stated that had spoken to the family that was with him when he admitted, and they verified that Resident #129 was a DNR. She stated that the MD would have completed the DNR form when she visited with Resident #129 for the first time. An interview was conducted with the Medical Doctor on 09/26/19 at 11:20 AM. The Medical Doctor stated that she rarely visited the facility and stated that she was covering for the Medical Director on 07/10/19 when Resident #129 was admitted to the facility. The Medical Doctor stated she had verbally discussed with the family and resident his code status and it was decided that he would remain a DNR. She added that she did not complete the advance directive DNR form because she thought the SW handled those things. She added that she was really only covering that day and was not familiar with the facility practices and believed the SW would take care of the advance director DNR form. An interview was conducted with the Director of Nursing (DON) on 09/26/19 at 4:24 PM. The DON stated that the Medical Director completed the Advance Directives when she would visit with the resident for the first time after admission. She stated that she was unaware that Resident #129 did not have any advance directives in his either his electronic medical record or his hard chart	F 578	"¿Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; A process was developed and put in place for nurses to determine Advance Directives, utilizing the MOST form, on admission. If a physician is not in the facility, nurses would obtain a verbal order. Facility Educator provided inservices to nurses on the new process Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. "¿ Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility. Medical Records Coordinator to review 100% of new admission and readmissions resident□s EMR for code status and validate corresponding Advance Directives documentation. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which	

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F 578	Continued From page 7 record. The DON stated she expected that every resident would have an advance directive in their medical record.	F 578	time frequency of monitoring will be determined by the QAPI Committee.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph	F 580		10/25/19

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F 580	Continued From page 8 (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, Responsible Party, and staff interviews the facility failed to notify the Responsible Party of a new physician order for eye drop medications for 1 of 3 residents reviewed for notification of changes (Resident #24). Findings included: Resident #24 was admitted to the facility on 02/24/17 with diagnoses which included glaucoma and Alzheimer's disease. A review of the quarterly Minimum Data Set (MDS) dated 07/02/19 assessed Resident #24 as being moderately impaired cognitively and required total to extensive assistance with activities of daily living. Review of physician orders revealed latanoprost (a medication used to treat glaucoma) 0.005% ophthalmic solution 1 drop each eye at bedtime	F 580	DISCLAIMER: 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 and State law. The following Plan of Correction is Date Certain for 10/25/2019 F 580 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #24□s Resident Representative	

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F 580	Continued From page 9 started 10/11/17. Dorzolamide (a medication used to treat glaucoma) 2% ophthalmic solution each eye twice a day started 04/30/18. Brigandine (a medication used to treat glaucoma) ophthalmic 0.2% solution each eye twice a day written on 06/24/19 for the diagnoses of glaucoma. The last physician order was reviewed on 06/24/19 by Nurse #9. During an interview on 09/25/19 at 5:29 PM the Responsible Party (RP) explained she was aware 2 different eye drops were administered to Resident #24 for glaucoma. The RP noted the nurse had a new eye drop to administer and wanted to know why she was not notified. The RP revealed she was not notified and wanted to know why the physician added a third eye drop to Resident #24's medication regimen. She was concerned the glaucoma had worsened for Resident #24. A phone interview was conducted on 09/27/19 at 10:13 AM with Nurse #9 who explained she was to notify the RP of new physician orders. Nurse #9 did not recall if she had notified the RP of the new physician order for eye drops for Resident #24. During an interview on 09/27/19 at 11:09 AM the Director of Nursing revealed it was her expectation the RP and/or family members were notified of any changes to their care which included new physician orders.	F 580	was notified by Director of Nursing on 10/16/19 of eye drop medication dated 6/24/19 ordered by physician. "¿Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Director of Nursing will review new orders for all residents for the period of 10/7/19 through 10/14/19, to ensure family notification of medication changes. "¿Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; By 10/25/19, Facility Educator will provide inservices to nurses on the new Electronic Medical Record (EMR) field to document Resident Representative notification prior to new medication administration. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. "¿ Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility.	

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F 580	Continued From page 10	F 580	Beginning 10/21/19, the Director of Nursing or designee will review 10 new orders weekly, for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. "¿Include dates when corrective action will be completed. The corrective action dates must be acceptable to the State. 10/25/19	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code a Minimum Data Set Assessment (MDS) for the use of antipsychotic medications for 1 of 5 residents reviewed for the use of unnecessary medications (Resident #78) The Findings Included: Resident #78 was admitted to the facility on 08/20/26 with diagnoses that included dementia	F 641	DISCLAIMER: 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 and State law.	10/25/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 11 with behavioral disturbances, hypertension and heart failure. A review of Resident #78's most recent quarterly MDS Assessment dated 08/12/19 revealed Resident #78 was cognitively impaired for daily decision making with physical behaviors directed towards others occurring 1-3 days during the look back period. Resident #78 was coded as receiving antipsychotics 7 of 7 days but under section M-0450A - "Resident received antipsychotic medications" the assessment was coded as "No- Antipsychotics were not received". A review of Resident #78's physician orders revealed an order written on 09/19/18 for Seroquel 25mg tablets to be given by mouth, two times a day. During an interview with MDS Nurse #2 on 09/27/19 at 9:58 AM, she reported section M-0450A should be coded as "yes - antipsychotics were received". She stated the way the system worked, unless she waited after selecting a response for it to give a green check mark, if she utilized the scroll button on her mouse, it would change the answer originally selected. She reported she would complete a modification and resubmit the quarterly MDS assessment with the corrected information. During an interview with the Director of Nursing on 09/27/19 at 1:21 PM, she reported it was her expectation that MDS Assessments be completed accurately and that the MDS Nurses take time to review their work before submitting the assessments to ensure the assessments were accurate.	F 641	The following Plan of Correction is Date Certain for 10/25/2019 F 641 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #78□s Minimum Data Set (MDS) Assessment section of Medication was reviewed and analyzed by the MDS Coordinator on 9/27/19. MDS Coordinator modified the assessment related to Antipsychotic Medications Received and resubmitted on 9/27/19 for accuracy of the resident□s assessment. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; MDS Coordinators were provided education on 9/27/19, by the Director of Case Mix & Compliance, regarding Federal and State regulation to ensure MDS Assessment accuracy in the section of Medication, related to Antipsychotic Medications Received. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Initial audit conducted by the Director of Case Mix & Compliance, reviewing MDS Assessments for the period of 30 days, to ensure MDS Assessment accuracy in the section of Medication (Section N), related to Antipsychotic Medications Received (Section items N0410A and N0450A-C). Indicate how the facility plans to monitor its performance to make sure that	

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F 641	Continued From page 12	F 641	solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility. Beginning 10/25/19, the Director of Case Mix & Compliance or designee, will conduct audits of 5 MDS Assessments weekly x 4 weeks, and then 10 MDS Assessments monthly x 2 months to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be documented on a MDS Assessment accuracy monitoring tool and shared by the MDS Coordinator with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. "¿Include dates when corrective action will be completed. The corrective action dates must be acceptable to the State. 10/25/19	
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	F 656		10/25/19

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F 656	Continued From page 13 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to implement a care plan to get a resident out of bed by 10:30 AM (Resident #125) and failed to use a green	F 656	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of	

