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	345562	A. BUILDING ______ B. WING ______	C 01/24/2020

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E 000	Initial Comments A recertification and complaint survey was conducted on 01/21/2020 through 01/24/2020. The facility is in compliance with the requirements of CFR 483.73, Emergency Preparedness. Event ID: RTQ511	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/21/20 through 01/24/20. There were 11 allegations investigated and 3 were substantiated with citation. Event ID# RTQ511.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to place a call light within reach for 2 of 3 residents reviewed for accommodation of needs. (Resident #26, Resident #39). Findings included: 1. Resident #26 was readmitted to the facility on 10/15/19 with medical diagnoses inclusive of type 2 diabetes mellitus with diabetic neuropathy and chronic obstructive pulmonary disease. Resident #26's significant change Minimum Data	F 558		

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

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Set (MDS) dated 10/21/19 specified the resident's cognition was intact, she had clear speech and could make her needs understood and understood others. The MDS also specified the resident received as needed pain medication for pain.

Resident #26's care plan updated with the significant change MDS identified a focus area for risk for falls. An identified intervention noted to keep call light within reach and answer timely.

During an observation and interview on 1/21/20 at 12:23 PM, Resident #26 reported she needed assistance from the nursing staff to receive pain medication. Resident #26's call light was tied to the right upper bedrail. Resident #26 stated she was unable to reach the call light to inform the nursing staff she needed pain medication. Resident #26 reported that she had verbally informed the nursing staff of her need while the staff member was in her room.

On 1/21/2020 at 1:02 PM. Resident #26 was observed sitting up in bed with the head of the bed raised with a lunch tray placed on the bedside table over her lap. The call light was attached to the mattress to the right of Resident #26. Resident #26 stated she had informed the nurse aide who brought in her lunch tray, she needed pain medication.

On 1/21/20 at 3:02 PM, an observation and interview were conducted with Nurse Aide (NA) #1. During the interview, she stated when Resident #26 was lying flat on her back, she could not reach for the call light due to her inability to turn and reposition herself. NA #1 stated nursing staff should attach the call bell to

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the blanket for Resident #26 to have access to use the call light. NA #1 reported she positioned the call light where the resident could have access when she raised the head of bed for Resident #26 to eat her lunch. NA #1 also stated she was reassigned to Resident #26 late morning after another nurse aide went home.

The nurse aide initially assigned to Resident #26 was not available for interview.

During an interview with the Director of Nursing (DON) on 1/22/20 at 2:32 PM, the DON stated Resident #26 should always have access to use the call light.

2. Resident #39 was readmitted to the facility on 8/15/19 with medical diagnoses inclusive of chronic congestive heart failure and chronic obstructive pulmonary disease.

Resident #39's last quarterly Minimum Data Set (MDS) dated 11/1/19, Section C - Cognition was not assessed. Resident #39's significant changed MDS dated 8/12/19 specified the resident's cognition was intact, she had clear speech and could make her needs understood and understood others.

Resident #39's care plan updated with the last quarterly MDS identified a focus area for risk for falls. An identified intervention noted to keep call light within reach and answer timely.

During an observation and interview on 1/22/20 at 1:11 PM, Resident #39 requested assistance with going to the bathroom. The call light was hanging on the outside of the left bedrail. Resident # 39 was sitting up in bed with the head of the bed

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raised. She was unable to locate her call light.

On 1/22/20 at 2:59 PM, an observation and interview were conducted with Nurse Aide (NA) #2. NA #2 reported Resident #39 required assistance to use the bedside commode. NA # 2 reported she had assisted Resident #39 to use the bedside commode at what she approximated 45 minutes prior to this interview. NA #2 reported Resident #39 could use the call light. Resident #39 was instructed to locate the call light tied to the left bedrail while lying on her right side. Resident #39 turned on her back and with instructions by NA #2 and was able to locate the call light and press to activate the light.

During an observation and interview with the Director of Nursing (DON) on 1/22/20 at 2:32 PM, Resident #39 was not able to locate the call light placed on the left side of the mattress. Resident #39 located and activated the call light when clipped to the blanket lying across her chest. The DON stated Resident #39 should always have access to the call light.

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,

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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 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 observation, family member and staff interviews, and record review, the facility failed to give a choice of time to be awakened for 1 of 5 residents observed during a morning medication pass (Resident #90).

The findings included:

Resident #90 was admitted to the facility on 07/08/14 with diagnoses which included dementia.

Resident #90's quarterly Minimum Data Set (MDS) dated 01/06/20 revealed an assessment of severely impaired cognition with receipt of daily administration of anti-anxiety medication.

Observation on 01/23/20 at 8:15 AM revealed Nurse #2 rubbed Resident #90's shoulders and asked Resident #90 to awaken. Resident #90

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F 561	Continued From page 5 appeared startled, sat up in bed and began to rapidly repeat the phrase, "what do I do?" Nurse #2 reassured Resident #90 and applied Lorazepam gel on Resident #90's inner wrists. Resident #90 appeared worried and repeated the phrase, "what do I do?" Interview with Nurse #2 on 1/23/20 at 8:20 AM revealed Resident #90's only scheduled medication in the morning was the Lorazepam gel. Nurse #2 explained Resident #90 required awakening for the application each morning. Telephone interview with Resident #90's family member on 01/23/20 at 11:29 AM revealed Resident #90 would not want to be awakened for application of the anti-anxiety medication. Resident #90's family member explained Resident #90's sleep should not be disturbed since tiredness would exacerbate anxiety. Interview with the Director of Nursing (DON) on 01/23/20 at 11:35 AM revealed Resident #90 should not be awakened for application of the Lorazepam gel. The DON reported Resident #90 should naturally awaken before administration of the medication.	F 561		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584		

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homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident, and staff interview, the facility failed to maintain a wall heating and air conditioning unit in working condition in 1 of 17 rooms observed on the 700 and 800 halls.

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Findings included:

Resident #49 was admitted to the facility on 7/31/2019. Her diagnoses was inclusive of Alzheimer's disease.

Resident #49's quarterly Minimum Data Set (MDS) dated 11/15/2019 revealed she had clear speech, could understand and be understood.

An observation and interview was completed on 1/21/2020 at 2:49 PM of Resident #49's room. Resident #49 was observed in her bed with the blanket covering her head. She verbalized it was cold and requested another blanket. The heating and air conditioning wall unit was observed to be blowing out cold air. Further observation of the heating and air conditioning unit's control panel revealed a digital temperature set at 76 degrees Fahrenheit (F). The setting was also observed on "heat" and "high".

An interview and observation was completed on 1/21/2020 at 3:36 PM with the Maintenance Director. He verbalized upon entrance into Resident #49's room, "Is the air on?" The Maintenance Director obtained an ambient temperature of the room via digital thermometer which read 60.9 degrees F. He further observed the heating and air conditioning wall unit and expressed the settings were on heat, high and the digital reading of the temperature was 76 degrees F. He communicated he checked the wall units monthly and had no concerns regarding the wall unit in Resident #49's room. The Maintenance Director could not recall the last time he checked the heating and air conditioning wall unit in Resident #49's room. He indicated the wall unit could not have been set right by

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nursing and he was not certain as to why this fluctuation in temperature occurred. He expressed when the setting was on heat, warm arm should blow out of the unit to the designated temperature set on the unit. The Maintenance Director explained he would reset the unit to determine if the compressors were working properly and warmer air would begin to blow out.

