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BRIAN CENTER HEALTH & REHAB/HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 An unannounced Recertification survey was conducted on 12/05/21 through 12/09/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #VOSV11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation were conducted from 12/05/21 through 12/09/21. 5 of the 19 allegations were substantiated. Event ID #VOSV11.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		1/17/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 01/06/2022

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

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to treat a resident (Resident #27) with respect when a staff member responded to the resident calling out, but failed to provide the resident time to voice her needs prior to exiting the room for 1 of 3 residents sampled for dignity. Findings included: Resident #27 was admitted to the facility on 10/1/2021 with diagnoses that included depression, cerebral infarction (a disruption of blood flow to the brain), and hemiplegia (paralysis of one side of the body). Review of an admission Minimum Data Set (MDS) dated 10/7/2021 revealed Resident #27 was cognitively intact with no behavioral issues, had one sided lower extremity impairment, and required extensive assistance with toileting,	F 550	This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of the plan of correction is not an admission that a deficiency exits or that one is cited correctly. This plan of correction is submitted to meet the requirements established by State and Federal law. Brian Center Hendersonville desires this plan of correction be considered the facilities allegation of compliance. F550 (D) How will this corrective action be accomplished for those residents found to have been affected by the deficient practice?	

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transferring, bed mobility, and dressing.

An observation on 12/05/21 at 11:43 AM revealed Resident #27 in her room calling out for help.

Observation on 12/05/21 at 11:47 AM revealed Nurse Aide (NA) #1 enter Resident #27's room, ask "What can I do for you?", and immediately walk away before Resident #27 could respond.

Observation and interview on 12/05/21 at 11:48 AM revealed NA #1 sitting in the Interim Director of Nursing's (DON) office. NA #1 stated she left the room because Resident #27 did not say she needed anything. NA #1 was unable to explain why she had not waited for Resident #27 to inform her of her needs.

Interview with Resident #27 on 12/05/21 at 3:14 PM revealed she felt staff didn't like when she put her call light on or requested assistance. She further revealed she felt the staff didn't believe that she needed something when she turned on her call light or asked for help.

Interview with the Interim DON on 12/05/21 at 2:53 PM revealed her expectation was that staff assist with resident needs, or let the resident know they'll return if they need another staff member to provide assistance. The Interim DON stated her expectation was that staff allow the resident adequate time to respond, and pause to learn what the resident needs.

Interview with the Administrator on 12/09/21 at 4:45 PM revealed her expectation was that staff assure residents receive help, and follow up with residents to assure they receive assistance.

F 550

Resident #27 has been reviewed with no negative effects. This residents needs/request were meet by other staff members who answered the call light when it was pressed again.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

All residents residing in the facility have the potential to be affected by the alleged deficient practice.

What measures will be put into place or systemic changes made to ensure the deficient practice will not occur?

NA #1 received verbal education on 12/5/21 by DON regarding call light response time, customer service and approach prior to leaving early from shift. NA #1 no longer is an employee at our facility. Nursing staff were in-serviced by DON/NHA on customer service and approach, residents rights, as well as call light response times and giving the residents enough time to explain what they are needing prior to exiting the room. Education starting on 12/5/2021-1/14/22. Education will be completed during orientation for all new hired licensed nursing staff including licensed nursing agency employees.

Indicate how the facility plans to monitor its performance to make sure that

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F 550	Continued From page 3	F 550	solutions are sustained? DON or Designee will audit 10 residents a week through interviews asking about call light response and if they felt staff responded in a respectful manner while giving enough time to ask for things they are needing. Audits to be completed weekly x 4 weeks, every other week x 2 months and monthly x 2 months. Any areas identified through this audit will be immediately corrected. The results of all audits will be brought to monthly QAPI for review and recommendations will be made as the committee determines. Date when corrective action will be completed? Date:1/17/2022	
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, record review, and interviews with the resident and staff the facility failed to place a call light within sight and reach for 1 of 1 resident reviewed for accommodation of needs (Resident #28). The findings included:	F 558	F558 (D) How will this corrective action be accomplished for those residents found to have been affected by the deficient practice?	1/17/22

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F 558

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Resident #28 was admitted to the facility on 7/28/21 with diagnoses that included dysphagia, Parkinson's, and dementia.

Review of the quarterly Minimum Data Set (MDS) dated 10/8/21 assessed Resident #28's cognition as being intact with unclear speech. The MDS functional status assessment of activities of daily living indicated Resident #28 required extensive assistance with bed mobility, transfers, and toilet use and was always incontinent of bladder and bowel.

An observation made on 12/06/21 at 9:06 AM revealed Resident #28 sitting upright in bed with the call light cord draped over the head of the bed. The part of the cord with the red button was dangling behind the bed and was out of the sight of the resident.

During an interview Resident #28 12/06/21 at 9:06 AM revealed she couldn't find the call light and wanted assistance from the nursing staff with getting out of bed.

An interview conducted on 12/06/21 at 9:26 AM revealed Nurse Aide (NA) #4 was assigned to care for Resident #28. NA #4 observed the location of Resident #28's call light and stated it was not within reach or sight of the resident and should always be.

An interview conducted on 12/06/21 at 9:39 AM revealed Nurse #7 was assigned to provide care for Resident #28. Nurse #7 stated she had been in Resident #28's room this morning but didn't see the call light was not in reach. Nurse #7

F 558

Resident #28 has been reviewed with no negative effects. Call light was placed within residents reach.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

All residents residing in the facility have the potential to be affected by the alleged deficient practice.

What measures will be put into place or systemic changes made to ensure the deficient practice will not occur?

NA #4 and Nurse #7 were educated by DON on call lights being within sight/reach at all times 12/6/2021. Nursing staff were in-serviced by DON/NHA on call lights being in reach/sight at all times starting on 12/5/2021-1/14/22. Education will be completed during orientation for all new hired Licensed Nursing staff including licensed nursing agency employees.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained?

DON or Designee will audit 10 residents a week through direct observation ensuring call lights are within sight and reach at all times. Audits to be completed weekly x 4 weeks, every other week x 2 months and monthly x 2 months. Any areas identified through this audit will be immediately corrected. The results of all audits will be brought to monthly QAPI for review and

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F 558	Continued From page 5 stated Resident #28 was able to use the call light and make her needs known and it should be within sight and reach. During an interview on 12/09/21 at 4:40 PM the Director of Nursing (DON) stated it was her expectation to place the call light within sight and ensure the resident could reach it. The DON revealed the Interdisciplinary Team members do ambassador rounds to check resident rooms for anything out of place.	F 558	recommendations will be made as the committee determines. Date when corrective action will be completed? Date:1-17-2022	
F 655 SS=B	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-	F 655		1/17/22

F 655

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(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident and staff interviews, the facility failed to complete baseline care plans in conjunction with the Interdisciplinary Team (IDT), resident and/or responsible party and failed to provide the resident or their responsible party with a written summary of the baseline care plan for 3 of 4 newly admitted residents (Resident #22, #115 and #113).

Findings included:

1. Resident #22 was admitted on 09/29/21 with multiple diagnoses that included right femur (thigh bone) fracture, chronic obstructive pulmonary disease (difficulty breathing), and chronic respiratory failure.