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F 656	Continued From page 14 edged mechanical lift sling as directed by the care plan (Resident #46). This affected 2 of 4 residents sampled for accidents. The findings included: 1. Resident #125 was admitted to the facility on 04/18/18 with diagnoses that included embolic stroke, hemiparesis, diabetes, depression, and osteoarthritis. Review of the quarterly Minimum Data Set (MDS) dated 06/10/19 revealed that Resident #125 was cognitively intact and required extensive to total assistance with activities of daily living including transfers. Review of care plan initiated on 09/05/19 read in part, Activity of Daily Living (ADL) function rehab: the goal read, functions at optima level and Resident #125 needs assistance with ADLs. The interventions included: prefers to be up by 10:30 AM. An observation and interview were conducted with Resident #125 on 09/23/19 at 11:49 AM. There was a sign on the wall behind the bed that read, plan of care: Resident #125 wants to be up no later than 10:30 AM. Resident #125 stated that this morning it was after 11:00 AM when the staff got her out of bed. She stated that the staff were aware of her wish to be up by 10:30 AM but a lot of times that did not happen because they did not have enough staff to help. An observation and interview were conducted with Resident #125 on 09/24/19 at 11:00 AM. Resident #125 was sitting in a shower chair in her room and had just finished her shower. She	F 656	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 and State law. The following Plan of Correction is Date Certain for 10/25/2019 F656 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #125 was interviewed on 10/2/19 by the Social Worker to review resident□s time preference to get up in time for morning activities. Resident□s preference was updated in the resident□s plan of care and direct care staff educated on resident preferences. During Annual Survey/Complaint Investigation observation on 9/23/19, NA #2 reviewed CareTracker (Electronic Plan of Care) and obtained the correct green edged lift sling, to perform Resident #46□s lift transfer. "¿Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Nursing and Social Services will conduct resident interviews and will update preferences and establish updated	

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F 656	Continued From page 15 stated that the staff just got her up about 10 minutes ago and had just given her a shower. An observation of Resident #125 was made on 09/25/19 at 11:15 AM. Resident #125 remained in bed at this time and was alert and verbal. She stated she was waiting on the staff to come and get her washed and dressed and then put her in her wheelchair for the day. An observation and interview were conducted with Nurse Aide (NA) #1 on 09/25/19 at 11:19 AM. NA #1 entered Resident #125 ' s room and apologized for not coming to her room sooner and stated she had been busy. NA #1 stated that she was aware that Resident #125 preferred to be out of bed by 10:30 AM but stated this morning she had to assist the residents on the other unit with breakfast because there was no staff to do so. NA #1 added that the previous Administrator had placed the care plan on the wall behind Resident #125's bed but stated sometimes she was not able to do that because there was not enough help. An interview was conducted with Nurse #1 on 09/26/19 at 10:10 AM. Nurse #1 confirmed that she was caring for and was familiar with Resident #125. She stated that she was aware Resident #125 preferred to be out of by 10:30 AM and they staff tried but with the lack of staff on the unit that did not always happen. A lot of times she was not out of bed by 10:30 AM because it was just not possible due to the lack of available staff. Nurse #1 stated that the staff were expected to follow the care plan as written and assist Resident #125 out of bed by 10:30 AM. An interview was conducted with the Director of	F 656	resident care plan and resident profile to reflect preferences On 10/14/19, 100% audit of lift slings was conducted by facility nursing staff to ensure the correct lift slings were being utilized during resident□s lift transfers. "¿Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; To ensure compliance with honoring resident□s out of bed preferences, Facility Educator to inservice nurses and nurse aides on utilizing CareTracker for information regarding resident□s preferences. To ensure compliance of staff utilizing the correct lift slings for lift transfers, Facility Educator to inservices nurses, nurse aides, and Hospice, to view CareTracker to obtain correct lift sling information and know where lift slings are located prior to initiating resident□s lift transfer. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. "¿ Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action	

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F 656	Continued From page 16 Nursing (DON) on 09/26/19 at 4:28 PM. The DON stated that she expected the staff to get Resident #125 out of by 10:30 AM per her choice and as directed by the care plan. 2. Resident #46 was readmitted to the facility on 07/08/19 with diagnoses that included cerebral vascular accident, right hemiparesis, immobility, and others. Review of the comprehensive Minimum Data Set (MDS) dated 07/15/19 revealed that Resident #46 was moderately impaired for daily decision making and no transfers occurred during the assessment reference period. No falls were reported since the re-entry to the facility. The MDS further indicated Resident #46 received hospice care. Review of a care plan initiated on 08/06/19 read in part, Falls: will be free from major injury. The interventions included transfer with mechanical lift and 2 person assist using a sling with green edging. An observation of Nurse Aide (NA) #1 and #2 was made on 09/23/19 at 4:16 PM. NA #1 indicated that she and NA #2 were going to transfer Resident #46 from his wheelchair to the bed. NA #2 went to the electronic care plan and confirmed that Resident #46 required a mechanical lift with a sling pad that had green edging. NA #1 and #2 entered Resident #46 room and when asked what the sling with green edging meant NA #2 pointed to the sling pad that was under Resident #46 and pointed to the color-coded edging. When NA #2 pointed to the edging she replied "this is the wrong pad" he needs a green one and this one is blue. NA #2 stated that she did not get Resident	F 656	evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility. To ensure compliance with honoring resident□s out of bed preferences, Social Workers or designee will conduct 5 resident interviews weekly. To ensure compliance of staff utilizing the correct lift slings for lift transfers, designated nursing staff to observe 10 slings weekly. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 656	Continued From page 17 #46 up that am that the hospice staff did. An interview was conducted with NA #3 and #4 on 09/25/19 at 9:12 AM. NA #3 and #4 confirmed that they worked with the hospice agency and visited Resident #46 every Monday, Wednesday, and Friday. Both NA #3 and NA #4 confirmed that they transferred Resident #46 to his wheelchair on 09/23/19 using the sling with the blue edge because it was in his room lying in his chair and they thought it was the correct sling. NA #3 stated that they did have access to the electronic care plan but had never been shown how to use it and the system located in the hallway had been broken for several months. NA #3 and #4 again confirmed that on 09/23/19 they had used the incorrect sling that was in Resident #46's chair and available for use but should have used the greed edged sling as directed by his plan of care. An interview was conducted with Nurse #1 on 09/25/19 at 5:40 PM. Nurse #1 confirmed that she routinely cared for and was familiar with Resident #46. Nurse #1 stated that all staff including hospice staff were expected to use the correct sling as directed by the plan of care. An interview was conducted with the Director of Nursing (DON) on 09/26/19 at 4:42 PM. The DON stated she would expect the hospice staff and facility staff to refer to the electronic care plan or written list and follow the plan of care as instructed.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		10/25/19

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F 677	Continued From page 18 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to provide incontinent care for 2 of 4 dependent residents (Resident #125 and Resident #27) reviewed for activities of daily living. The findings included: 1. Resident #125 was admitted to the facility on 04/18/18 with diagnoses that included embolic stroke, hemiparesis, diabetes, depression, and osteoarthritis. Review of the quarterly Minimum Data Set (MDS) dated 06/10/19 revealed that Resident #125 was cognitively intact and required total assistance with toileting. The MDS further revealed that Resident #125 was always incontinent of bladder and bowel. Review of a care plan initiated on 09/05/19 read, Genitourinary: the goal read, no genitourinary complications, no urinary tract infections requiring hospitalization, unable to sit on commode and prefers not to use the bed pan, and Resident #125 was at risk for recurring urinary tract infections. The interventions included: provide incontinent care routinely as needed. An observation and interview were conducted with Resident #125 on 09/25/19 at 10:20 AM. Resident #125 was resting in bed with her eyes open. She stated that her brief was soiled with urine and no one had been in to provide care to her since third shift. She further stated that no	F 677	DISCLAIMER: 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 and State law. The following Plan of Correction is Date Certain for 10/25/2019 F677 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility will conduct an audit of all residents with incontinence, to include residents #27 and #125, to determine toileting needs and frequency. A toileting program and/or incontinence program will be developed to address specific areas of incontinence care for each resident. This program will be included in the resident□s plan of care and on the resident□s caretracker profile. The facility educator will inservice nurses and nurse aides on updated care plans and updated resident profiles for incontinence care.	