A follow up observation was completed on 1/22/2020 at 9:44 AM of Resident #49's room. The heating and air conditioning wall unit was observed to be blowing hot air. Resident #49 had no complaints regarding room temperature.

An interview was completed on 1/22/2020 at 9:49 AM with nurse aide (NA) #4. She explained she worked at the facility 2 to 3 days per week. She verbalized she was familiar with Resident #49 and was her assigned aide on 1/20/2020 during the night shift (11:00 PM to 7:00 AM). NA #4 expressed Resident #49 was cold natured and typically layered her clothing. Resident #49 liked for her covers to be over her head when she was in bed. NA #4 did not recall any concerns with the heating and air conditioning wall unit. She communicated everything was working fine. She continued to communicate she worked with Resident #49 on 1/21/2020 during the day shift (7:00 AM to 3:00 PM). NA #4 assisted Resident #49 that morning with care and had no concerns with the heating and air conditioning wall unit. NA #4 could not recall the temperature of the room. NA #4 explained after lunch and prior to her leaving for the day, she briefly checked on Resident #49 and could not recall if the heating and air conditioning wall unit was working. NA #4 was not certain about the room temperature as she explained she quickly entered the room and

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F 584	Continued From page 9 quickly went out of the room. NA #4 indicated this was the first time she was hearing of the wall unit not working properly. An interview was completed on 1/22/2020 at 3:20 PM with the Medication Aide. The Medication Aide explained she last checked on Resident #49 on 1/21/2020 around 11:30 AM. She noticed the room was warm and the heating and air conditioning unit was functioning properly. The Medication Aide verbalized the resident had not mentioned any concerns to her regarding her heating and air conditioning wall unit not working. A follow up interview was completed with the Maintenance Director on 1/22/2020 at 5:00 PM who stated he was mistaken when he explained he completed monthly audits of the wall units. The Maintenance Director continued to explain he completed monthly audits of the air conditioning units in the attic. He communicated quarterly he checked the air filters in the wall units in the resident rooms. He verbalized that when there was an issue in the resident rooms, he relied on the staff to complete a work order in the Tels system (system of tracking maintenance requests/ work orders), so that he could follow up appropriately. The Maintenance Director could not recall the last check of Resident #49's heating and air conditioning wall unit for proper function. An interview was completed on 1/23/2020 at 11:42 AM with the Administrator. He stated the Maintenance Director during his daily rounds should be communicating with staff regarding maintenance issues in resident rooms versus solely relying on Tels system.	F 584		
F 636	Comprehensive Assessments & Timing	F 636		

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CFR(s): 483.20(b)(1)(2)(i)(iii)

§483.20 Resident Assessment
The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must

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include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to complete a comprehensive assessment in the area of cognition before the assessment was submitted to the national data base for 1 of 4 sampled residents (Resident #53) reviewed for resident assessment.

The findings included:

1. Resident #53 was readmitted to the facility on 2/9/17 with medical diagnoses inclusive of chronic respiratory failure and dysphasia.

A review of Resident #53's annual Minimum Data Set (MDS) assessment dated 10/3/19 revealed Section C- Cognition had not been assessed.

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F 636	Continued From page 12 Further review revealed the MDS Nurse's signature indicated the annual assessment as completed and accurate. The annual assessment dated 10/3/19 was transmitted and accepted by the national data base. On 1/23/2020 at 3:32 PM an interview was conducted with the Social Worker (SW). The SW reported she was employed by the facility in November 2019. The SW reported she was not responsible for completing the cognition section for Resident #53 on 10/3/19. During an interview with the MDS Nurse on 1/23/2020 at 3:49 PM, she reported she was responsible for reviewing all MDS assessments for completion and accuracy. The MDS Nurse explained Section C was assigned to the facility's social worker and during a time frame in 2019, the facility was without a social worker. The MDS nurse stated the cognition section was not completed nor assigned to another staff to conduct an assessment during this time. The MDS did not identify the time frame the facility was without a social worker. The MDS Nurse stated she had not attempted to complete the cognition section for Resident #53 on the MDS dated 10/3/19. The Administrator stated during an interview on 1/23/2020 at 3:53 PM, when the facility was down a key position, he expected another department head trained in the area of the MDS assessment to complete the cognition section. He also stated the MDS Nurse should have reviewed the entire assessment prior to submitting her signature that indicated the MDS was complete and accurate. The Administrator indicated the cognition of Resident #53 should have been assessed or an	F 636		

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F 636	Continued From page 13 attempt made to complete Section C of the MDS prior to transmission.	F 636		
F 642 SS=D	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete three (3) quarterly Minimum Data Set (MDS) assessments in the area of cognition, and one (1) quarterly MDS	F 642		

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assessment in the areas of cognition and mood before the assessments were submitted to the national data base for 4 of 8 residents (Resident #23, #53, #43 and #44) reviewed for resident assessments.

The findings included:

1. Resident #23 was readmitted to the facility on 11/17/17 with medical diagnoses inclusive of chronic obstructive pulmonary disease and unspecified dementia.

A review of Resident #23's quarterly Minimum Data Set (MDS) assessment dated 10/18/19 revealed Section C- Cognition had not been assessed. Further review revealed the MDS Nurse's signature indicated the quarterly assessment as completed and accurate. The quarterly assessment dated 10/18/19 was transmitted and accepted by the national data base.

On 1/23/2020 at 3:32 PM an interview was conducted with the Social Worker (SW). The SW reported she was employed by the facility in November 2019. The SW reported she was not responsible for completing the cognition section for Resident #23 on 10/18/19.

During an interview with the MDS Nurse on 1/23/2020 at 3:49 PM, she reported she was responsible for reviewing all MDS assessments for completion and accuracy. The MDS Nurse explained Section C was assigned to the facility's social worker and during a time frame in 2019, the facility was without a social worker. The MDS Nurse stated the cognition section was not completed nor assigned to another staff to

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conduct an assessment during this time. The MDS did not identify the time frame the facility was without a social worker. The MDS Nurse stated she had not attempted to complete the cognition section for Resident #23 on the MDS dated 10/18/19.

The Administrator stated during an interview on 1/23/2020 at 3:53 PM, "when the facility was down a key position, he expected another department head trained in the area of the MDS assessment to complete the cognition section. He also stated the MDS nurse should have reviewed the entire assessment prior to submitting her signature that indicated the MDS was complete and accurate. The Administrator indicated the cognition of Resident #23 should have been assessed or an attempt made to complete Section C of the MDS prior to transmission.

2. Resident #53 was readmitted to the facility on 2/89/17 with medical diagnoses inclusive of chronic respiratory failure and unspecified osteoarthritis.

A review of Resident #53's quarterly Minimum Data Set (MDS) assessment dated 11/22/19 revealed Section C- Cognition had not been assessed. Further review revealed the MDS Nurse's signature indicated the quarterly assessment was completed and accurate. The quarterly assessment dated 11/22/19 was transmitted and accepted by the national data base.