The admission Minimum Data Set (MDS) dated 10/05/21 coded Resident #22 with intact cognition

F 655

F655 (B)

How will this corrective action be accomplished for those residents found to have been affected by the deficient practice?

Resident #22 and #115 no longer resides in our facility. Resident #113 care plan was reviewed and a written summary was signed and a copy was provided to the resident at bedside.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

All new admissions have the potential to be affected by the alleged deficient

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for daily decision making.

Review of Resident #22's medical record revealed no evidence a written summary of the baseline care plan was given to the resident.

During an interview on 12/09/21 at 9:51 AM, Resident #22 did not recall discussing her baseline care plan with facility staff after her admission or receiving a written summary of her baseline care plan.

During an interview on 12/08/21 at 2:00 PM, the MDS Nurse explained nursing staff completed the baseline care plan as part of the admission paperwork but was not sure if they reviewed the baseline care plan with the resident or their Responsible Party (RP) or gave them a written summary of the baseline care plan. The MDS Nurse explained the Interdisciplinary Team (IDT) met with the resident and/or their RP 72 hours after the resident's admission; however, the IDT did not review the baseline care plan at that time with the resident and/or their RP or provide them with a written summary.

During an interview on 12/09/21 at 9:25 AM, Nurse #2 stated she assisted nursing staff with completing the new admission paperwork which included the Admission Data Collection (ADC) nursing assessment. Nurse #2 explained when completing the assessment, depending on how a question was answered, it populated a baseline care plan with interventions to check if applicable. Nurse #2 stated she did not review the baseline care plan with the resident and/or their RP or provide them with a written summary.

During an interview on 12/09/21 at 12:32 PM,

F 655

practice.

What measures will be put into place or systemic changes made to ensure the deficient practice will not occur?

Education for Licensed Nursing staff and IDT was initiated 12/8/2021-1/14/22 by DON regarding formulation of baseline care plans and reviewing the care plan with residents and/or RP, providing them with a written summary within 48hrs of admission per regulation guidelines. Licenses nurses are to completed the baseline careplan assessments and RN-nurse management or MDS RN will validate and review it in PCC and print two copies one to be given to resident and/or RP and one to be signed and kept for our records within 48hrs. If the 48hrs occurs on the weekend our RN weekend supervisor will validate, review and print two copies one to be given to the resident and/or RP and one to be signed and kept for our records. Education will be completed during orientation for all new hired Licensed Nursing staff including licensed nursing agency employees.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained?

DON or Designee will audit new admission baseline care plans to ensure they are formulated and a written summary is provided to resident and/or RP within 48hrs to comply with regulation

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F 655	Continued From page 8 Nurse #3 stated she assisted nursing staff with completing new admission paperwork. Nurse #3 explained the baseline care plan components were included in the ADC nursing assessment. Nurse #3 stated when completing the assessment, she did not review the baseline care plan with the resident and/or their RP or provide them with a written summary. During an interview on 12/09/21 at 4:23 PM, the Interim Director of Nursing (IDON) explained the baseline care plan was triggered as part of the ADC nursing assessment. The IDON was not sure who was responsible for reviewing the baseline care plan with the resident and/or their RP and providing them with a written summary. The IDON confirmed she was aware of the regulation indicating a resident and/or their RP should be provided with a written summary of the baseline care plan within 48 hours of admission and would expect for staff to follow the regulation guidelines. During an interview on 12/09/21 at 4:45 PM, the Administrator stated she was not aware baseline care plans were not reviewed with and provided to the resident and/or their RP within 48 hours of admission. The Administrator stated they currently did not have a system in place to ensure residents and their RP received a written summary of their baseline care plan within the timeframe specified in the regulation but would be developing a process to ensure compliance. 2. Resident #115 was admitted to the facility on 11/26/21 with multiple diagnoses that included obstructive hypertrophic cardiomyopathy (condition in which the heart muscle becomes abnormally thick and may block blood flow out of	F 655	guidelines. Audits to be completed weekly x 4 weeks, every other week x 2 months and monthly x 2 months. Any areas identified through this audit will be immediately corrected. The results of all audits will be brought to monthly QAPI for review and recommendations will be made as the committee determines. Date when corrective action will be completed? Date: 1/17/2022	

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the heart), major depression and chronic pain.

The Brief Interview for Mental Status (BIMS) assessment dated 11/26/21 indicated Resident #115 had intact cognition for daily decision making.

The admission Minimum Data Set (MDS) dated 12/02/21 for Resident #115 was currently in progress and not completed.

Review of Resident #115's medical record revealed no evidence a written summary of the baseline care plan was given to the resident.

During an interview on 12/09/21 at 3:00 PM, Resident #115 did not recall discussing her baseline care plan with facility staff after her admission or receiving a written summary of her baseline care plan.

During an interview on 12/08/21 at 2:00 PM, the MDS Nurse explained nursing staff completed the baseline care plan as part of the admission paperwork but was not sure if the admitting nurse reviewed the baseline care plan with the resident or their Responsible Party (RP) or gave them a written summary of the baseline care plan. The MDS Nurse explained the Interdisciplinary Team (IDT) met with the resident and/or their RP 72 hours after the resident's admission; however, the IDT did not review the baseline care plan at that time with the resident and/or their RP or provide them with a written summary.

During an interview on 12/09/21 at 9:25 AM, Nurse #2 stated she assisted nursing staff with completing the new admission paperwork which included the Admission Data Collection (ADC)

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F 655	Continued From page 10 nursing assessment. Nurse #2 explained when completing the assessment, depending on how a question was answered, it populated a baseline care plan with interventions to check if applicable. Nurse #2 stated she did not review the baseline care plan with the resident and/or their RP or provide them with a written summary. During an interview on 12/09/21 at 12:32 PM, Nurse #3 stated she assisted nursing staff with completing new admission paperwork. Nurse #3 explained the baseline care plan components were included in the ADC nursing assessment. Nurse #3 stated when completing the assessment, she did not review the baseline care plan with the resident and/or their RP or provide them with a written summary. During an interview on 12/09/21 at 4:23 PM, the Interim Director of Nursing (IDON) explained the baseline care plan was triggered as part of the ADC nursing assessment. The IDON was not sure who was responsible for reviewing the baseline care plan with the resident and/or their RP and providing them with a written summary. The IDON confirmed she was aware of the regulation indicating a resident and/or their RP should be provided with a written summary of the baseline care plan within 48 hours of admission and would expect for staff to follow the regulation guidelines. During an interview on 12/09/21 at 4:45 PM, the Administrator stated she was not aware baseline care plans were not reviewed with and provided to the resident and/or their RP within 48 hours of admission. The Administrator stated they currently did not have a system in place to ensure residents and their RP received a written	F 655		

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summary of their baseline care plan within the timeframe specified in the regulation but would be developing a process to ensure compliance.

3. Resident #113 was admitted to the facility on 12/02/21 with multiple diagnoses that included open wound of right front wall of thorax (chest), diabetes, and rheumatoid arthritis.

The Admission Data Collection (ADC) nursing assessment dated 12/02/21 indicated Resident #113 was alert and oriented to person and place, able to follow directions, had a Peripherally Inserted Central Catheter (PICC; thin tube inserted through a vein in the arm), and was a fall risk.

The admission Minimum Data Set (MDS) dated 12/08/21 for Resident #113 was currently in progress and not completed.