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F 677	Continued From page 19 one had been into see if I was wet or soiled. She added it was uncomfortable but did not burn or hurt at this point. Resident #125 was able to pull the covers back and pointed out that the wet indicator strip on the front of her brief was dark blue indicating it was wet. An observation and interview were conducted with Resident #125 on 09/25/19 at 10:55 AM. Resident #125 remained in bed and was alert and verbal. She confirmed that she was still wet, and no one had been into provide any care to her thus far on first shift. Again Resident #125 pulled her covers back and again indicated the wet indicator strip on the front of her brief was dark blue indicating it was wet. An observation and interview were conducted with Resident #125 on 09/25/19 at 11:11 AM. Resident #125 remained in bed and alert and verbal. She again confirmed that she was wet, and no staff had been into provide care for her. Resident #125 was observed to turn the call light on, and Nurse #1 entered room and stated she would go and get someone to help her. An observation and interview were conducted with Nurse Aide (NA) #1 on 09/25/19 at 11:19 AM. NA #1 entered Resident #125's room and apologized for not coming to her room sooner and stated she had been busy. NA #1 confirmed that this was the first time she had been able to provide any care to Resident #125 that day because there was no staff on the other unit, and she had to go and assist with serving breakfast and then assist residents that needed help with eating. She added that she had just returned to her unit and was just getting started on providing care to her residents. NA #1 was observed to turn	F 677	"¿Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The facility will conduct an audit of all residents with incontinence to determine toileting needs and frequency to develop a toileting or bowel and bladder program specific to each resident. "¿Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; A toileting program and/or incontinence program will be developed to address specific areas of incontinence care for each resident. This program will be included in the resident□s plan of care and on the resident□s caretracker profile. New admissions will be assessed for bowel and bladder requirements and an appropriate plan of care will be created to address each resident□s care needs. The facility educator will inservice nurses and nurse aides on updated care plans and updated resident profiles for incontinence care. "¿ Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC	

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F 677	Continued From page 20 Resident #125 onto her left side and remove her brief that when open smelled heavily of urine and when thrown in the trash can made a loud thud. The inner contents of the brief were bunched together due to the excessive moisture. Resident #125's buttocks and peri area were observed and were not red or excoriated but were visibly shiny with moisture when the soiled brief was removed. NA #1 again confirmed she had not been able to provide any care to Resident #125 because there was not enough staff to feed the resident on the other unit and she had gone to assist those residents with breakfast. An interview was conducted with Nurse #1 on 09/26/19 at 10:10 AM. Nurse #1 confirmed that she was caring for Resident #125 on 09/25/19 and was familiar with her needs and stated she required a lot of assistance with her activities of daily living including incontinent care. Nurse #1 stated it was not acceptable for Resident #125 to be wet for as long as she was. She confirmed that NA #1 had gone to the other unit to assist with breakfast because for some reason the staff on that unit had not arrived at the facility yet and there was no one to assist the residents with breakfast. An interview was conducted with the Director of Nursing (DON) on 09/26/19 at 4:28 PM. The DON stated that she was unaware that NA #1 had to assist the other unit with breakfast and was unaware that the staff on the other unit had not shown up to work as scheduled. The DON stated it was unacceptable for Resident #125 to have been wet for as long as she was before the staff came to provide care to her. The DON stated she has told the staff numerous times that if things got busy and they got behind to communicate that	F 677	is integrated into the quality assurance system of the facility. To ensure compliance with providing bathroom assistance, Director of Nursing or designee will audit ensure implementation of incontinence program interventions for all those residents identified during the audit. Director of Nursing or designee will audit 5 new admissions each week to ensure appropriate interventions have been put in place. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 677	Continued From page 21	F 677		

to her, and she would do whatever they needed. The DON stated she expected the staff to provide incontinent care to Resident #125 and all residents when they needed it and they should not be lying in a soiled brief for very long.

2. Resident #27 was admitted to the facility on 08/11/15 with diagnoses that included benign hypertension, breast neoplasm, chest pain, chronic obstructive pulmonary disease, and vascular dementia.

Review of a care plan initiated on 07/23/19 read, Genitourinary: the goal read, no genitourinary complications, Resident #27 was incontinent of bowel and bladder, and no skin injury through the next review. The interventions included: provide incontinent care frequently and routinely and as needed.

Review of the quarterly Minimum Data Set (MDS) dated 09/12/19 revealed that Resident #27 had long and short-term memory problems and was moderately cognitively impaired for daily decision making. The MDS further revealed that Resident #27 required total assistance with toileting and was always incontinent of bowel and bladder.

An interview was conducted with Nurse Aide (NA) #1 on 09/25/19 at 10:09 AM. NA #1 confirmed that she was caring for Resident #27 and was familiar with her care. She stated that she had not been able to provide any care to Resident #27 thus far on the shift because there was no staff on the other unit, and she had to go and assist with serving breakfast and then assist residents that needed help with eating. She added that she had just returned to her unit and was just getting started on providing care to her residents. NA #1

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F 677	Continued From page 22	F 677		

again confirmed she had not changed or provided any activity of daily living care to Resident #27 thus far on her shift.

An observation and interview were conducted with the Wound Nurse (WN) on 09/25/19 at 10:39 AM. The WN indicated that she was not aware of any wounds that Resident #27 had but stated she would go and observe her bottom just to make sure. The WN was observed to enter Resident #27's room and turn her onto her left side. When the covers were pulled back there was a strong smell of urine and the brief that Resident #27 had on was wet all the way to the edge of the brief. The inner contents of the brief were all bunched together from the moisture and when the brief was removed and thrown in the trash can it made a loud thud noise from the weight of the soiled brief. The WN stated she was going to provide incontinent care to Resident #27 at this time. Resident #27's buttock and peri area were observed to be of normal color for her ethnicity and was not excoriated. Resident #27 indicated that she could not recall when the last time she had been changed that day but thought it was earlier in the shift.

An interview was conducted with Nurse #1 on 09/26/19 at 10:10 AM. Nurse #1 confirmed that she was caring for Resident #27 on 09/25/19 and was familiar with her needs and stated she required a lot of assistance with her activities of daily living including incontinent care. Nurse #1 stated it was not acceptable for Resident #27 to be wet and soiled for a long period of time. She confirmed that NA #1 had gone to the other unit to assist with breakfast because for some reason the staff on that unit had not arrived at the facility yet and there was no one to assist the residents

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F 677	Continued From page 23 with breakfast. An interview was conducted with the Director of Nursing (DON) on 09/26/19 at 4:28 PM. The DON stated that she was unaware that NA #1 had to assist the other unit with breakfast and was unaware that the staff on the other unit had not shown up to work as scheduled. The DON stated it was unacceptable for Resident #27 to have been wet and heavily soiled before the staff came to provide care to her. The DON stated she has told the staff numerous times that if things got busy and they got behind to communicate that to her, and she would do whatever they needed. The DON stated she expected the staff to provide incontinent care to Resident #27 and all residents when they needed it and they should not be lying in a soiled brief for very long. An interview was conducted with NA #5 on 09/27/19 at 9:32 AM. NA #5 confirmed that she had worked third shift on 09/24/19 and provided care to Resident #27. NA #5 stated that made her last round and changed Resident #27 on 09/25/19 at 6:15 AM to 6:30 AM. She added that she had been wet but was not heavily soiled because she had also changed her earlier on the shift.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		10/25/19