On 1/23/2020 at 3:32 PM an interview was conducted with the Social Worker (SW). The SW reported she was employed by the facility in

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November 2019. The SW reported she was not responsible for completing the cognition section for Resident #53 on 11/22/19.

During an interview with the MDS Nurse on 1/23/2020 at 3:49 PM, she reported she was responsible for reviewing all MDS assessments for completion and accuracy. The MDS Nurse explained Section C was assigned to the facility's social worker and during a time frame in 2019, the facility was without a social worker. The MDS Nurse stated the cognition section was not completed nor assigned to another staff to conduct an assessment during this time. The MDS did not identify the time frame the facility was without a social worker. The MDS Nurse stated she had not attempted to complete the cognition section for Resident #53 on the MDS dated 11/22/19.

The Administrator stated during an interview on 1/23/2020 at 3:53 PM, "when the facility was down a key position, he expected another department head trained in the area of the MDS assessment to complete the cognition section. He also stated the MDS nurse should have reviewed the entire assessment prior to submitting her signature that indicated the MDS was complete and accurate. The Administrator indicated the cognition of Resident #53 should have been assessed or an attempt made to complete Section C of the MDS prior to transmission.

3.Resident #43 was admitted to the facility on 4/29/2014. Her diagnoses included dementia without behavioral disturbance, dysphagia, and pain in left hip.

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Resident #43's quarterly Minimum Data Set (MDS) assessments dated 10/25/2019 and 11/12/2019 were reviewed. Both assessments revealed Section C- Cognition and Section D- Mood had not been assessed. Further review of both assessments revealed the MDS Nurse signed off on the assessments as being complete. Both assessments were transmitted and accepted by the national data base.

An interview was completed on 1/23/2020 at 3:32 PM with the Social Worker (SW). She stated she has been employed at the facility since November 2019. The SW verbalized during Resident #43's 10/25/2019 quarterly assessment, she was not employed at the facility. She continued to verbalize during Resident #43's 11/12/2019 quarterly assessment, she was in training at a different facility.

An interview was completed on 1/23/2020 at 3:49 PM with the MDS Nurse. She stated she reviewed the assessments for completion and accuracy. The MDS Nurse explained there was a vacant Social Work position and certain sections were not assessed. The MDS Nurse communicated she did not attempt to complete those sections and no other department manager was assigned those areas for completion and accuracy. The MDS Nurse reported she signed the MDS as complete and accurate.

An interview was completed on 1/23/2020 at 3:53 PM with the Administrator. He verbalized when the facility was down a key position, he would expect for another department, that can complete that section of the MDS, to pick up the slack. The Administrator expressed the MDS should be complete and accurate prior to transmission.

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F 642	Continued From page 18 4. Resident #44 was admitted to the facility on 06/01/17 with diagnoses which included dementia. Resident #44's quarterly Minimum Data Set (MDS) dated 11/7/19 did not contain documentation of a cognitive assessment. The MDS Nurse electronically signed and certified the MDS as complete. Observation of Resident #44 on 01/21/19 at 10:30 AM revealed Resident #44 wandered on the unit in a wheelchair. Resident #44 was not able to be interviewed due to confusion. Interview with the MDS Nurse on 01/23/20 at 3:49 PM revealed she reviewed the MDS and checked for completeness and accuracy. The facility's vacant social worker position caused the absence of a cognitive assessment The MDS Nurse reported she signed the MDS as complete.	F 642		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:	F 679		

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Based on observations, family member and staff interviews, and record review, the facility failed to provide an ongoing resident centered activities program based on identified resident's individual interests of music, religious gatherings, and group activities for 4 of 6 sampled cognitively impaired residents reviewed for activities (Resident #143, #77, #12 and #44).

Findings included:

1. Resident #143 admitted to the facility on 9/24/2019. Diagnoses were inclusive of dementia with behavioral disturbance.

Resident #143's admission Minimum Data Set (MDS) dated 9/30/2019 revealed she was severely cognitively impaired. Review of Section F (Preferences for Customary Routine and Activities) revealed Resident #143 preferred being in large groups, listening to music, and keeping up with the news. The Activity Care Area Assessment did not trigger.

Resident #143's Activity Progress assessment dated 12/24/2019 revealed she enjoyed bingo, socials, music, and religious activities. Resident #143 was coded as being passive with her participation level but attended activities out of her room daily.

Resident #143's Activity Participation record for December 2019 revealed she had not participated in 1:1 activity programming and participated in 2 group activity programs.

Resident #143's Activity Participation record for January 2020 revealed no participation in group activity programs.

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An observation was completed on 1/22/2020 at 10:57 AM of Resident #143. She was observed sitting in her geri-chair in the common area on her unit. The television was observed playing. Resident #143 had her eyes closed.

An observation was completed on 1/22/2020 of the 2:00 PM Gospel Music activity. Resident #143 was not in attendance. She was observed in her geri-chair sitting in the hallway in front of the courtyard doors away from the activity area. Resident #143 had her eyes closed.

An interview was completed with Nurse Aide (NA) #5 on 1/23/2020 at 9:31 AM. The NA verbalized Resident #143 required total care and was up to her geri-chair daily. The NA was not aware of any specific activities provided to Resident #143.

An interview was completed on 1/23/2020 at 9:38 AM with the Activities Director (AD). She stated she has been at the facility since July of 2019. The AD explained she was responsible for completing the activity assessments. She explained for residents with dementia she focused on their senses- feeling, hearing, touching, smelling, and conversing (if able). She expressed Resident #143 often looked for her family. She enjoyed being around people and that assisted her with being calm and relaxed. The AD explained she trialed bingo with Resident #143 and let her call out the numbers which worked for a while. The AD verbalized she did not trial any other interests with Resident #143. She also indicated Resident #143 was not invited to the afternoon music programming.

A telephone interview was completed with

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Resident #143's family on 1/23/2020 at 11:52 AM. The family stated, "Mother has always been very personable. She would enjoy being around others and not just left in her room". Family expressed it would be nice if Resident #143 were in activities. Family verbalized Resident #143 enjoyed music, socials, and being around others. Resident #143's family further expressed she may not be able to verbalize all her wants at this time, but staff could attempt some social interaction.

An interview was completed with the Administrator on 1/23/2020 at 5:15 PM who communicated activity programming should be developed around the needs and interests of the residents, including those residents with cognitive impairment.

2. Resident #77 was admitted to the facility on 06/12/19 with diagnoses which included Alzheimer's Disease.

Resident #77's admission Minimum Data Set (MDS) dated 06/19/19 revealed an assessment of severely impaired cognition. The MDS indicated it was very important to Resident #77 to listen to music and participate in religious services or practices. The Activity Care Area Assessment did not trigger.

Resident #77's quarterly activity progress note dated 12/19/19 indicated Resident #77 enjoyed music and special events and individual pursuits of television viewing and family visits.

Resident #77's most recent quarterly MDS dated 01/02/20 documented an assessment of severely impaired cognition.

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Resident #77's care plan dated 01/15/20 indicated Resident #77 liked to be with others socially and feel connected to people. Family and other visits were to be encouraged.