Review of Resident #113's medical record revealed no evidence a written summary of the baseline care plan was given to the resident and/or the Responsible Party (RP).

During an interview on 12/08/21 at 2:00 PM, the MDS Nurse explained nursing staff completed the baseline care plan as part of the admission paperwork but was not sure if the admitting nurse reviewed the baseline care plan with the resident or their RP or gave them a written summary of the baseline care plan. The MDS Nurse explained the Interdisciplinary Team (IDT) met with the resident and/or their RP 72 hours after the resident's admission; however, the IDT did not review the baseline care plan at that time with the resident and/or their RP or provide them with a written summary.

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F 655	Continued From page 12	F 655		

During an interview on 12/09/21 at 9:25 AM, Nurse #2 stated she assisted nursing staff with completing the new admission paperwork which included the Admission Data Collection (ADC) nursing assessment. Nurse #2 explained when completing the assessment, depending on how a question was answered, it populated a baseline care plan with interventions to check if applicable. Nurse #2 stated she did not review the baseline care plan with the resident and/or their RP or provide them with a written summary.

During an interview on 12/09/21 at 12:32 PM, Nurse #3 stated she assisted nursing staff with completing new admission paperwork. Nurse #3 explained the baseline care plan components were included in the ADC nursing assessment. Nurse #3 stated when completing the assessment, she did not review the baseline care plan with the resident and/or their RP or provide them with a written summary.

During an interview on 12/09/21 at 4:23 PM, the Interim Director of Nursing (IDON) explained the baseline care plan was triggered as part of the ADC nursing assessment. The IDON was not sure who was responsible for reviewing the baseline care plan with the resident and/or their RP and providing them with a written summary. The IDON confirmed she was aware of the regulation indicating a resident and/or their RP should be provided with a written summary of the baseline care plan within 48 hours of admission and would expect for staff to follow the regulation guidelines.

During an interview on 12/09/21 at 4:45 PM, the Administrator stated she was not aware baseline

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F 655	Continued From page 13 care plans were not reviewed with and provided to the resident and/or their RP within 48 hours of admission. The Administrator stated they currently did not have a system in place to ensure residents and their RP received a written summary of their baseline care plan within the timeframe specified in the regulation but would be developing a process to ensure compliance.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must 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	F 656		1/17/22

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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 record review and staff interviews, the facility failed to develop a comprehensive, individualized care plan for a resident with a Level II Preadmission Screening and Resident Review (PASRR) for 1 of 1 resident reviewed for PASRR (Resident #22).

Findings included:

Resident #22 was admitted on 09/29/21 with multiple diagnoses that included right femur (thigh bone) fracture, anxiety disorder, and depression.

The PASRR Level II Determination Notification letter for Resident #22, with an effective date of 08/23/21 and expiration date of 11/21/21, revealed nursing facility placement was appropriate for a 90-day period with specialized services that consisted of psychiatric services provided by a Psychiatrist and rehabilitative services. A second PASRR Level II Determination Notification letter for Resident #22, with an effective date of 11/22/21 and expiration date of 12/22/21, revealed nursing facility

F 656

F656 (D)

How will this corrective action be accomplished for those residents found to have been affected by the deficient practice?

Resident #22 no longer resides in our facility. Care plan for this resident was updated to reflect level II Pasrr on 12/8/21 prior to resident discharging from facility.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

All residents in facility with level II Pasrr have the potential to be affected by the alleged deficient practice.

What measures will be put into place or systemic changes made to ensure the deficient practice will not occur?

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F 656	Continued From page 15 placement was appropriate for a 30-day period with specialized services that consisted of psychiatric services provided by a Psychiatrist and rehabilitative services. The admission Minimum Data Set (MDS) dated 10/05/21 coded Resident #22 with intact cognition for daily decision making. The MDS noted she had been evaluated by Level II PASRR and determined to have a serious mental illness and/or intellectual disability. Review of Resident #22's active care plans, last reviewed/revised on 11/05/21, revealed no care plan that addressed her Level II PASRR status or the specialized services needed as described in the PASRR Level II Determination Notification letter. During an interview on 12/08/21 at 2:00 PM, the MDS Nurse confirmed Resident #22 had a Level II PASRR. The MDS Nurse explained either she or the Social Worker (SW) typically included a resident's Level II PASRR status as part of the cognition care plan. She added they had overlooked Resident #22's Level II PASRR and therefore, a care plan was not developed. During an interview on 12/08/21 at 3:49 PM, the SW explained when completing her sections of the MDS assessments, she tried to initiate care plans at that time and if she wasn't able, the MDS Nurse would assist. The SW stated she was not aware a resident's Level II PASRR should be care planned to address the specialized services needed. She confirmed Resident #22 had a Level II PASRR and a care plan was not developed.	F 656	Education for MDS nurse and Social Worker was completed on 12/8/2021 by NHA/DON regarding formulation of comprehensive, individualized care plans for any resident with a level II Pasrr status. If turnover occurs in these positions education will be completed for new hires during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained? DON or Designee will audit residents with level II Pasrrs to ensure care plans are formulated. Audits to be completed weekly x 4 weeks, every other week x 2 months and monthly x 2 months. Any areas identified through this audit will be immediately corrected. The results of all audits will be brought to monthly QAPI for review and recommendations will be made as the committee determines. Date when corrective action will be completed? Date:1/17/2022	

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F 656	Continued From page 16 During an interview on 12/08/21 at 4:41 PM, the Interim Director of Nursing stated she would expect for care plans to be comprehensive and reflect the care needs of the resident. During an interview on 12/09/21 at 4:45 PM, the Administrator stated a care plan for Level II PASRR should have been developed for Resident #22. The Administrator added it was her expectations that resident care plans were comprehensive and individualized.	F 656		
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 accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to adhere to a Physician order and Speech Therapist (ST) recommendation that no straws be provided to a resident (Resident # 28) at risk for aspiration (accidental breathing in food or fluid into the lungs) for 1 of 3 sampled residents reviewed for nutrition. Findings included: Resident # 28 was admitted to the facility 10/3/2021 with diagnosis that included dysphagia following a stroke, pneumonitis due to inhalation	F 689	F689 (D) How will this corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident #28 has been reviewed with no negative effects. How will the facility identify other residents having the potential to be affected by the same deficient practice?	1/17/22

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F 689 Continued From page 17

of food and vomit, protein-calorie malnutrition, ulcerative proctitis (a form of chronic inflammatory bowel disease), non-Alzheimer's dementia, Parkinson's disease, and diabetes.

Review of a physician's order dated 10/6/2021 at 1:53 PM revealed Resident # 28 was to receive a puree texture diet. The directions stated no straws.

The Medicare 5-day Minimum Data Set (MDS) dated 10/8/2021 revealed Resident # 28 was cognitively intact, had a swallowing disorder, feeding tube, mechanically altered and therapeutic diet.

Observation on 12/9/2021 at 12:11 PM revealed Resident # 28 sitting in a wheelchair in her room with her lunch tray in front of her. Resident # 28's lunch tray included a cup of water with a straw in it. Resident # 28's lunch tray ticket stated "Dysphagia puree diet. No straws."