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F 689	Continued From page 24 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to transfer a resident using the correct mechanical lift sling for 1 of 4 residents reviewed for accidents (Resident #46). The findings included: Review of the mechanical lift sling recommendations contained the following information, visibly inspect sling prior to each use to ensure sling is the correct type, size, and design to handle lifting. The recommendations further indicated the following specifications: Small 75-125 pounds (lbs.) Red, Medium 125-174 lbs. Yellow, Large 175-249 lbs. green, X-large 200-399 lbs. blue, XX-large 400-600 lbs. orange, and XXX-large 601-1000 lbs. grey. Resident #46 was readmitted to the facility on 07/08/19 with diagnoses that included cerebral vascular accident, right hemiparesis, immobility, and others. Review of the comprehensive Minimum Data Set (MDS) dated 07/15/19 revealed that Resident #46 was moderately impaired for daily decision making and no transfers occurred during the assessment reference period. No falls were reported since the re-entry to the facility. The MDS further indicated Resident #46 received hospice care. Review of a care plan initiated on 08/06/19 read in part, Falls: will be free from major injury. The interventions included transfer with mechanical lift and 2 person assist using a sling with green	F 689	DISCLAIMER: 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 and State law. The following Plan of Correction is Date Certain for 10/25/2019 F689 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; During Annual Survey/Complaint Investigation observation on 9/23/19, NA #2 reviewed CareTracker (Electronic Plan of Care) and obtained the correct green edged lift sling, to perform Resident #46□s lift transfer. "¿Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 10/14/19, 100% audit of lift slings was conducted by facility nursing staff to ensure the correct lift slings were being utilized during resident□s lift transfers.	

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F 689	Continued From page 25 edging. Review of Resident #46's medical record indicated on 09/11/19 his weight was 179 lbs. An observation of Nurse Aide (NA) #1 and #2 was made on 09/23/19 at 4:16 PM. NA #1 indicated that she and NA #2 were going to transfer Resident #46 from his wheelchair to the bed. NA #2 went to the electronic medical record and confirmed that Resident #46 required a mechanical lift with a sling pad that had green edging. NA #1 and #2 entered Resident #46 room and when asked what the sling with green edging meant NA #2 pointed to the sling pad that was under Resident #46 and pointed to the color-coded edging. When NA #2 pointed to the edging she replied "this is the wrong pad" he needs a green one and this one is blue. NA #1 went to the clean utility room and obtained the sling with green edging and proceed to place the correct sling under Resident #46. Once the blue edged sling was removed and the green edged sling was under Resident #46, he was safely transferred to the bed. NA #2 stated that she did not get Resident #46 up that am that the hospice staff did. An interview was conducted with NA #3 and #4 on 09/25/19 at 9:12 AM. NA #3 and #4 confirmed that they worked with the hospice agency and visited Resident #46 every Monday, Wednesday, and Friday. They confirmed that when they visited Resident #46, they bathed him, shaved him, provided mouth care, emptied his catheter and transferred him to the wheelchair. Both NA #3 and NA #4 confirmed that they transferred Resident #46 to his wheelchair on 09/23/19 using the sling with the blue edge because it was in his	F 689	"¿Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; To ensure compliance of staff utilizing the correct lift slings for lift transfers, Facility Educator to inservices nurses, nurse aides, and Hospice, to view CareTracker to obtain correct lift sling information and know where lift slings are located prior to initiating resident□s lift transfer. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. "¿ Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility. To ensure compliance of staff utilizing the correct lift slings for lift transfers, designated nursing staff to observe 10 slings weekly. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency	

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F 689	Continued From page 26 room lying in his chair and they thought it was the correct sling. NA #3 stated that they did have access to the electronic care system but had never been shown how to use it and the system located in the hallway had been broken for several months. NA #4 stated that a member of the staff had shown them this morning how to use the care tracker system and showed them how to find the correct sling pad for Resident #46 and indicated they had used the sling with the green edge on 09/25/19 when they transferred Resident #46. NA #3 and #4 again confirmed that on 09/23/19 they had used the incorrect sling that was in chair and available for use. An interview was conducted with Nurse #1 on 09/25/19 at 5:40 PM. Nurse #1 confirmed that she routinely cared for and was familiar with Resident #46. Nurse #1 stated that there was a list in the nursing station that indicated which sling each resident required and the staff including hospice were expected to refer to the list and use the correct sling to transfer Resident #46 and all residents. An interview was conducted with the Director of Nursing (DON) on 09/26/19 at 4:42 PM. The DON stated that one of the staff members had told her that NA #3 and #4 from hospice had used the incorrect lift pad to transfer Resident #46 on 09/23/19. The DON stated that there was a list of each resident and the sling that they required in each nursing station and all staff including hospice staff have access to it. I would expect them to refer to the list and use the correct sling for each resident that they transfer. She added that the list was updated each month after weights were obtained.	F 689	of monitoring will be determined by the QAPI Committee.	

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F 725	Continued From page 27	F 725		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interview the facility failed to provide sufficient nursing staff that resulted in incontinent care not being provided (Resident #125 and Resident #27), failed to have sufficient nursing staff to honor a residents choice to get out of bed by 10:30 AM (Resident #125), and failed to have	F 725	DISCLAIMER: 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	10/25/19

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F 725	Continued From page 28 sufficient staff to implement and follow a care plan that directed the staff to get a resident out of bed by 10:30 AM (Resident #125). This affected 3 of 11 sampled residents. The findings included: This tag is cross referred to F677: Based on observations, record review, resident and staff interview the facility failed to provide incontinent care for 2 of 4 dependent residents (Resident #125 and Resident #27) reviewed for activities of daily living. This tag is cross referred to F561: Based on observations, record review, resident and staff interview the facility failed to honor a resident wish to be out of bed by 10:30 AM for 1 of 3 resident reviewed for choices (Resident #125). This tag is cross referred to F656: Based on observations, record review, resident and staff interview the facility failed to implement a care plan to get a resident out of bed by 10:30 AM (Resident #125) and failed to use a green edged mechanical lift sling as directed by the care plan (Resident #46). This affected 2 of 4 residents sampled for accidents. An interview was conducted with Resident #125 on 09/23/19 at 11:55 AM. Resident #125 stated that a lot of time there was only 1 Nurse Aide (NA) to care for all the residents on her unit and indicated she had to wait awhile to receive her meal tray or any care that she needed. An interview was conducted with NA #1 on 09/25/19 at 10:06 AM. NA #1 stated that the on her unit they used to have 6 NA's and in the last	F 725	prepared and/or executed solely because it is required by the provisions of Federal and State law. The following Plan of Correction is Date Certain for 10/25/2019 F725 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility will conduct an audit of all residents with incontinence to determine toileting needs and frequency. A toileting program and/or incontinence program will be developed to address specific areas of incontinence care for each resident. This program will be included in the resident□s plan of care and on the resident□s caretracker profile. The facility educator will inservice nurses and nurse aides on updated care plans and updated resident profiles for incontinence care. Resident #125 was interviewed on 10/2/19 by the Social Worker to review resident□s time preference to get up in time for morning activities. Resident□s preference was updated in the resident□s plan of care and resident profile. The facility has recruited additional staff to fill multiple position vacancies throughout the facilty.	