Observation on 01/21/20 at 11:38 AM revealed Resident #77 seated in a wheelchair in the doorway to her room. Resident #77 smiled and responded to her name. Resident #77 self-propelled in and out of the room.

Observation on 01/21/20 at 12:13 PM revealed Resident #77 repeatedly took on and off her eyeglasses until the lunch meal delivered to her at 12:20 PM.

Observation on 01/21/20 at 3:21 PM revealed Resident #77 seated in a wheelchair in the doorway to her room. Resident #77 rolled the wheelchair back and forth with both legs.

Observation on 01/22/20 at 11:13 AM revealed Resident #77 opening and closing her room door independently while seated in a wheelchair.

Observation on 01/22/20 at 2:31 PM revealed Resident #77 opened and closed dresser drawers in her room.

Observation on 01/23/20 at 9:28 AM revealed Resident #77 independently self-propelled up and down the hallway.

Interview on 01/23/20 at 11:07 AM with Nurse Aide (NA) #3 revealed Resident #77's usual routine consisted of self-propelling on the nursing unit. NA# 3 explained Resident #77 appeared to enjoy going in and out of her room.

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During an interview with Nurse #3 on 01/23/20, Nurse #3 reported Resident #77 wandered on the unit in the wheelchair when awake.

Telephone interview with Resident #77's family member on 01/24/20 at 9:09 AM revealed Resident #77 did not like to be alone. Resident #77's family member explained Resident #77 loved music, especially singing gospel, and exercises.

An interview was conducted on 01/24/20 at 9:16 AM with the Activity Assistant. The Activity Assistant reported the Activity Director was not available for interview. The Activity Assistant explained Resident #77 did not have an on-going activity program but did receive in room visits. The Activity Assistant reported Resident #77 did not receive invitations to group music activities or access to music in her room. The Activity Assistant confirmed Resident #77 did not receive an invitation to the gospel music activity held on 01/22/20 at 2:00 PM in the facility.

Interview with the Administrator on 01/24/20 at 9:34 AM revealed staff should provide Resident #77 with an ongoing activity program specific to her interests and cognition.

3. Resident #12 was admitted to the facility on 03/27/19 with diagnoses which included dementia.

Resident #12's admission Minimum Data Set (MDS) dated 04/03/19 revealed an assessment of severely impaired cognition. The MDS indicated it was very important to Resident #12 to listen to music, keep up with the news, and be

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F 679	Continued From page 24 around pets. The Activity Care Area Assessment did not trigger. Resident #12's care plan revised on 10/28/19 listed interventions to include visits by the activity staff weekly to offer or exchange books. Resident #12's most recent quarterly MDS dated 01/13/20 documented an assessment of severely impaired cognition. Observation on 01/21/20 at 9:57 AM and 11:47 AM revealed Resident #12 seated in a wheelchair asleep at table in the dining area. At 3:15 PM on 01/21/20, Resident #12 was asleep in his bed. Observation on 01/22/20 at 9:31 AM revealed Resident #12 seated in a wheelchair at a table in the dining area. Resident #12 was alert and smiled when greeted with his name. Observation at 01/22/20 at 9:44 AM and 11:11 AM revealed Resident #12 seated in a wheelchair with clasped hands. Resident #12 watched staff members and did not initiate conversation. Interview with Nurse Aide (NA) #3 on 01/23/20 at 11:12 AM revealed Resident #12's usual routine was to sit in the wheelchair until after the lunch meal. NA #3 reported resident #12 returned to bed in the afternoon until the supper meal. NA #3 was not aware of any activities provided to Resident #12. During an interview with Nurse #3 on 01/23/20 at 11:51 AM, Nurse #3 reported Resident #12 remained seated in the wheelchair at the same table until after lunch. Nurse #3 explained Resident #12 was confused and did not	F 679		

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participate in activities.

Interview with the Activity Assistant on 01/24/20 at 9:22 AM revealed the facility's Activity Director was not available for interview. The Activity Assistant reported Resident #12 would refuse offers of group activities. The Activity Assistant reported there was no individualized activity program or plan for Resident #12.

Interview with the Administrator on 01/24/20 at 9:34 AM revealed staff should provide Resident #12 with an ongoing activity program specific to his interests and cognition.

4. Resident #44 was admitted to the facility on 06/01/17 with diagnoses which included dementia.

Resident #44's annual Minimum Data Set (MDS) dated 05/17/19 revealed an assessment of moderately impaired cognition. The MDS indicated it was very important to Resident #44 to do things with large groups of people and favorite activities. The MDS indicated it was somewhat important to Resident #44 to listen to music, have books and magazines to read and listen to music. The Activity Care Area Assessment did not trigger.

Resident #44's cognition was not assessed on the most recent quarterly MDS dated 11/07/19.

Resident #44's care plan revised 11/18/19 documented Resident #44 attended activities outside the room but required daily reminders.

Resident #44's activity progress note dated 01/13/20 documented Resident #44 attended

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activities out of the room daily and enjoyed talking to peers and staff.

Observation on 01/21/20 at 10:31 AM revealed Resident #44 self -propelled in a wheelchair on the nursing unit. Resident #44 repeatedly asked, "I do not know what I am doing. Can you help?"

Observation on 01/21/20 at 3:17 PM revealed Resident #44 seated in a wheelchair at a table in the dining area. Resident #44 appeared worried and asked Nurse #3 to help her find out what to do. Nurse #3 gently reassured Resident #44 and Resident #44 smiled.

Observation on 01/22/20 at 9:46 AM revealed Resident #44 self-propelled in a wheelchair in a circular route in the dining and activity area on the nursing unit.

Observation on 01/22/20 at 2:26 PM revealed Resident #44 seated in a wheelchair holding a rolled towel under the left arm. Resident #44 stated she felt fine but did not know what to do. Resident #44 stroked the rolled towel.

Observation on 01/23/20 at 11:04 AM revealed Resident #44 announced a desire to go home since company had arrived. Resident #44 self-propelled in a wheelchair in a circular route in the dining and activity area.

Interview with Nurse Aide (NA) #3 on 01/23/20 revealed Resident #44's daily routine consisted of meals in the dining area and self-propelling in a wheelchair on the nursing unit.

Interview with Nurse #3 on 01/23/20 revealed Resident #44 used to have artificial flowers to

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rearrange which kept her occupied. Nurse #3 reported the flowers and vase were no longer in Resident #44's room. Nurse #3 explained Resident #44 spent her waking hours up in a wheelchair.

Interview with the Activity Assistant on 01/24/20 at 9:28 AM revealed the Activity Director was not available for interview. The Activity Assistant reported Resident #44 went to the beauty shop weekly and attended group activities. The Activity Assistant reported Resident #44 did not remain long at group activities due to a short attention span and confusion. The Activity Assistant reported no other activities were provided to Resident #44.

Interview with the Administrator on 01/24/20 at 9:34 AM revealed staff should provide Resident #12 with an ongoing activity program specific to his interests and cognition.

F 697 SS=G

Pain Management
CFR(s): 483.25(k)

§483.25(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, resident interviews, staff interviews and nurse practitioner interview, the facility failed to respond to a resident's complaint of pain for 1 of 3 sampled residents reviewed for pain management (Resident #26).