Interview with the Speech Language Pathologist (SLP) on 12/9/2021 at 12:22 PM revealed she'd assessed Resident # 28's swallow function on 10/5/2021 following a stroke. The SLP stated a feeding tube was placed for Resident # 28's primary nutrition and she wanted food by mouth to keep her body in tune. The SLP stated she ordered "no straws" as Resident # 28 had aspiration pneumonia, she didn't want to worsen it, and straws could potentially cause her to aspirate again.

A follow up observation on 12/9/2021 at 12:46 PM revealed Resident # 28 remained sitting in a wheelchair in her room with a cup of water containing a straw on the tray table in front of her.

F 689

All residents in facility with physician orders or speech therapy recommendations for no straws have the potential to be affected by the alleged deficient practice.

What measures will be put into place or systemic changes made to ensure the deficient practice will not occur?

Education for dietary aide #3 was completed 12/9/2021 by dietary manager regarding meal tray tickets being followed and meal tray tickets matching meal trays prior to leaving the kitchen including no straws. Education was initiated to all dietary staff by dietary manager 12/9/2021-1/14-2022 regarding meal tray tickets being followed and meal tray tickets matching meal trays prior to leaving the kitchen including no straws. Education will be completed during orientation by dietary manager for all new hired dietary employees.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained?

Dietary Manager or Designee will audit meal trays through direct observation for those residents in facility with physician orders or speech therapy recommendations for no straws to ensure meal trays and meal tray tickets match. Audits to be completed weekly x 4 weeks, every other week x 2 months and monthly x 2 months. Any areas identified through

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F 689	Continued From page 18 Interview with the Nurse # 7 on 12/9/2021 at 12:54 PM revealed she set up Resident # 28's lunch tray and drink with a straw. The nurse stated she was supposed to read Resident # 28's tray ticket to assure she provided the correct tray and there were no food allergens being served. The nurse stated there should have been no straw provided if the tray ticket notated "no straws" and she did not see this on the tray ticket. The nurse further stated the straw came wrapped with the silverware on Resident # 28's tray, which was provided by the kitchen. Interview with the Dietary Manager (DM) on 12/9/2021 at 1:02 PM revealed the Dietary Aides (DA) rolled up silverware before each meal and this included a fork, knife, spoon, and straw, unless the tray ticket notated "no straw". The DM stated part of the DA's training included reading tray tickets for meal service and they received further training to communicate work expectations. Interview with DA # 3 on 12/9/2021 at 1:07 PM revealed he rolled up the lunch meal silverware and this included a fork, knife, spoon, and straw, unless the tray ticket stated, "no straw". DA # 3 stated a silverware roll up with no straw would be put off to the side to designate it for a specific resident and he could not recall if he'd done so for Resident # 28. DA # 3 stated it was his responsibility to roll up her silverware without a straw, the kitchen staff worked as a team, and it was everyone's responsibility to read resident's tray tickets. Interview with the Director of Nursing (DON) on 12/9/2021 at 4:24 PM revealed it was her	F 689	this audit will be immediately corrected. The results of all audits will be brought to monthly QAPI for review and recommendations will be made as the committee determines. Date when corrective action will be completed? Date:1/17/2022	

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F 689	Continued From page 19 expectation that resident meal orders were followed. Interview with the Administrator on 12/9/2021 at 4:45 PM revealed she performed kitchen audits every month. The Administrator stated the kitchen staff pre-packaged silverware, her expectation was that resident tray tickets be read, and what was served matched the tray ticket. The Administrator stated a tray with a straw should not have come out of the kitchen unless it was correct.	F 689		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to administer medications prescribed to treat anxiety and chronic obstructive pulmonary disease (difficulty breathing) per physician's orders resulting in the resident experiencing increased anxiety for 1 of 1 resident reviewed for medication errors (Resident #22). Findings included: Resident #22 was admitted on 09/29/21 with multiple diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), anxiety disorder, and depression. The admission Minimum Data Set (MDS) dated 10/05/21 assessed Resident #22 with intact	F 760	F760 (D) How will this corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident #22 no longer resides in our facility. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents in facility that are administered medications have the potential to be affected by the alleged deficient practice.	1/17/22

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F 760

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cognition and noted she received antidepressant medication 6 of 7 days and antianxiety medication 5 of 7 days during the MDS assessment period.

The December 2021 Medication Administration Record (MAR) for Resident #22 revealed the following physician orders:
Buspirone HCI (medication used to treat anxiety) 5 mg two times a day at 8:00 AM and 8:00 PM for anxiety.
Symbicort Aerosol 160-4.5 micrograms (MCG)/ACT - inhale 2 puffs orally 2 times a day at 8:00 AM and 8:00 PM for COPD. Rinse mouth after use, do not swallow.
Ipratropium-Albuterol Solution 0.5-2.5 (3) mg/3 milliliters (ml) - inhale orally three times a day at 9:00 AM, 1:00 PM, and 9:00 PM for COPD.
Ativan 0.5 mg every 6 hours as needed (PRN) for anxiety.

During an observation and interview on 12/05/21 at 11:40 AM, Resident #22 was lying in bed, alert and displayed no signs of respiratory distress. Resident #22 reported she was experiencing increased anxiety because she had not received her 8:00 AM medications which included her breathing treatments and anxiety medications. Resident #22 explained she had severe COPD and the treatments made it easier for her to breathe and when she didn't get her medications on time, it became more difficult to breathe which in turn, caused her greater anxiety. She added when her anxiety became "out of whack" it was much harder to get it back under control. The surveyor intervened on behalf of Resident #22 and spoke with nursing staff.

The Medication Administration Audit Report for 12/05/21 for Resident #22 revealed the

F 760

What measures will be put into place or systemic changes made to ensure the deficient practice will not occur?

Education provided by DON to Nurse #6 verbally on 12/10/21 on timely medication pass and asking for assistance if falling behind. Education provided by DON on 12/10/21-1/14/22 for Licensed Nursing staff regarding medication administration/administration times remembering the hour before and hour after rule as well as the need to ask/seek for assistance when falling behind on scheduled medication times. Education will be completed during orientation for all new hired Licensed Nursing staff including licensed nursing agency employees.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained?

DON or Designee will audit/review the medication administration report in point click care for late medication administration. Audits to be completed 5xs a week x 2 weeks, 3xs a week x 4 weeks, every other week x 2 months and monthly x 2 months. Any areas identified through this audit will be immediately corrected. The results of all audits will be brought to monthly QAPI for review and recommendations will be made as the committee determines.

Date when corrective action will be

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F 760	Continued From page 21	F 760		

administration time for the 8:00 AM scheduled dose of Buspirone was 11:50 AM, the administration time for the 8:00 AM scheduled dose of Symbicort Aerosol was 11:53 AM, and the administration time for the 9:00 AM scheduled dose of Ipratropium-Albuterol Solution was 11:53 AM. In addition, the administration time for the requested Ativan PRN was 11:54 AM.

During a telephone interview on 12/06/21 at 4:50 PM, Nurse #6 confirmed on 12/05/21 she did not administer Resident #22's medications that were scheduled for 8:00 AM and 9:00 AM until approximately 12:00 PM, which included the PRN Ativan Resident #22 requested. Nurse #6 explained she was assigned to a hall and half and was "pulled in so many directions" going back and forth between the halls, she just got behind on administering medications. Nurse #6 voiced she did not notify anyone she was running behind and did not ask for assistance.