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F 725	Continued From page 29 year they had cut the number to 3, so in a year her work load has doubled. She stated, "we do the best we can." NA #6 indicated that she was not able to complete her scheduled showers consistently and there was not enough staff on the next shift to do them so in the end the resident just missed their scheduled shower. She added that this morning she had to serve breakfast to both units and because of the lack of staff, her residents did not get incontinent care for an extended period of time. She added that they had 6 residents who required assistance with feeding and it usually took an hour and a half to complete that and left even less time for patient care. NA #1 stated they have a lot of complaints about patient care but there was just not enough of us to do everything that needed to be done. An interview was conducted with NA #8 on 09/25/19 at 2:16 PM. NA #8 stated she had worked at the facility for 18 years and "staffing is very bad." She stated that most of the time there was 1 NA on the hall to care for 18-20 residents and when there was only 1 NA on the hall, she was only able to provide incontinent care to her residents 1 time during her shift. NA #8 stated she had 7 residents who required assistance with meals and that took most of her shift to feed them so she did the best she could. When NA #8 informed the previous administration of the staffing issue she stated she was informed that she could be easily replaced, so NA #8 stated we just keep working and doing the best we can. An interview was conducted with NA #6 on 09/25/19 at 3:20 PM. NA #6 stated that when she first came to work at the facility, they had 2-3 NAs on each hall then they dropped it to 2 NAs on each hall, then dropped it again to 1 NA on each	F 725	"¿Address how the facility will identify other residents having the potential to be affected by the same deficient practice; The facility will conduct an audit of all residents with incontinence to determine toileting needs and frequency to develop a toileting or bowel and bladder program specific to each resident. Nursing and Social Services will conduct resident interviews and will update preferences and establish updated resident care plan and resident profile to reflect preferences "¿Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; At the facility, a Hiring/Job Fair is scheduled on 10/18/19 with assistance from Human Resources (HR) and Continuing Care Senior Leadership. The facility will be offering staff incentives for individuals working additional shifts, as new staff are onboarded. Facility has scheduled new weekly meetings with HR for progress updates, reviewing steps of hiring on a tracking grid with HR sharing progress from onboarding to filling a new position. "¿ Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must	

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F 725	Continued From page 30 hall with a person that went between 2 halls or a split. NA #6 added "if we have 4 nurse aides on the entire unit that is good day." She added that on the evening shift she was responsible for all patient care, bathing, showering, feeding, and putting all the residents to bed. She stated that the night shift was supposed to do laundry but a lot of time she also had to do that because the residents did not have any night clothes to wear. NA #6 stated that the residents would get better care if we had more staff on the units. An interview was conducted with NA #7 on 09/25/19 at 4:01 PM. NA #7 stated that the facility had lost a lot of staff since they changed to 12-hour shifts. She stated they hire staff, but they won't stay long. 4 NAs on a on a unit is unheard of and most of the time they work with 2-3 and on occasion 1 NA per hall which is not enough to provide all the care that the residents required. NA #7 stated on the days that they only have 2 NA on each unit she hoped and prayed that the family members would not come in and find out. She added that rarely did the Nurses have time to come and help out. An interview was conducted with Nurse #3 on 09/25/19 at 4:12 PM. Nurse #3 stated "staffing is pretty shabby, and we don't have much of it." She stated that the NAs were stressed to the max and most time they had 3 NAs to take care of 30 plus residents. Nurse #3 stated that the patients needed direct care and they would turn on their call light, but we just can not get there to help them. "I help the NAs as much as possible but with my medication pass and wound care it is just not always feasible." An interview was conducted with Nurse #1 on	F 725	be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility. To ensure compliance with staffing assistance, Social Workers or designee will conduct 5 resident interviews weekly. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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09/26/19 at 10:10 AM. Nurse #1 stated that she had worked at the facility on and off for four years and "staffing is terrible." "Honestly it should not happen, but we have 1 NA on the hall" Nurse #1 stated that it was unacceptable for residents to be soiled for long periods of time. She stated that showers were not consistently being completed because there was not enough staff. Nurse #1 stated that there was plenty of nurses in the building and if all the nurse would take 1 resident to feed that would free up the NAs to provide better care timelier to our residents.

An interview was conducted with the Director of Nursing (DON) on 09/26/19 at 4:51 PM. The DON stated that she expected the facility to maintain a level of staff to meet the needs of the resident and she felt like they had done that. She added that she had hired a lot of staff lately. The DON stated that the onboarding process was long and that was a barrier in retaining staff at times and usually took 4 to 6 weeks to get the staff in the building to work. She added that she had a good pool of nurses that were able to help out when needed and a lot of administrative nurses that would work the medication cart if needed. The DON stated that they usually did not work with 1 NA on the hall because she would put a nurse on the hall to perform patient care before she would let 1 NA work the hall alone.

An interview was conducted with the Interim Administrator on 09/26/19 at 7:10 PM. The Administrator stated he had not been at the facility long enough to assess the staffing issue within the building. He stated he would expect that there was enough staff to meet the safety and welfare needs of the residents.

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F 770	Continued From page 32	F 770		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review, nursing, pharmacy, laboratory services staff and medical director interviews, the facility failed to provide laboratory services as ordered for 1 of 5 residents reviewed for unnecessary medications. (Resident #92) The findings included: Resident #92 was readmitted to facility on 9/10/19 with medical diagnoses inclusive of diabetes mellitus and hypertension. Resident #92's minimum data set (MDS) dated 9/17/19 revealed that he was cognitively intact. A review of Resident #92's medical record revealed physician orders for Eliquis (an anticoagulant) 5mg milligrams twice a day. The medical record also revealed an order dated 9/19/19 at 11:17 am for weekly complete blood count for total 4 weeks then monthly. The start date for the order was 9/20/19 routine collection every 7 days. The order was reviewed by the nurse on 9/19/19 at 11:19 am.	F 770	DISCLAIMER: 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 and State law. The following Plan of Correction is Date Certain for 10/25/2019 F770 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 9/26/19 lab was obtained for Resident #92. Results of the lab were provided to Medical Director on 9/27/19 with new orders for ABT therapy related to	10/25/19

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F 770	Continued From page 33 An interview was conducted on 9/25/19 26 at 10:02 PM with Nurse #4. She was the preceptor for a new nurse during orientation on 9/19/19. Nurse #4 instructed the new nurse of the process for checking orders for laboratory services by acknowledging and reviewing the order seen on the computer. Nurse #4 informed the new nurse that the lab draw was routine and that a label would be printed on the day of the draw, 9/20/19. Nurse #4 contacted the facility's lab and was informed by staff in the lab that the order date was 9/21/19. The lab confirmed bloodwork had not been obtained for Resident #92 on that date. On 9/25/19 at 4:32 PM, an interview was conducted with the Director of Pharmacy Services regarding orders for laboratory services with long term care drug regimen review. The director stated the specimen should have been drawn at the next routine check which would have been on 9/20/19. During an interview with Nurse #5 on 9/25/19 at 4:41 PM, he reported the process for obtaining a specimen for laboratory services once the order was reviewed by the nurse. Nurse #5 stated a label would print with the resident's name, then a nurse would place the label in the binder labeled "Lakeview Inn (500 hall) Lab Draws" for the date of the blood draw. Nurse #5 confirmed there was no sheet dated 9/20/19 and 9/21/19 that had a label for Resident #92. On 9/27/19 at 1:14 PM, an interview was conducted with the client service manager of the facility's lab. The service manager reported she reviewed the order put in on 9/19/19 with a request to start on 9/20/19. She reported the label did not print until 9/21/19. The service	F 770	Leukocytosis. "¿Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Director of Nursing will review lab orders for the period of 10/1/19 through 10/14/19, to ensure lab obtained as ordered. "¿Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Lab orders will be reviewed daily in clinical meeting and tracked in a centralized book in supervisors office for completion and MD notification by night shift supervisors. Facility educator will in-service Supervisory staff on new process for reconciling lab orders. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. "¿ Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility.	