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The findings included:

Resident #26 was readmitted to the facility on 10/15/19 with medical diagnoses inclusive of type 2 diabetes mellitus with diabetic neuropathy and malignant neoplasm of spinal cord.

Resident #26's significant change Minimum Data Set (MDS) dated 10/21/19 specified the resident's cognition was intact, she had clear speech and could make her needs understood and understood others. The MDS also specified the resident received as needed pain medication for pain.

Resident #26's care plan updated with the significant change MDS identified a focus area for potential pain, acute/chronic pain related to thoracic spine. The identified goal noted resident will voice a level of minimal pain daily through next review date.

A review of Resident #26's physician's orders revealed the following orders for pain: 1/9/2020 Menthol (topical analgesic) gel 5 % to apply to left shoulder topically every 6 hours as needed for pain, 10/15/19 Oxycodone hydrochloride(narcotic) 5 milligrams (mg) every 4 hours as needed for pain, 12/4/19 Meloxicam (nonsteriodal anti-inflammatory) 7. 5mg in the morning for arthritis, and 9/15/19 Tylenol 325mg (2 tablets) two times a day for pain.

An observation was made on 1/21/2020 at 12:23 PM of Resident #26 lying on her back in bed. During the interview, she reported experiencing pain and she had informed a nurse aide of the need for pain medication. Resident #26 stated

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her pain was located in her back. She rated the pain as a seven on a scale of 1 to 10 with 10 being the worse.

On 1/21/2020 at 12:40 PM, Resident #26 reported the pain had increased "a little" and no one came to administer pain medication. Again, she rated the pain as seven. Resident #26 also stated, "the nurses take their time giving pain medicine."

On 1/21/2020 at 1:02 PM. Resident #26 was observed sitting up in bed with the head of the bed raised and not able to raise her arm to eat the lunch meal placed on the bedside table over her lap. Resident #26 stated the pain in her back was so that she was not able to feed herself. Resident #26 displayed facial grimacing during this observation. Resident #26 reported she had not received pain medication requested and was unable to eat due to discomfort in her back. Resident #26 stated she informed "everyone" that came into the room to "let the nurse know (she) needed something for pain."

During an interview with Nurse Aide (NA) #1 on 1/21/2020 at 3:02 PM, she reported Resident #26 had requested pain medication twice during the day shift (7:00 AM - 3:00 PM). NA#1 stated Resident #26 was reassigned to her after mid-morning when another nurse aide was no longer needed on the hall. NA#1 stated Resident #26 had requested pain medication during lunch. NA#1 stated she forgot to inform the nurse at this time. NA #1 reported the second time Resident #26 requested pain medication was prior to the end of the day shift (7:00 AM - 3:00 PM) and before she left the facility for an appointment at the change of shift from day to evening shift (3:00

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F 697	Continued From page 30 PM). NA #1 stated Nurse #1 was informed of Resident #26's request for pain medication and Nurse #1 walked past and stated, "okay." A review of Resident #26's medication administration (MAR) indicated Resident #26 received scheduled Meloxicam 7. 5mg and Tylenol 325mg (2 tablets) on the morning of 1/21/2020. Nurse #1 administered the medication to Resident #26. On 1/21/2020 at 3:34 PM, an interview was conducted with Nurse #1. During the interview, Nurse #1 stated a nurse aide had not informed her of Resident #26's request for pain medication during the day shift or prior to Resident #26 leaving the facility for an orthopedic appointment. Nurse #1 reported she administered scheduled morning medication to Resident #26. Nurse #1 stated Resident #26 did not report pain during this time. The Director of Nursing (DON) was interviewed on 1/21/2020 at 4:48 PM. During the interview, the DON reviewed Resident #26's as needed orders for pain. The DON stated nurses should assess every resident for pain due to the population in the facility. She also stated a pain assessment should take place at minimum every shift. The DON expressed her expectation for nurse aides to report to the nurses the name of residents who report pain and request pain medication. The DON suggested a task on the medication administration record (MAR) should prompt nurses to complete a pain assessment every shift. The DON acknowledged Resident #26's MAR did not include a task for pain assessment.	F 697		

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On 1/21/20 at 05:09 PM, after returning from an orthopedic appointment to evaluate her pain, Resident #26 reported she did not receive pain medication before she left the facility. She reported she had a cortisone shot during the appointment that has helped to relieve her pain.

Review of an orthopedic consultation note dated 01/21/2020 revealed Resident #26 was seen for follow up of her extremely arthritic left shoulder. It was noted she recently had surgery on her back to remove a tumor in her spinal cord based on computerized tomography (CT) scan findings at her last visit. Resident #26 reported she had been in significant pain in her left arm. On examination revealed pseudo paralysis of her left arm. Resident #26 received an injection of cortisone (steroid hormone) and a local anesthetic agent. The consultation note recommended a follow up in 4 to 5 months.

During an interview with the Nurse Practitioner (NP) on 1/24/2020 at 11:38 AM, she stated Resident #26 has "pain a lot of the time." The NP also stated a report of pain should be a priority for the nursing staff. The NP reported the indication of a pain assessment was a task initiated by the facility.

F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

§483.45(g) Labeling of Drugs and Biologicals
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

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§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observations, manufacturer's recommendation, record review, and staff interview, the facility failed to discard an expired insulin vial in 1 of 4 medication carts (200 hall cart) and failed to date two (2) insulin vials observed on the medication cart that were available for resident use in 1 of 4 medication carts (200 hall cart). Additionally, the facility failed to properly store an insulin injection pen that was unopened and not dated in 1 of 4 medication carts (300 hall cart) and failed to label and date a vial of Lidocaine that was available for resident use in 1 of 4 medication carts (300 hall cart).

Findings included:

Manufacturer's guideline for Toujeo Solostar pens read in part:

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Unopened Toujeo SoloSTAR® pens must be kept refrigerated.

Facility policy titled "Insulin Storage" (no date) read in part:
All insulin products will be refrigerated prior to first use.

A. An observation was made of the 200 hall medication cart on 1/24/2020 at 9:33 AM which revealed a vial of Levemir (an insulin used to treat diabetes) with an open date of 11/22/2019. Further observation of the 200 hall medication cart revealed two (2) vials of Humulin 70/30 (an insulin used to treat diabetes) which had no open date.

An interview was completed on 1/24/2020 at 9:46 AM with Nurse #4 who explained third shift was responsible for checking the medication carts for expired medications, as well as, making sure medications were properly labeled. Nurse #4 verbalized she did not check the medication cart this morning prior to starting her shift. The expired Levemir had not been used, as another vial was observed on the medication cart within expiration date. She explained her normal practice was to complete a quick check of the medication cart to ensure medications were in place prior to starting her medication administration pass. Nurse #4 indicated she would dispose of the medication and reorder the medication from pharmacy.