During a telephone interview on 12/09/21 at 1:38 PM, the facility Medical Doctor (MD) explained Resident #22 had end-stage COPD with anxiety. The MD stated it was a significant error that Resident #22 was not administered her scheduled 8:00 AM and 9:00 AM medications on 12/05/21 until 11:54 AM. The MD added he did not feel Resident #22 receiving the medications late put her in imminent danger but it definitely affected her level of comfort due to increased anxiety.

During an interview on 12/09/21 at 4:23 PM, the Interim Director of Nursing (IDON) was unaware Resident #22 did not receive her scheduled 8:00 AM and 9:00 AM medications on 12/05/21 until 11:54 AM and stated she was not informed by

Provider's plan of correction (F 760):

completed?
Date:1/17/2022

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F 760	Continued From page 22 Nurse #6 that she ran behind with administering medications. The IDON explained there was a Nurse Supervisor as well as other nurses in the facility that could have assisted Nurse #6 had she let them know. The IDON stated it was her expectation for medications to be administered within the timeframe of one hour before or after the scheduled time.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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. §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:	F 761		1/17/22

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F 761	Continued From page 23 Based on observations, record review, interviews with staff and the Pharmacist the facility failed to label insulin pens with an open date when stored at room temperature on the medication cart; the facility failed to lock an unsupervised medication cart accessible to residents and staff; and failed to discard an opened multi-dose vial of pneumococcal vaccine stored inside the medication refrigerator for 2 of 3 medication administration carts and 1 of 1 medication storage room reviewed for medication labeling and storage. The findings included: 1. A review of the pharmacy's insulin storage recommendations dated 3/2020 revealed unopened and opened lantus and novolog pens should be stored refrigerated until the expiration date or 28 days at room temperature. Novolog pens should be stored refrigerated until the expiration date or 28 days at room temperature. During an observation with Nurse #4 on 12/7/21 at 2:53 PM the medication cart for Hall 300 revealed a 100 units/milliliter (ml) of insulin lantus multi-dose pen with no open date and a 100 units/ml insulin novolog multi-dose pen with no open date. During an interview on 12/7/21 at 2:53 PM Nurse #4 revealed she had not used either of the insulin pens at this time and was unsure when the pens were placed on the cart. Nurse #4 stated insulin should be stored in the refrigerator until needed and label with an open date when placed on the medication cart then discarded 28 days after removed from the refrigerator.	F 761	F761 (E) How will this corrective action be accomplished for those residents found to have been affected by the deficient practice? No resident identified. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents receiving insulin have the potential to be affected by the alleged deficient practice. All residents in the facility have the potential to be affected by the alleged deficient practice regarding medication cart being left unlocked and unattended. All residents receiving the flu vaccine have the potential to be affected by the alleged deficient practice. What measures will be put into place or systemic changes made to ensure the deficient practice will not occur? Education initiated on by DON 12/10/21-1/14/22 for Licensed Nursing staff regarding proper medication storage including insulin pens and unopened pens being stored in the refrigerator until needed and labeled with an open date when placed on medication cart. Nurse #5 was educated on 12/7/2021 by DON/NHA regarding medication carts being locked and in designated storage area when not in use. Nurse #4 was verbally educated on proper insulin pen storage and dating	

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During an interview on 12/07/21 at 5:03 PM the Interim Director of Nursing (DON) revealed she checked the dates of both insulin pens for when the pharmacy delivered and stated both pens were still within the 28-day period of being good for use. The DON revealed insulin pens should be dated when removed from the refrigerator and placed on the medication cart to determine the date it should be discarded.

A second interview on 12/09/21 at 4:32 PM the Interim DON revealed she didn't think the insulin pens were put in the refrigerator and instead were placed directly on medication cart.

During an interview on 12/09/21 at 5:31 PM the Pharmacist revealed insulin pens were stored in ice bags when delivered to the facility and were to be placed in the refrigerator. The Pharmacist revealed the pharmacy delivered insulin pens with a sticker stating to put in the refrigerator and with a sticker that should be filled out the date the insulin pen was placed at room temperature. The Pharmacist stated if insulin pens were not labeled with an open date it would be unclear how long the insulin was stored out of the refrigerator.

2. An observation of Hall 200/600 medication cart on 12/07/21 at 3:26 PM with Nurse #5 revealed the cart was being stored in a lounge area and left unlocked and unattended where residents and other staff members could access medications being stored on the cart.

During an interview on 12/07/21 at 3:26 PM Nurse #5 stated she had placed the medication cart in the lounge area but forgot to lock it. Nurse #5 revealed the cart should have been locked and was in a place accessible to both staff and

F 761

by DON on 12/7/21. Licensed Nursing staff education initiated on 12/10/2021-1/14/22 regarding medication carts being locked and stored in designated areas when not in use. Licensed Nursing staff education initiated on 12/10/2021-1/14/22 regarding the proper medication storage of flu vaccines in the refrigerator being mindful of expiration dates. Education will be completed during orientation for all new hired Licensed Nursing staff including licensed nursing agency employees.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained?

DON or Designee will audit medication carts for any unopened insulin pens and will audit refrigerator for any expired medications. Audits to be completed 5xs a week x 2 weeks, 3xs a week x 4 weeks, every other week x 2 months and monthly x 2 months. Any areas identified through this audit will be immediately corrected. The results of all audits will be brought to monthly QAPI for review and recommendations will be made as the committee determines.

Date when corrective action will be completed?
Date:1/17/2022

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residents. Nurse #5 revealed she liked to keep her medication cart within her sight when not in use but today she was working the split Hall 200/600 and since she has worked at the facility the lounge area was where she was told to store the cart and that's what she's been doing.

During an interview the on 12/09/21 at 4:32 PM the Interim DON revealed she was not sure where the nurses were told to store medication carts when not in use and mostly saw carts placed on the halls. The Interim DON revealed it was her expectation medication carts would be locked when left unattended by the nurses.

During an interview on 12/07/21 at 4:42 PM the Administrator revealed the nurses were asked to place the medication carts in the hallway or lounge area when not in use and it was her expectation the carts were locked when placed in an area accessible to residents and other staff when left unsupervised by the nurse.

3. A review of the manufacturer's instructions for storage and handling of Afluria Quadrivalent flu vaccine stated store refrigerated, once the stopper of the multi-dose vail has been pierced the vial must be discarded within 28 days.

An observation with the Staff Development Manager (SDM) on 12/07/21 at 4:18 PM revealed the medication storage refrigerator contained an opened and used multi-dose vial of Afluria Quadrivalent flu vaccine with an open date of 11/5/21.

During an interview on 12/7/21 at 4:18 PM the SDM revealed her, and the nurse assigned to Hall 300 were responsible for medications kept in

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F 761	Continued From page 26 the storage room and if a nurse needed something, they had to get her or the Hall 300 nurse. The SDM revealed multi-dose vials of Afluria Quadrivalent vaccine were kept in the refrigerator and when opened were good for 30 days and the vial should've been thrown away on 12/5/21. The SDM removed the vial from the refrigerator and stated she would discard it.	F 761		
F 808 SS=E	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 interviews with staff the facility failed to provide therapeutic diets as prescribed by the physician for 3 of 4 residents reviewed for nutrition (Resident #17, Resident #19, and Resident #59). The findings included: 1. Resident #17 was admitted to the facility on 7/2/21 with diagnoses including anemia and non-pressure chronic ulcers of the lower left and right leg. A review of the care plan revised on 7/6/21 identified Resident #17 had chronic anemia with the goal to remain free of signs or symptoms of	F 808	F808 (E) How will this corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident #17, #19, and #59 have been reviewed with no negative effects. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents in facility with orders for therapeutic diets have the potential to be	1/17/22

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F 808

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complications related to anemia through the review date. Interventions included review diet and make recommendations as required.