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F 770	Continued From page 34 manager for the lab could not identify a reason why the label printed a day late. The service manager reported that the facility was aware that no one from the reference lab draws blood on evenings and the weekend. She also stated the facility has the understanding that blood draws should be completed by the nurse on the evening and weekend shifts. An interview with Nurse #6 and Nurse #7 on 9/27/19, both nurses reported on 9/21/19 they were assigned to residents in Lakeview Inn (500 hall) where Resident #92 resided in the facility. Both nurses reported they were aware of the responsibility to draw blood on the weekend. Both nurses stated there was no label in the binder for laboratory services that identified Resident #92 required bloodwork to be obtained on 9/21/19. During an interview with the Director of Nursing (DON) on 9/27/19 at 11:07 AM, the DON stated her expectation was bloodwork for the lab was completed as ordered. During an interview with the Medical Director on 9/27/19 at 11:46 AM, she reported that the lab work should have been drawn as ordered since Resident #92 was on an anticoagulant. She also stated that Resident #92 experienced no harm and lab work was reordered on 9/26/19.	F 770	Beginning 10/21/19, the Director of Nursing or designee will review 10 new lab orders weekly to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that	F 804		10/25/19

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F 804	Continued From page 35 conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on 6 resident interviews (Residents #72, #186, #5, #53, #31, and #125), a Resident Council Meeting, observations, a test tray evaluation and record review, the facility failed to provide food that was served at an appetizing temperature for 6 of 7 residents reviewed for palatable foods. The findings included: 1a. Resident #72 was admitted to the facility on 3/23/12. Review of a quarterly Minimum Data Set (MDS) assessment dated 8/9/19 assessed Resident #72 with adequate hearing, clear speech, understood by others, able to understand others and intact cognition. The MDS assessed Resident #72 as being independent with eating, requiring set up help only. Resident #72 was interviewed on 09/24/19 at 10:54 AM. During the interview Resident #72 expressed that for greater than 6 months the food served at the facility had not been good. The Resident described the food as having no taste, "terrible" and repetitious, especially pork giving ham and bacon as examples. Resident #72 described the last meal of the month (quiche and tomatoes) as being the worst meal of the month thus far. The Resident stated this was brought to the attention of the certified dietary manager (CDM) and other food concerns was discussed with him when he attended Resident Council	F 804	DISCLAIMER: 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 and State law. The following Plan of Correction is Date Certain for 10/25/2019 F804 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Identified residents were interviewed to update likes/dislikes on resident meal profiles. Personal preferences were updated for meal cards by Dietary General Manager. Updated menu suggestions were identified to include in new menu rotations. "¿Address how the facility will identify other residents having the potential to be affected by the same deficient practice;	

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F 804	Continued From page 36 meetings. A follow up interview was conducted with Resident #72 on 09/25/19 at 3:41 PM. Resident #72 stated she received a lunch meal that day that was not hot and not good (meat loaf, mashed potatoes and green peas) so she ordered a chicken sandwich from the café. Resident #72 also expressed that she had ongoing conversations with the CDM about her food concerns and all he said was "What else can I get you?" or told her "I will take care of it.", but she expressed nothing gets done. Resident #72 further stated that the lunch for the previous Monday was not good and clarified that "It was ham again, we get too much pork, the broccoli was over-cooked, and the sweet potatoes had no taste." The CDM was interviewed on 09/26/19 at 10:03 AM. The CDM stated in interview that he began his role as CDM in November 2018, 10 months ago. He stated that he attended Resident Council Meetings often and that he was aware of resident food concerns expressed during Resident Council meetings. He stated that when a resident expressed a concern during Resident Council, he responded to that individual resident by asking the resident what else he could get them to eat and based on their response, he updated their food preferences on their tray ticket. He also stated that he was made aware that some residents did not like the meatloaf served for lunch on 9/25/19, but further stated that an alternate entrée was available for residents to choose. The CDM stated that when he spoke to Resident #72 in the past about food, he did not ask her why she did not want a food, so he was not aware that he was updating her food	F 804	Food concerns identified during the Annual Survey/Complaint Investigation, were reviewed with the Resident Food Council by the General Manager on 10/9/19. Residents were provided the opportunity to review the cycle menus and adjustment were made based on resident□s recommendations. New items will be included based on input from the Food Council, and other items will cycle off based on same input. On 10/10/19, service vendor calibrated the hot plates in the pods. 7 hot plates were working properly and 1 pulled from service and being replaced due to defective heating elements. On 10/11/19, service vendor checked heat lamps and 3 heat lamps were pulled from service and scheduled to be repaired. "¿Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; By 10/23/19, General Manager conducting inservices with dietary staff to pull defective hot plates and heat lamps from services to ensure not utilized during resident□s meal service. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation.	

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F 804	Continued From page 37 preferences because she did not like the food. An interview occurred with nurse aide #8 (NA #8) on 09/26/19 at 1:45 PM. During the interview, NA #8 stated that she often returned food to the kitchen because residents complained that they did not like the food served. NA #8 stated when she returned food to the kitchen, she told the dietary staff and the CDM that she was returning the food item because the resident did like it. NA #8 stated the CDM would respond that he would update the resident's food preferences and get them something else. NA #8 further stated that residents still complained that updating their food preferences did not resolve the problem because the food did not get better and that as a result many residents ordered food out. 1b. Res #5 was admitted to the facility 10/16/18. A quarterly Minimum Data Set (MDS) assessment dated 6/27/19 assessed Resident #5 with minimum difficulty hearing, clear speech, able to understand others, able to be understood by others, and intact cognition. The MDS assessed Resident #5 as being independent with eating, requiring set up help only. An observation of Resident #5 having lunch occurred on 09/25/19 at 1:06 PM. During the observation, Resident #5 expressed that he discussed with staff during a recent care plan meeting that he wanted to change his diet from a no added salt diet to a low sodium diet because his food was too bland and had no taste. He further stated that even adding a little salt did not help because the food provided by the facility tasted terrible. The CDM was interviewed on 09/26/19 at 10:03	F 804	Beginning 10/7/19, General Manager began a new process of conducting test tray audits utilizing a test tray audit tool. The test tray audit measures temperature, presentation, taste, and texture and will be conducted for 5 trays per week, covering the diet spread, for a period of 90 days. "¿ Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility. To ensure compliance with food being served at an appetizing temperature, on 10/15/19, Social Workers or designee, began conducting 5 resident interviews weekly. Resident interviews will be conducted for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Any identified issues will be corrected at that time. Results of the monitoring will be shared by the Social Worker with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. "¿Include dates when corrective action will be completed. The corrective action dates must be acceptable to the State.	

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AM. The CDM stated in interview that he began his role as CDM in November 2018, 10 months ago. He stated that when a resident expressed a concern he responded to that individual resident by asking the resident what else he could get them to eat and based on their response, he updated their food preferences on their tray ticket. He also stated that he was made aware that some residents did not like the meatloaf served for lunch on 9/25/19, but further stated that an alternate entrée was available for residents to choose. The CDM further stated that he had spoken to Resident #5 in the past and updated his food preferences related to sausage gravy but did not ask the Resident why he wanted to make a change to his preferences, so he was not aware that he did not like the food.