B. An observation was made of the 300 hall medication cart on 1/24/2020 at 9:51 AM which revealed an unopened Toujeo Solostar pen. The pen had a blue sticker affixed to the barrel which read- refrigerate until opened. Further

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F 761	Continued From page 34 observation revealed one (1) vial of Lidocaine Hcl (local anesthetic that works by causing temporary numbness/loss of feeling in the skin and mucous membranes) solution which had no open date or resident name. An interview was completed on 1/24/2020 at 10:00 AM with Nurse #3 who explained she did a quick check of the medication cart prior to medication administration for anything out of the norm. Nurse #3 verbalized the Lidocaine should have been labeled and dated for the specific resident and the insulin pen should have been refrigerated until use tonight. Nurse #3 indicated she would dispose of the medications. An interview was completed with the Director of Nursing (DON) on 1/24/2020 at 10:08 AM. She stated insulin should be refrigerated until needed and once removed from refrigeration, the insulin should be properly labeled with open date and expiration date. Night nurses should be completing their weekly checks on the night shift. The DON continued to explain nurses should also check their carts prior to starting their shifts. The pharmacist comes in monthly and completed random cart audits for expiration/ storage. The last audit was completed in January 2020. Any medication pulled from the e-kit (emergency kit) should be labeled and dated once opened. If the medication was pulled for a specific resident, the residents name should be on the medication. The DON verbalized she did not have an audit in place from the nightly medication cart checks.	F 761		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink	F 805		

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Continued From page 35
Each resident receives and the facility provides-

§483.60(d)(3) Food prepared in a form designed to meet individual needs.
This REQUIREMENT is not met as evidenced by:
Based on an observation, resident interview, family interview, staff interviews and review of the medical record, the facility failed to provide 1 of 2 sampled residents at high risk of aspiration due to a history of aspiration pneumonia (Resident #75) with a vegetable juice thickened to nectar consistency, as recommended by speech therapy.

The findings included:

Resident #75 was re-admitted to the facility 11/21/19 after a hospitalization for aspiration pneumonia.

Diagnoses included cerebrovascular accident with dysphagia, among others.

An annual Minimum Data Set assessment and Care Area Assessment, both dated 11/27/19 documented that Resident #75 was assessed with intact cognition, clear speech, understood/understands, and required the assistance of a staff person with meals.

Review of speech therapy (ST) progress notes dated 01/2/20 revealed a recommendation for Resident #75 to receive nectar thickened liquids (NTL) and to be positioned at 90 degrees during oral intake and for 20 minutes after oral intake due to his history of aspiration pneumonia and continued high risk of silent aspiration. The ST recommendation for Resident #75 was

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transcribed to a diet order.

A care plan and Resident Care Guide last revised 1/22/20 documented that Resident #75 required NTL as the safest consistency of fluids tolerated due to his diagnoses of dysphagia, history of aspiration and non-compliance. The goal included no signs/symptoms of aspiration. Interventions included for nursing staff to provide the recommended fluid consistency and to encourage Resident #75 to adhere to and consume NTL to meet his fluid needs.

On 01/21/20 at 12:56 PM Resident #75 was observed in his room in bed with his lunch tray while a family member assisted him with his lunch meal. Review of his meal tray card revealed a diet order for NTL. The tray card recorded Resident #75 would receive 6 ounces of a vegetable juice which had not yet been provided. An interview with Resident #75 and his family revealed that they could not recall the last time Resident #75 received vegetable juice thickened to a nectar consistency, but that the juice was often received "just as is, right out of the can."

Nurse Aide #6 (NA #6) was observed to enter Resident #75's room on 01/21/20 at 1:00 PM and asked the Resident if he needed anything. Resident #75 requested 2 cups of vegetable juice. NA #6 was observed to pour the vegetable juice into a cup for Resident #75 from a pitcher, returned at 1:03 PM with the vegetable juice, placed the cup of vegetable juice on Resident #75's lunch tray, but the juice was not thickened to a nectar consistency. Nurse #4 was observed to enter the room of Resident #75 at 1:05 PM and asked Resident #75 if everything was okay and encouraged him to eat his lunch meal.

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An interview occurred on 01/22/20 at 12:45 PM with NA #6. The interview revealed that all of Resident #75's fluids came on his meal tray from the kitchen except the vegetable juice which was kept in the refrigerator in the dining room on the unit. NA #6 said when Resident #75 asked him for vegetable juice at lunch on "yesterday" (01/21/20), "I poured it right out of the pitcher because I did not know it was supposed to be thickened." NA #6 said he should have reviewed Resident #75's meal tray card prior to providing him with the vegetable juice.

An interview with Nurse #4 occurred on 01/22/20 at 2:56 PM. Nurse #4 stated Resident #75 was non-compliant with his diet order because he did not like the NTL consistency, but staff were trained to encourage compliance. Nurse #4 further stated that she did not notice that his vegetable juice was not thickened when she came into his room on 01/21/20 during the lunch meal. She stated that "He usually drinks it that way without problems."

On 01/21/20 at 6:08 PM, the Director of Nursing (DON) stated in interview that nursing staff were trained to review tray cards and compare the tray card to the items each resident received on their meal tray. She stated that nursing staff should provide each resident with food items per their diet order. The DON further stated that Resident #75 had a diet order for NTL and that the vegetable juice he received was a thin liquid that should be thickened to a nectar consistency per his diet order.

An interview with the ST occurred on 01/22/20 at 04:51 PM. The ST stated that Resident #75 still

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required liquids thickened to a nectar consistency for safe swallowing due to his history of aspiration. The ST stated that if Resident #75 drank any fluids by mouth, the fluid should be thickened to a nectar consistency. The ST also stated that if the beverage was not available pre-thickened then nursing staff should follow instructions on the label for thickening. The ST further stated that the vegetable juice the facility provided was a thin liquid and should be thickened according to the instructions on the label to a nectar consistency for Resident #75.

During an interview on 01/23/20 at 1:49 PM, the Nurse Practitioner (NP) stated that due to a recent ST evaluation, Resident #75 required NTL due to dysphagia he developed after a massive stroke he had about 2 years ago. The NP further stated that despite Resident #75's non-compliance with his diet and thickened liquids, nursing staff should still provide him liquids per his diet order and encourage his compliance.

F 806 SS=D — F 806

Resident Allergies, Preferences, Substitutes
CFR(s): 483.60(d)(4)(5)

§483.60(d) Food and drink
Each resident receives and the facility provides-

§483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;

§483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;
This REQUIREMENT is not met as evidenced by:

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Based on observations, interviews with residents and staff and medical record review the facility failed to provide 3 of 11 sampled residents with their food preferences. Resident #75 did not receive peanut butter and jelly sandwiches or a vegetable juice, Resident #80 did not receive fruit for dessert and Resident #31 did not receive sliced turkey without gravy and cranberry sauce per their preferences.

The findings included:

1 A. Resident #75 was re-admitted to the facility on 11/21/19. Diagnoses included cerebrovascular accident with dysphagia, and diabetes mellitus type 2, among others.

An annual Minimum Data Set assessment and Care Area Assessment, both dated 11/27/19 documented that Resident #75 was assessed with intact cognition, clear speech, understood/understands, and required the assistance of a staff person with meals.

A care plan last revised 1/22/20 documented that Resident #75 was at risk for fluid volume deficit and at nutritional risk for weight loss due to non-compliance with his diet order and dysphagia. Interventions included for nursing staff to assess for and provide food preferences and encourage compliance with diet order.