A review of a physician order written on 9/22/21 revealed Resident #17 was prescribed a regular diet of regular consistency and texture and upgraded to continue double protein.

A review of the quarterly Minimum Data Set (MDS) dated 10/1/21 assessed Resident #17's cognition as being intact. The MDS functional status for activities of daily living assessed Resident #17 as needing supervision with setup help with eating. The MDS assessment of nutritional status determined there was no known weight loss or gain.

An observation on 12/05/21 at 12:31 PM revealed Resident #17 was served 1 slice of ham and had eaten all the food on the plate. The meal ticket read regular diet with double protein.

A second observation on 12/8/21 at 12:03 PM revealed Resident #17's meal ticket read double protein. Resident #17 was served turkey cut into smaller bite size portions.

An interview was conducted on 12/08/21 at 12:11 PM with the Dietary Manager (DM). The DM explained double protein meant 2 portions of meat should be served on Resident #17's plate. The DM explained if the diet card read double protein when ham was served the plate should have 2 pieces of ham and if not, it was a mistake. The DM explained the system in place was for kitchen staff to read the meal ticket and ensure the food on the plate was correct before sent to the resident.

F 808

affected by the alleged deficient practice.

What measures will be put into place or systemic changes made to ensure the deficient practice will not occur?

Education for dietary and nursing staff provided by DON/Dietary Manager on 12/10/2021-1/14/22 on following physician diet orders related to therapeutic diets including textures and double protein while verifying the accuracy of plated diet prior to leaving the kitchen and before serving the meal tray to the resident. Education will be completed during orientation for all new hired, Dietary staff and Licensed Nursing staff including licensed nursing agency employees.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained?

Dietary Manager or Designee will audit meal trays through direct observation for those residents in facility with physician orders for texture modified diets and double protein to ensure meal trays and meal tray tickets match. Audits to be completed weekly x 4 weeks, every other week x 2 months and monthly x 2 months. Any areas identified through this audit will be immediately corrected. The results of all audits will be brought to monthly QAPI for review and recommendations will be made as the committee determines.

Date when corrective action will be

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A second interview was conducted with the DM on 12/08/21 at 5:16 PM. The DM revealed he spoke with the Cook who said he served the resident a large portion of turkey but did not state it was a double portion.

An interview was conducted on 12/08/21 at 12:23 PM with Dietary Aide (DA) #2. DA #2 explained his job included reading meal tickets to ensure the food on the plate was correct and double protein meant there should be 2 portions of meat on the plate.

During an interview on 12/09/21 at 4:39 PM the Director of Nursing (DON) revealed resident diet orders should be followed and if Resident #17's diet order stated double protein she expected it would be on the plate when served to the resident.
2. Resident #19 was admitted to the facility on 6/7/2012.

A Physician's order dated 7/12/2021 revealed Resident #19 was to receive a dysphagia diet.

Record review of Resident #19's annual Minimum Data Set (MDS) dated 9/1/2021 revealed she had severe cognitive impairement, no natural teeth or tooth fragments and required supervision with eating.

Observation on 12/5/21 at 12:13 PM revealed Resident #19 eating lunch in the dining room. Resident # 19 was observed to be edentulous, her tray ticket read dysphagia diet with chopped Brussel sprouts, and her lunch tray included whole Brussel sprouts which she did not eat.

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Review of the facility's menu for 12/5/2021 revealed Brussel sprouts were to be chopped on the dysphagia diet.

Interview with the Dietary Manager (DM) on 12/9/2021 at 1:02 PM revealed the Dietary Aide (DA) on the front of the service line set up resident trays, another DA double checked the tray for accuracy, and it was everyone's responsibility to check the tray tickets before they left the kitchen. The DM stated he encouraged everyone to look at all aspects of tray delivery, part of the DA's training included reading tray tickets for meal service, and they received further training to communicate work expectations.

Interview with the Director of Nursing (DON) on 12/9/2021 4:24 PM revealed it was her expectation that physician diet orders be followed.

Interview with the Administrator on 12/9/2021 at 4:45 PM revealed her expectation was that staff read the meal tray tickets. The Administrator stated a meal tray should not come out of the kitchen unless it was correct, the food served should match the ticket, and the food should be chopped for a dysphagia diet order.

3. Resident #59 was admitted to the facility on 4/16/2021.

A Physician's order dated 4/15/2021 revealed she was to receive a dysphagia diet.

Record review of Resident #59's admission MDS dated 4/22/2021 revealed she had mild cognitive impairment, obvious or likely broken natural teeth and required assistance with eating.

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Observation on 12/5/21 12:46 PM revealed Resident #59 sitting in bed with her lunch tray on the bedside table in front of her. Resident #59's tray ticket read dysphagia diet with chopped Brussel sprouts, and her lunch tray included whole Brussel sprouts which she did not eat.

Review of the facility's menu for 12/5/2021 revealed Brussel sprouts were to be chopped on the dysphagia diet.

Interview with the Dietary Manager (DM) on 12/9/2021 at 1:02 PM revealed the Dietary Aide (DA) on the front of the service line set up resident trays, another DA double checked the tray for accuracy, and it was everyone's responsibility to check the tray tickets before they left the kitchen. The DM stated he encouraged everyone to look at all aspects of tray delivery, part of the DA's training included reading tray tickets for meal service, and they received further training to communicate work expectations.

Interview with the Director of Nursing (DON) on 12/9/2021 4:24 PM revealed it was her expectation that physician diet orders be followed.

Interview with the Administrator on 12/9/2021 at 4:45 PM revealed her expectation was that staff read the meal tray tickets. The Administrator stated a meal tray should not come out of the kitchen unless it was correct, the food served should match the ticket, and the food should be chopped for a dysphagia diet order.

F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g)	F 810		1/17/22

§483.60(g) Assistive devices

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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, record review, and staff interviews, the facility failed to follow a physician order for an assistive device to promote a resident's independence with eating for 1 of 3 sampled residents reviewed for nutrition (Resident #28).

Findings included:

Resident # 28 was admitted to the facility 10/3/2021 with diagnosis that included dysphagia following a stroke, pneumonitis due to inhalation of food and vomit, protein-calorie malnutrition, ulcerative proctitis (a form of chronic inflammatory bowel disease), non-Alzheimer's dementia, Parkinson's disease, and diabetes.

Review of a physician's order dated 10/6/2021 at 1:53 PM revealed Resident # 28 was to receive a puree texture diet. The directions stated send small portions of food in bowls.

The Medicare 5-day Minimum Data Set (MDS) dated 10/8/2021 revealed Resident # 28 had a swallowing disorder, feeding tube, mechanically altered and therapeutic diet.