An interview occurred with nurse aide #8 (NA #8) on 09/26/19 at 1:45 PM. During the interview, NA #8 stated that she often returned food to the kitchen because residents complained that they did not like the food served. NA #8 stated when she returned food to the kitchen, she told the dietary staff and the CDM that she was returning the food item because the resident did like it. NA #8 stated the CDM would respond that he would update the resident's food preferences and get them something else. NA #8 further stated that residents still complained that updating their food preferences did not resolve the problem because the food did not get better and that as a result many residents ordered food out.

1c. Resident #186 was admitted to the facility 7/27/19. An admission Minimum Data Set (MDS) assessment dated 8/3/19 assessed Resident #186 with adequate hearing, clear speech, able to

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understand others, able to be understood by others, clear speech and intact cognition. The MDS assessed Resident #186 as requiring set up help and supervision during meals by 1 staff member.

Resident #186 stated on 9/24/19 at 11:31 AM that the food had no taste and that she did not like the food. She expressed she shared this with the certified dietary manager (CDM) many times but that he would respond by updating her food preferences or say he would take care of it, but that the food did not get better.

The CDM was interviewed on 09/26/19 at 10:03 AM. The CDM stated in interview that he began his role as CDM in November 2018, 10 months ago. He stated that when a resident expressed a concern about their food he responded to that individual resident by asking the resident what else he could get them to eat and based on their response, he updated their food preferences on their tray ticket. He also stated that he was made aware that some residents did not like the meatloaf served for lunch on 9/25/19, but further stated that an alternate entrée was available for residents to choose.

An interview occurred with nurse aide #8 (NA #8) on 09/26/19 at 1:45 PM. During the interview, NA #8 stated that she often returned food to the kitchen because residents complained that they did not like the food served. NA #8 stated when she returned food to the kitchen, she told the dietary staff and the CDM that she was returning the food item because the resident did like it. NA #8 stated the CDM would respond that he would update the resident's food preferences and get them something else. NA #8 further stated that

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residents still complained that updating their food preferences did not resolve the problem because the food did not get better and that as a result many residents ordered food out.

1d. Resident #53 was admitted to the facility 9/9/10. A quarterly Minimum Data Set (MDS) dated 7/26/19 assessed Resident #53 with minimum difficulty hearing, clear speech, able to understand others, able to be understood by others and intact cognition. The MDS assessed Resident #186 as independent with eating requiring set up help only.

An interview occurred with Resident #53 on 09/27/19 at 12:46 PM. Resident #53 stated during the interview that she did not like the taste of the food provided by the facility. She described the food as lacking taste and seasoning, bland and that she did not like the food selections. As a result, Resident #53 stated that she ordered out 3 - 4 times per week. She further stated that she communicated her food concerns to staff.

The CDM was interviewed on 09/26/19 at 10:03 AM. The CDM stated in interview that he began his role as CDM in November 2018, 10 months ago. He stated that when a resident expressed a concern about their food, he responded to that individual resident by asking the resident what else he could get them to eat and based on their response, he updated their food preferences on their tray ticket. He also stated that he was made aware that some residents did not like the meatloaf served for lunch on 9/25/19, but further stated that an alternate entrée was available for residents to choose.

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An interview occurred with nurse aide #8 (NA #8) on 09/26/19 at 1:45 PM. During the interview, NA #8 stated that she often returned food to the kitchen because residents complained that they did not like the food served. NA #8 stated when she returned food to the kitchen, she told the dietary staff and the CDM that she was returning the food item because the resident did like it. NA #8 stated the CDM would respond that he would update the resident's food preferences and get them something else. NA #8 further stated that residents still complained that updating their food preferences did not resolve the problem because the food did not get better and that as a result many residents ordered food out.

1e. Resident #31 was admitted to the facility 5/8/15. A quarterly Minimum Data Set (MDS) assessment dated 7/5/19 assessed Resident #31 with adequate hearing, clear speech, able to understand others and be understood by others and intact cognition. The MDS assessed Resident #186 as independent with eating requiring set up help only.

An interview was conducted with Resident #31 on 09/27/19 at 1:04 PM. During the interview, Resident #31 stated that she ate most meals in the dining room and that at times her food was cold when served and that the food was "not something I want to eat every day." Resident #31 further described the food as repetitious and the lunch/dinner meals often lacked taste. Resident #31 stated she expressed these concerns to staff.

The CDM was interviewed on 09/26/19 at 10:03 AM. The CDM stated in interview that he began

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his role as CDM in November 2018, 10 months ago. He stated that when a resident expressed a concern about their food, he responded to that individual resident by asking the resident what else he could get them to eat and based on their response, he updated their food preferences on their tray ticket. He also stated that he was made aware that some residents did not like the meatloaf served for lunch on 9/25/19, but further stated that an alternate entrée was available for residents to choose.

An interview occurred with nurse aide #8 (NA #8) on 09/26/19 at 1:45 PM. During the interview, NA #8 stated that she often returned food to the kitchen because residents complained that they did not like the food served. NA #8 stated when she returned food to the kitchen, she told the dietary staff and the CDM that she was returning the food item because the resident did like it. NA #8 stated the CDM would respond that he would update the resident's food preferences and get them something else. NA #8 further stated that residents still complained that updating their food preferences did not resolve the problem because the food did not get better and that as a result many residents ordered food out.

1f. A Resident Council Meeting was held on 9/26/19 at 10:00 AM. During the meeting Resident #72 stated at 10:24 AM that the food prepared by the facility was so good, that sometimes she "had to order out." Resident #72 continued to report that the food was very bland, that you just can't eat it and much of the food was thrown out because the residents just did not want to eat it. Several residents who also attended the meeting shook their heads in agreement.

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The CDM was interviewed on 09/26/19 at 10:03 AM. The CDM stated in interview that he began his role as CDM in November 2018, 10 months ago. He stated that he attended Resident Council Meetings often and that he was aware of resident food concerns expressed during Resident Council meetings. He stated that when a resident expressed a concern during Resident Council, he responded to that individual resident by asking the resident what else he could get them to eat and based on their response, he updated their food preferences on their tray ticket. He also stated that he was made aware that some residents did not like the meatloaf served for lunch on 9/25/19, but further stated that an alternate entrée was available for residents to choose.

An interview occurred with nurse aide #8 (NA #8) on 09/26/19 at 1:45 PM. During the interview, NA #8 stated that she often returned food to the kitchen because residents complained that they did not like the food served. NA #8 stated when she returned food to the kitchen, she told the dietary staff and the CDM that she was returning the food item because the resident did like it. NA #8 stated the CDM would respond that he would update the resident's food preferences and get them something else. NA #8 further stated that residents still complained that updating their food preferences did not resolve the problem because the food did not get better and that as a result many residents ordered food out.

1g. Resident #125 was admitted to the facility on 04/18/18 with diagnoses that included embolic stroke, hemiparesis, diabetes, depression, and osteoarthritis.

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F 804	Continued From page 44	F 804		

Review of the quarterly Minimum Data Set (MDS) dated 06/10/19 revealed that Resident #125 was cognitively intact and required set up assistance with eating.

An interview with Resident #125 was conducted on 09/23/19 at 11:58 AM. Resident #125 stated that her food that was served from the facility was usually cold and most of the time had no flavor. She indicated she got plenty to eat only because her family kept lots of snacks in her room.