Resident #75 was observed during two meals on 01/21/20. One observation occurred at 12:56 PM for the lunch meal and the second observation occurred at 5:57 PM for the supper meal. The meal tray card for each meal documented Resident #75 would receive a peanut butter and jelly sandwich and 6 ounces of a nectar thickened

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F 806	Continued From page 40 (NT) vegetable juice. At lunch and supper, Resident #75 did not receive the peanut butter and jelly sandwich and at supper Resident #75 did not receive or the NT vegetable juice. Resident #75 stated in interviews with each observation that he often did not receive the sandwich or juice as he had requested. He further stated that he always asked for 2 servings of juice, but often only received 1 serving. On 01/21/20 at 01:00 PM Resident #75 was observed to request 2 servings of vegetable juice during his lunch meal, but only received one serving. An interview with Nurse Aide #7 (NA #7) on 01/21/20 at 6:11 PM revealed she was trained to look at the meal tray cards and make sure each resident had all food items according to their diet order/preference. NA #7 also stated that if anything was missing she was trained to go and get the item for the resident. She further stated that it was an oversight that Resident #75 did not get the peanut butter and jelly sandwich or the vegetable juice with his supper meal. Nurse Aide #8 (NA #8) was interviewed on 01/21/20 at 06:19 PM and stated she was trained to review meal tray cards and to compare it to what the resident received on their meal tray. NA #8 further stated that she forgot to look at the meal tray card for Resident #75 and was not aware that he was supposed to receive a peanut butter and jelly sandwich or a vegetable juice with his supper meal. Dietary aide #1 (DA #1) stated in an interview on 01/21/20 at 06:45 PM that she plated the supper	F 806		

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F 806	Continued From page 41 meal for Resident #75 for the past week and prepared a peanut butter and jelly sandwich for him about 3 times, because he asked for it. DA #1 stated she had not reviewed his diet order and did not know that he requested to receive a peanut butter and jelly sandwich with each meal. Nurse Aide #6 (NA #6) stated in an interview on 01/22/20 at 12:45 PM that he saw Resident #75 receive a peanut butter and jelly sandwich with meals at times, but not at all meals. NA #6 further stated that Resident #75 always asked for 2 glasses of the vegetable juice, but that he did not always provide Resident #75 with 2 glasses of vegetable juice because he wanted Resident #75 to eat more of his food. An interview with Nurse #4 occurred on 01/22/20 at 2:56 PM. Nurse #4 stated that she did recall times when Resident #75 did not receive a peanut butter and jelly sandwich because it was not available. On 01/21/20 at 6:08 PM, the Director of Nursing stated in interview that nursing staff were trained to review tray cards and compare the tray card to the items each resident received on their meal tray. She stated that nursing staff should provide each resident with food items per their diet order/preference. The Assistant Dietary Manager stated in an interview on 01/22/20 at 3:23 PM that dietary aides were responsible to review meal tray cards and to provide each resident with the food items per their diet order and food preferences. 1 B. Resident #31 was admitted to the facility on 9/18/19.	F 806		

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Diagnoses included end stage renal disease requiring hemodialysis, hypertension, hyperlipidemia, diabetes mellitus type 2, obesity and recurrent major depressive disorder, among others.

An admission Minimum Data Set assessment and Care Area Assessment, both dated 9/25/19, assessed Resident #31 with moderately intact cognition, adequate hearing/vision, usually understood/understands, clear speech, and required limited staff assistance of one person with meals.

A September 2019 care plan identified Resident #31 at nutritional risk due to diagnoses of obesity, end stage renal disease requiring hemodialysis, diabetes mellitus, type 2 and non-compliance with fluid restrictions. Care plan goals and interventions included to follow the diet as ordered and provide food preferences. Review of the diet order revealed Resident #31 received a regular diet.

Resident #31 was observed during the supper meal on 01/21/20 at 5:15 PM. During the meal observation, Resident #31 received roasted turkey with gravy. Review of her meal tray card revealed she requested roasted turkey with no gravy and cranberry sauce. When Resident #31 received her supper meal, she declined her meal and requested turkey without gravy with cranberry sauce. DA #1 was observed to inform Resident #31 that she saw the Resident's request for turkey without gravy and cranberry sauce, but because the cranberry sauce was not available, she just plated her meal according to the menu. Resident #31 asked what else was available and

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accepted the offer of a turkey wrap instead.

Resident #31 stated in an interview on 01/21/20 at 5:40 PM that she requested a renal diet, but after talking to the consultant Registered Dietitian (RD), they agreed on regular diet that Resident #31 would modify her diet per her request. Resident #31 continued in interview to state that she often did not receive foods per her preference, especially on the days she returned from dialysis. Staff would tell her the food item she wanted had run out or just was not available and then offer her a turkey sandwich or a salad. Resident #31 further stated she was tired of always eating a turkey sandwich or a salad.

An interview with Dietary Aide #1 (DA #1) occurred on 01/21/20 at 6:45 PM. DA #1 stated that for the past week, she plated the supper meal for Resident #31 and was not able to provide her with all her food preferences because they were not available. DA #1 further stated that at the supper meal that evening (01/21/20), she saw the Residen's written request for roasted turkey without gravy and cranberry sauce on the meal tray card, but because the cranberry sauce was not available, she just plated the Resident what was on the menu. The DA #1 further stated that when she told Resident #31 that the cranberry sauce was not available and asked her what she wanted, the Resident accepted the turkey wrap.

The Assistant Dietary Manager (ADM) stated in an interview on 01/22/20 at 3:23 PM that dietary staff were responsible to review meal tray cards and to provide each resident with foods per their preference. The ADM also stated that Resident #31 often requested her foods without gravy and

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cranberry sauce, but because the cranberry sauce was only ordered at Thanksgiving, it was not provided to her. The ADM further stated that Resident #31 should receive her foods without gravy and that the cranberry sauce could be purchased or prepared and provided to Resident #31 when requested.

During an interview on 01/22/20 at 5:57 PM, the RD stated that she had spoken to Resident #31 several times and that the resident mentioned to her that for the last few weeks she did not receive foods per her preference. The RD further stated that Resident #31 requested a renal diet but after discussion with the Resident they agreed on a regular diet that Resident #31 would modify with written requests for her preferences. The RD also stated that when Resident #31 told her several weeks ago that her food preferences were not being honored, she referred the Resident to the certified dietary manager (CDM) to resolve this, but the problem had not been resolved because the facility just hired a new CDM in the last 2 weeks.

1C. Resident #80 was admitted to the facility 12/26/19.

Diagnoses included congestive heart failure, diabetes mellitus type 2, hypertension, chronic kidney disease stage 2, and chronic respiratory failure, among others.

Review of the admission Minimum Data Set assessment and Care Area Assessment, both dated 1/8/20 assessed Resident #80 with adequate hearing/vision, clear speech, able to be understood/understand, intact cognition, and required limited staff assistance of one staff

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person with meals.

A care plan, revised 1/23/20, documented Resident #80 was at risk for complications of high/low blood sugars due to her diagnosis of diabetes mellitus type 2 with goals and interventions to honor her dietary order and preferences.