Observation on 12/9/2021 at 12:11 PM revealed Resident # 28 sitting in a wheelchair in her room with her lunch tray in front of her. Resident # 28's lunch tray included a scoop of mashed potatoes on a plate and she did not attempt to scoop them

F 810

F810 (D)

How will this corrective action be accomplished for those residents found to have been affected by the deficient practice?

Resident #28 has been reviewed with no negative effects.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

All residents in facility who require special eating equipment, utensil and assistive devices have the potential to be affected by the alleged deficient practice.

What measures will be put into place or systemic changes made to ensure the deficient practice will not occur?

Education provided to dietary and nursing staff on 12/10/2021-1/14/22 by DON/Dietary Manager on following physician orders as indicated on the meal tray ticket for use of adaptive equipment/devices to promote resident�s independence with eating including bowls. Education will be completed during orientation for all new hired Dietary staff

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from the plate. Resident # 28's tray ticket stated "Dysphagia puree diet. Food in bowls."

Interview with the Speech Language Pathologist (SLP) on 12/9/2021 at 12:22 PM revealed she'd assessed Resident # 28's swallow function on 10/5/2021 following a stroke. The SLP stated a feeding tube was placed for Resident # 28's primary nutrition and she wanted food by mouth to keep her body in tune. The SLP stated Resident' # 28 had more independence holding food in a bowl, as she was unable to scoop from a plate. The SLP further stated Resident # 28 expressed mashed potatoes were the warmest, hardiest food she wanted to eat.

Interview with the Nurse # 7 on 12/9/2021 at 12:54 PM revealed she set up Resident # 28's lunch tray. The nurse stated she was supposed to read Resident # 28's tray ticket to assure she provided the correct tray and there were no food allergens being served. The nurse stated she did not know why Resident # 28's food was supposed to be served in bowls.

Interview with the Dietary Manager (DM) on 12/9/2021 at 1:02 PM revealed the Dietary Aide (DA) on the front of the service line set up resident trays, another DA double checked the tray for accuracy, and it was everyone's responsibility to check the tray tickets before they left the kitchen. The DM stated he encouraged everyone to look at all aspects of tray delivery, part of the DA's training included reading tray tickets for meal service, and they received further training to communicate work expectations.

Interview with DA #3 on 12/9/2021 at 1:07 PM revealed Resident #28 was to receive puree food

and Licensed Nursing staff including licensed nursing agency employees.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained?

Dietary Manager or Designee will audit meal trays through direct observation for those residents in facility with physician orders or therapy recommendations for use of appropriate adaptive equipment during meals, ensuring that meal trays match meal tray tickets. Audits to be completed weekly x 4 weeks, every other week x 2 months and monthly x 2 months. Any areas identified through this audit will be immediately corrected. The results of all audits will be brought to monthly QAPI for review and recommendations will be made as the committee determines.

Date when corrective action will be completed?
Date:1/17/2022

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F 810	Continued From page 33 in bowls and he participated in her lunch tray set up. The DA stated the kitchen staff worked as a team and it was everyone's responsibility to read the resident tray tickets. Interview with the Director of Nursing (DON) on 12/9/2021 at 4:24 PM revealed it was her expectation that resident meal orders were followed. Interview with the Administrator on 12/9/2021 at 4:45 PM revealed she performed kitchen audits every month. The Administrator stated her expectation was that resident tray tickets be read, and the food served matched the tray ticket. The Administrator stated a tray should not have come out of the kitchen unless it was correct.	F 810		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		1/17/22

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F 812	Continued From page 34 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to 1) ensure 2 of 4 dietary staff (dietary aide #1 and cook) had all hair covered during food production, which had the potential to cause cross-contamination of food served to residents and 2) remove expired food stored ready for use in 2 of 2 refrigerators (the walk-in and reach-in refrigerators). Findings included: 1) Observation in the kitchen on 12/05/21 9:48 AM revealed Dietary Aide (DA) #1's hair was not contained in a hair net as she wrapped silverware on the tray service line. A continuous observation in the kitchen on 12/05/21 from 9:51 AM through 9:55 AM revealed Dietary Aide (DA) #1's hair was not contained in a hair net as she cut and dished pieces of cake for the lunch service meal. Interview with the Dietary Manager (DM) on 12/05/21 9:55 AM revealed DA #1 was supposed to be wearing a hair net for food safety, and he asked her to place her hair net on. The DM stated he conducted monthly staff education which included food safety topics. Observation in the kitchen on 12/05/21 at 10:00 AM revealed the cook's hair fashioned in a bun with loose ends of hair hanging down the front and sides of her head. A hair net covered the bun and not the loose ends of hair hanging down the front or sides of her head as she prepared food behind the tray service line.	F 812	F812 (E) How will this corrective action be accomplished for those residents found to have been affected by the deficient practice? No residents were identified How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents in facility whom receive food from the kitchen have the potential to be affected by the alleged deficient practice. What measures will be put into place or systemic changes made to ensure the deficient practice will not occur? Education provided to DA #1 on 12/5/2021 by Dietary Manager regarding the proper application and usage of hair nets in the kitchen to avoid cross-contamination. Education provided to all dietary staff 12/5/2021-1/14/22 by Dietary Manager regarding food storage, dating, removal, discarding of expired foods including spices or sauces from both the refrigerators and proper use of hair nets. Education will be provided by dietary manager to all new dietary staff during orientation. Indicate how the facility plans to monitor	

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F 812	Continued From page 35 Observation in the kitchen on 12/05/21 at 10:06 AM revealed DA #1's hair fashioned in a bun with loose ends of hair hanging down the front, back, and sides of her head. A hair net covered the bun and not the loose ends of hair hanging down the front, back, or sides of her head. Interview with the DM on 12/05/21 at 10:13 AM revealed the hair net was supposed to cover the whole head and any loose ends of hair. Observation on 12/05/21 11:53 AM revealed DA #1's hair fashioned in a bun with loose ends of hair hanging down the front, back, and sides of her head. A hair net covered the bun and not the loose ends of hair hanging down the front, back, or sides of her head as she set up lunch trays on the service line. Observation on 12/06/21 9:29 AM revealed DA #1's hair fashioned in a bun with loose ends of hair hanging down the front, back, and sides of her head. A hair net covered the bun and not the loose ends of hair hanging down the front, back, or sides of her head as she prepared sandwiches in the food preparation area. Observation on 12/07/21 6:56 AM revealed DA #1's hair fashioned in a bun with loose ends of hair hanging down the front, back, and sides of her head. A hair net covered the bun and not the loose ends of hair. Observation on 12/07/21 at 7:29 AM revealed DA #1's hair fashioned in a bun with loose ends of hair hanging down the front, back, and sides of her head. A hair net covered the bun and not the loose ends of hair as she spoke with the DM	F 812	its performance to make sure that solutions are sustained? Dietary Manager or Designee will audit staff daily for proper use of hair nets ensure all hair is covered at all times through direct observation. Dietary Manager or Designee will also audit dry storage rooms, both refrigerators and freezers for proper food storage, dates and expired foods. Both of these audits are to be completed daily x 2 weeks, weekly x 4 weeks, every other week x 2 months and monthly x 2 months. Any areas identified through this audit will be immediately corrected. The results of all audits will be brought to monthly QAPI for review and recommendations will be made as the committee determines. Date when corrective action will be completed? Date:1/17/2022	

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F 812	Continued From page 36 behind the tray service line. Follow up interview with the DM on 12/08/21 2:10 PM revealed his expectation was hair be covered with a hair net. Interview with the facility Administrator on 12/09/21 at 4:45 PM revealed her expectation was that hair nets be worn in the kitchen, be put on at the beginning of the shift, and they were expected to cover the entirety of the hair. 2) Observation on 12/05/21 9:55 AM revealed an unlabeled, undated container of food in the reach-in refrigerator. The Dietary Manager (DM) stated the food was American cheese and the container should have been labeled and dated. Observation in the walk-in refrigerator on 12/05/21 at 10:02 AM revealed a container of barbeque sauce with an opened date of 11/4/2021. The DM stated the barbeque sauce container should have been "tossed.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		1/17/22

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a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations and interviews with staff the facility failed to remove gloves and perform hand hygiene after providing incontinence care Nurse Aide #3 (NA) and failed to remove gloves and perform hand hygiene between meal tray delivery and setup (NA #2 and NA #1) for 3 of 7 facility staff observed for infection control.