A follow up observation and interview were conducted with Resident #125 on 09/25/19 at 1:30 AM. Resident #125 was in the dining room on her unit and was eating her lunch tray that consisted of meat loaf, mashed potatoes with gravy, and green peas. She stated that it had "decent" flavor but was not very hot and she was looking forward to eating the dessert her family had brought into her.

1h. An observation of the lunch meal preparation was conducted on 09/25/19 at 12:30 AM. The lunch meal consisted of meat loaf, mashed potatoes, gravy, and green peas. The kitchen staff was observed to load the food onto a meal cart that would be delivered to the resident unit.

An observation of the lunch meal being delivered to the resident unit was made on 09/25/19 at 12:40 AM. The dietary staff began plating each residents tray on the unit and at 1:15 PM all resident lunch trays had been plated and were being distributed to the residents.

On 09/25/19 at 1:15 PM the dietary staff plated a regular test. There was no visible steam to the

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F 804	Continued From page 45 lunch tray and the gravy was partially congealed on top of the mashed potatoes. The Dietary Manager (DM) sampled a bite of the meat loaf, mashed potatoes, and green peas. After the test tray had been sampled the DM agreed the meat loaf was not hot and at best was room temperature. The texture and flavor were suitable but lacked an appetizing temperature. The DM stated he needed to figure out how keep and maintain the temperature of the food from the kitchen to the point of service. The DM stated that he expected the food to be hot when served to the residents.	F 804		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to follow diet instructions per physician orders for 2 of 2 residents reviewed for therapeutic diets (Resident #61 and Resident #121). Findings included: 1. Resident #61 was admitted to the facility 12/02/14 with diagnoses which included cerebral vascular accident and abnormal weight loss.	F 808	DISCLAIMER: 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 and State law.	10/25/19

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F 808	Continued From page 46 A physician order written 05/03/19 instructed Resident #61 receive a mechanically altered diet. A review of the quarterly Minimum Data Set (MDS) dated 08/01/19 assessed Resident #61 to be cognitively intact with no swallowing disorders. Resident #61 required supervision with eating with a 5% or greater weight gain during the look back period of the assessment. Nutritional needs were supplemented with 26-50% of total calories and 501 or greater milliliters of daily fluid intake were provided via tube feedings. A nutrition care plan revised 08/08/19 described a goal to meet nutritional intake needs with interventions which included to provide Resident #61 with a mechanical soft diet. A nutrition note dated 09/23/19 described Resident #61 as having a history of weight loss, as being able to feed self with setup assistance, and remained on a mechanical soft diet. Resident #61 had started eating with improved meal intake. Supplemental bolus feeds were provided if meal intake was less than 50% plus a bolus at bedtime. During an observation on 09/23/19 at 12:22 PM Resident #61 was served a slice of non-mechanically altered ham which appeared to be approximately 2.5 centimeters thick. Other residents were observed to have mechanically altered ham pieces on their plates. During an interview on 09/23/19 at 12:52 PM Nurse #8 confirmed the diet card instructions for Resident #61 read in part to provide mechanical soft food. Nurse #8 revealed the ham served to Resident #61 was not the correct consistency	F 808	The following Plan of Correction is Date Certain for 10/25/2019 F808 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 10/16/19, the Dietician reviewed the diet order for Resident #61 and Resident #121 and validated that each resident□s diet order matched the tray card. "¿Address how the facility will identify other residents having the potential to be affected by the same deficient practice; By 10/25/19, the Facility Educator to inservice nurses, nurse aides, and dietary staff, to follow the instructions on the diet card when serving residents their meals. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. Beginning 10/3/19, the Registered Dietician audited and validated that all existing therapeutic dietary orders were accurate. The Dietary Department will ensure that all resident meal profiles are consistent with validated therapeutic diet orders. "¿Address what measures will be put into	

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F 808	Continued From page 47 and/or texture of a mechanically soft food. Nurse #8 did not recall which staff member served the food tray for Resident #61. An interview was conducted on 09/26/19 at 10:26 AM with the Director of Nursing (DON) who explained it was her expectation for staff to follow the instructions on the diet card when serving residents their meals. The system in place was for staff to read the instructions on the diet card to ensure the meal served was the correct consistency and/or texture. The DON felt Resident #61 was served a non-altered slice of ham due to an oversight made by the staff. During an interview on 09/26/19 at 10:29 AM the Interim Administrator revealed it was his expectation diet orders were followed by staff serving food to residents. He expected residents were served the correct recommended consistency and/or texture of food per instructions on their diet card. He explained the system in place was for staff to read the diet card. 2. Resident #121 was admitted to the facility 05/29/19 with diagnoses which included depression and anxiety. The quarterly Minimum Data Set (MDS) dated 09/03/19 assessed Resident #121 as being moderately impaired cognitively and requiring supervision with eating. No identified swallowing problems or weight loss and/or gain. The nutrition care plan revised 07/19/19 described a goal for Resident #121 to tolerate the diet as prescribed with interventions which included to provide a mechanical soft diet with nectar thick liquids.	F 808	place or systemic changes made to ensure that the deficient practice will not recur; On 10/25/19, a new process was implemented to ensure that Dietary department validates each meal ticket for consistency with current orders at each meal. During meal service, the nursing staff will ensure that the meal ticket matches the consistency of food or liquid on the resident tray prior to service to each resident. By 10/25/19, the Facility Educator to inservice nurses, nurse aides, and dietary staff, the new process. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. "¿ Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility. To ensure compliance with diet orders, beginning 10/21/19, the Registered Dietician or designee will audit 10 tray cards weekly during meals, for a period of 90 days at which time frequency of	

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F 808	Continued From page 48 A physician order written 09/16/19 instructed Resident #121 be provided a mechanical soft diet with nectar thick liquids. During an observation on 09/23/19 at 12:29 PM the diet card for Resident #121 read in part nectar thick liquids. Resident #121 was served tea with ice cubes which appeared to be of a non-thickened consistency and/or texture. During an interview on 09/23/19 at 12:38 PM Nurse Aide (NA) #11 checked the tea served to Resident #121 and confirmed the consistency and/or texture was not nectar thick and removed the glass of ice tea. She checks the diet card of residents to ensure the correct consistency and/or texture was served but did not recall serving tea to Resident #121. During an observation on 09/23/19 at 12:43 PM NA #12 adds 2 packets of nectar thick mix to 8 oz of tea for Resident #121 per instructions on the thickener packet. She revealed drinks were made per diet card instructions and served by staff in the dining room but did not recall serving tea to Resident #121. An interview was conducted on 09/26/19 at 10:26 AM with the Director of Nursing (DON) who explained it was her expectation for staff to follow the instructions on the diet card when serving residents. The system in place was for staff to read the instructions on the diet card to ensure they served the correct consistency and/or texture. The DON felt Resident #121 was served non-thickened tea due to an oversight made by the staff.	F 808	monitoring will be determined by the QAPI Committee. Any identified issues will be corrected at that time. Results of the monitoring will be shared by the Registered Dietician with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. "¿Include dates when corrective action will be completed. The corrective action dates must be acceptable to the State. 10/25/19	

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F 808	Continued From page 49 During an interview on 09/26/19 at 10:29 AM the Interim Administrator revealed it was his expectation diet orders were followed by staff serving residents. He expected residents were served the correct recommended consistency and/or texture per instructions on their diet card. He explained the system in place was for staff to read the diet card.	F 808		