Resident #80 was observed on 01/21/20 at 5:54 PM to receive her supper meal with set up of her tray completed by Nurse Aide #7 (NA #7). The meal tray card recorded Resident #80 should receive "fruit only" for dessert. The supper meal tray for Resident #80 included ice cream for dessert, but no fruit. The Resident's overbed table included a cup of pudding. Resident #80 said she received the pudding for dessert with her lunch meal that day instead of fruit. Resident #80 further stated that she often received desserts other than fruit and had to repeatedly request fruit for dessert to get it. Resident #80 also stated that she preferred fruit for dessert with each meal because she was a diabetic, but at times she was told by staff that fruit was not available.

An observation of the supper meal tray line occurred on 01/2120 at 6:00 PM and revealed orange slices and grapes were available on the supper meal tray line.

NA #7 was interviewed on 01/21/20 at 6:11 PM. During the interview, NA #7 stated that she was trained to look at the meal tray cards and make sure residents received all the foods that were recorded on the meal tray card. The NA further stated that if something was missing, she was trained to tell the dietary staff or to go get the missing item. NA #7 further stated that she did

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not look at the meal tray card for Resident #80 when she set up her supper meal tray that evening which was why she did not realize the Resident preferred fruit for dessert.

An interview with Dietary Aide #1 (DA #1) occurred on 01/21/20 at 6:45 PM. DA #1 stated that for the past week, she plated the supper meal for Resident #80, but that she did not know Resident #80 was supposed to get fruit for dessert, so she gave her dessert according to the menu. DA #1 also stated that had she known Resident #80 wanted fruit, she would have given her the orange slices and grapes that were available as dessert that evening instead of the ice cream.

On 01/21/20 at 6:08 PM, the Director of Nursing stated in interview that nursing staff were trained to review tray cards and compare the tray card to the items each resident received on their meal tray. She stated that nursing staff should provide each resident with food items per their diet order/preference.

The Assistant Dietary Manager stated in an interview on 01/22/20 at 3:23 PM that dietary aides were responsible to review meal tray cards and to provide each resident with the food items per their diet order and food preferences.

The consultant Registered Dietician (RD) was interviewed on 01/22/20 at 5:54 PM and stated that Resident #80 requested to receive fruit only for dessert due to her diagnosis of diabetes mellitus type 2. The RD stated this request was added to her diet order and that she expected Resident #80 to receive fruit only for dessert per her preference.

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F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with a resident and staff and medical record review the facility failed to provide 1 of 2 sampled residents (Resident #75) with a divided plate for meals as recommended by occupational therapy. The findings included: Resident #75 was re-admitted to the facility on 11/21/19. Diagnoses included cerebrovascular accident with dysphagia, weight loss and diabetes mellitus type 2, among others. An annual Minimum Data Set assessment and Care Area Assessment, both dated 11/27/19 documented that Resident #75 was assessed with intact cognition, clear speech, understood/understands, and required the physical assistance of a staff person with meals. Review of January 2020 occupational therapy (OT) progress notes, revealed a recommendation for a divided plate to increase the percentage of food intake and independence with meals. This recommendation was written as a diet order and recorded as adaptive equipment on the meal tray card. A care plan last revised 1/22/20 documented that	F 810		

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Resident #75 was at risk nutritional risk for weight loss due to limited range of motion. Interventions included for nursing staff to assess for, provide and encourage compliance with the diet order.

Resident #75 was observed during two meals on 01/21/20. One observation occurred at 12:56 PM for the lunch meal and the second observation occurred at 5:57 PM for the supper meal. The meal tray card for each meal documented Resident #75 would receive a divided plate as adaptive equipment. During both observations Resident #75 did not receive his foods on a divided plate. For the lunch meal, Resident #75 was assisted with his meal by a family member and ate 75% of his meal. For the supper meal, Resident #75 attempted to feed himself with some staff supervision and ate 25% of his meal. Resident #75 stated that he used to receive his foods on a divided plate, but for "the last couple of weeks or so" he had not. He continued to express that he felt the divided plate helped him feed himself when he received it.

An interview with Nurse Aide #7 (NA #7) on 01/21/20 at 6:11 PM revealed she was trained to look at the meal tray cards and make sure each resident had all items according to their diet order. NA #7 also stated that if anything was missing she was trained to go and get the item for the resident. She further stated that it was an oversight that Resident #75 did not get the divided plate, she did not see that recorded on the meal tray card.

Nurse Aide #8 (NA #8) was interviewed on 01/21/20 at 06:19 PM and stated she was trained to review meal tray cards and to compare it to what the resident received on their meal tray. NA

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#8 further stated that she forgot to look at the meal tray card for Resident #75 and was not aware that he was supposed to receive his foods on a divided plate.

Dietary staff #1 (DS #1) stated in an interview on 01/21/20 at 06:45 PM that she plated the supper meal for Resident #75 for the past week, but did not review his meal tray card so she did not know he was supposed to receive his foods on a divided plate.

Nurse Aide #6 (NA #6) stated in an interview on 01/22/20 at 12:45 PM that he did not know Resident #75 was supposed to receive his foods on a divided plate, but that he should have read the diet order on his meal tray card.

An interview with Nurse #4 occurred on 01/22/20 at 2:56 PM. Nurse #4 stated that she had not observed Resident #75 receive foods on a divided plate and did not know he was supposed to have adaptive equipment with his meals.

On 01/21/20 at 6:08 PM, the Director of Nursing stated in interview that nursing staff were trained to review tray cards and compare the tray card to the items each resident received on their meal tray. She stated that nursing staff should provide each resident with all items per their diet order.

The Assistant Dietary Manager stated in an interview on 01/22/20 at 3:23 PM that dietary staff were responsible to review meal tray cards and to provide each resident with the food items per their diet order.

The Occupational Therapist (OT) was interviewed on 01/23/20 at 10:44 AM. The OT stated that on

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F 810	Continued From page 50 re-admission, Resident #75 had poor strength and endurance which presented him with difficulty getting his food on his spoon/fork. She stated he routinely ate 25 - 50% of meals during this time and despite encouragement he refused to allow staff to feed him. The OT further stated that during the OT evaluation/treatment, he demonstrated increased food intake with the divided plate which encouraged independence with meals and improved food intake. She also stated that since he refused staff assistance with meals most of the time, he would benefit from having the divided plate.	F 810		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the annual recertification survey of 01/10/19. This was for one recited deficiency that was originally cited in January 2019 and subsequently recited on the current recertification. The recited deficiency was in the area of self -determination. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.	F 867		

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Findings included:

This tag is cross referenced to:
F 561: Self Determination: Based on observation, family member and staff interviews, and record review, the facility failed to give a choice of time to be awakened for 1 of 5 residents observed during a morning medication pass (Resident #90).

During the recertification survey of 01/10/19 the facility was cited at F 561 for failing to allow a choice of the time to awaken in the morning for 1 of 2 sampled residents (Resident #79).

During an interview with the Administrator on 01/24/20 at 02:05 PM, he stated the facility was not aware the responsible responsible party for Resident #90 preferred the resident not be awakened to give medication. The Administrator also indicated there did not appear to be the same circumstances for two years.