The findings included:

1. An observation of urinary incontinence care being provided for Resident #28 was made on 12/07/21 at 5:47 AM. NA #3 was observed to don gloves, remove an incontinence brief that was wet with urine and a cloth pad that was wet with urine. NA #3 cleaned Resident #28's perineal area and buttocks and without removing her gloves or performing hand hygiene she applied a clean incontinence brief, adjusted the height of the bed using the bed remote and pushed a button to restart the feeding pump. NA #3 removed her gloves and without performing hand hygiene left the room to get a gown and new top sheet from the linen cart then returned to

F880 (E)

How will this corrective action be accomplished for those residents found to have been affected by the deficient practice?

Resident #28 has been reviewed with no negative effects.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

All residents in facility have the potential to be affected by the alleged deficient practice.

What measures will be put into place or systemic changes made to ensure the deficient practice will not occur?

Education verbally provided by DON to NA #1 and NA #2 on 12/5/2021, and NA #3 on

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F 880	Continued From page 39 Resident #28's room. Without performing hand hygiene NA #3 donned a new pair of gloves and dressed Resident #28 in the gown and covered the resident with the top sheet then placed the call light in reach. During an interview on 12/07/21 at 6:00 AM NA #3 acknowledge she didn't remove her gloves after providing incontinence care or before she touched other items in Resident #28's room. NA #3 stated she should've removed her gloves and performed hand hygiene after she finished cleaning Resident #28. NA #3 explained alcohol-based dispensers were located outside resident rooms and she was more familiar with those being inside the room. NA #3 revealed she was aware resident rooms had a sink with soap and water available and stated she should've removed her gloves and washed her hands. An interview conducted on 12/07/21 at 2:25 PM with the Staff Development Manager (SDM) revealed she was in-charge of Infection Control training and stated she would expect NA #3 to wash her hands after a dirty process such as incontinence care before moving to a clean area or touching personal items. An interview conducted on 12/09/21 at 4:23 PM with the DON revealed it was her expectation NA staff to perform hand hygiene during and between resident care. 2. A continuous observation of meal tray delivery and setup on Hall 300 was made on 12/05/21 from 12:02 PM through 12:06 PM. Alcohol-based hand rub dispensers were attached to the wall by the entry door of resident rooms and sinks with soap, water, and paper towels were available in	F 880	12/7/2021 on proper hand hygiene and proper glove usage when providing peri care and passing meal trays. Education provided by DON/ADON to licensed nursing staff 12/5/2021-1/12/2022 on controlling and preventing the spread of infection through the use of appropriate methods including hand hygiene and proper glove usage. SDC provided education to full time facility staff including agency staff that were scheduled and available on 1/7/22 and 1/11/22 regarding hand hygiene, hand washing vs sanitizing and proper glove usage. Education will be completed during orientation for all new hired staff including agency employees. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained? DON or Designee will audit hand hygiene and proper use of gloves following peri care and during tray pass/setup through direct observation of staff. Audits to be completed 5xs a week x 2 weeks, 3xs a week x 4 weeks, every other week x 2 months and monthly x 2 months. Any areas identified through this audit will be immediately corrected. The results of all audits will be brought to monthly QAPI for review and recommendations will be made as the committee determines. Date when corrective action will be completed? Date:1/17/2022	

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resident rooms. NA #2 was observed readjusting the height and location of resident's tray table and without performing hand hygiene exited the room. NA #2 removed a second meal tray from the cart then entered a second room and assisted with meal tray setup by opening cartons of milk and juice. NA #2 also readjusted a blanket on the bed then left the room. Without performing hand hygiene NA #2 removed a third meal tray from the cart and entered a third room and after placing the meal tray in front of the resident NA #2 exited the room.

During an interview on 12/05/21 at 12:06 PM NA #2 revealed she received hand hygiene education and knew when items in a resident's room were touched hand hygiene should be done. NA #2 revealed resident alcohol-based hand rub was available along with soap and water to wash her hands and stated she should've preformed hand hygiene between meal tray delivery and setup.

An interview conducted on 12/07/21 at 2:25 PM with the Staff Development Manager (SDM) revealed she was in-charge of Infection Control training and stated she would expect the NA staff to wash their hands after touching personal items in the residents room and before serving the next resident their meal tray.

During an interview on 12/09/21 at 4:36 PM the Director of Nursing (DON) stated the facility had placed alcohol-based hand sanitizer in hallways for the purpose of hand hygiene and it was her expectation for the NA staff to use between serving meals trays and touching resident personal items.

3. During a continuous observation on 12/05/21

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12:03 PM to 12:15 PM, Nurse Aide (NA) #1 was observed wearing gloves as she retrieved a meal tray from the food cart positioned in the middle of the resident hall, entered room #511, placed the meal tray on the overbed table and moved the table closer to the resident. NA #1 then exited the room to retrieve a clothing protector from the linen cart, returned to room #511, assisted the resident with putting on the clothing protector, uncovered the food on the tray and exited the room without removing her gloves and performing hand hygiene. NA #1 returned to the food cart, retrieved another meal tray, entered room #510, placed the meal tray on the overbed table, moved the table closer to the resident, and exited the room without removing her gloves or performing hand hygiene.

An interview attempt with NA #1 on 12/05/21 at 12:30 PM was unsuccessful.

During an interview on 12/07/21 at 2:30 PM, the Staff Development Manager (SDM) stated all staff were trained and expected to sanitize hands in-between meal tray delivery, especially when they are providing meal set-up assistance and moving overbed tables.

Telephone attempts on 12/07/21 at 2:33 PM and 12/08/21 at 1:16 PM for an interview with NA #1 were unsuccessful.

During an interview on 12/09/21 at 4:23 PM, the Interim Director of Nursing (IDON) stated it was her expectation for staff to perform hand hygiene when entering/exiting resident rooms and in-between meal tray delivery. The IDON added staff should not wear gloves out in the resident hall after touching resident items and exiting the

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F 880	Continued From page 42 room. During an interview on 12/09/21 at 4:45 PM, the Administrator explained hand sanitizer units were mounted by each resident's door and staff were expected to perform hand hygiene when entering/exiting resident rooms and in-between meal tray delivery. She added gloves should not be worn out in the hall after exiting a resident's room.	F 880		