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	345363	A. BUILDING _____ B. WING _____	C 04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPASS HEALTHCARE AND REHAB HAWFIELDS, INC	2502 S NC 119 MEBANE, NC 27302

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F 000	INITIAL COMMENTS The surveyor entered the facility on 4/24/22 to conduct a complaint survey and exited on 4/26/22. Additional information was obtained on 4/27/22 and 4/28/22. Therefore, the exit date was changed to 4/28/22. Four of eleven complaint allegations were substantiated. Event YRKF11 NC Intakes: 186740; 188170; 188355; 188233	F 000		
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 observation, record review, staff interview, Responsible Party interview, Nurse Practitioner interview, and Physician interview, for a dependent resident with altered sleep patterns, the facility failed to assess how the schedule of getting the resident in and out of bed for rest/sleep could potentially be contributing to falls and injuries and thereby implement routines to better help her sleep cycle. This was for one (Resident # 1) of three sampled residents reviewed for falls. The findings included: Resident # 1 was initially admitted to the facility on 1/12/16. The resident was 98 years of age. The resident had diagnoses of Alzheimer's	F 689	F689 Revised Free of accident hazards This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate	5/20/22

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

Electronically Signed | 05/13/2022

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F 689	Continued From page 1 dementia with behavioral disturbance, delusional disorders, hypertensive heart disease, chronic kidney disease, atherosclerosis, anxiety disorder, insomnia, vitamin D deficiency, gastroesophageal reflux disease, hypertension, osteoporosis, sensorineural hearing loss, chronic pain, history of breast carcinoma, history of dizziness and giddiness, and history of hip fracture in 2016. Resident # 1's 1/22/22 quarterly MDS (Minimum Data Set) assessment coded Resident # 1 as severely cognitively impaired and as needing extensive assistance with bed mobility, transfers, dressing, and hygiene. She was non-ambulatory and had a history of one fall without major injury since the prior MDS assessment. Resident # 1 was also coded as having daily behavioral problems that were not directed at others. The resident's care plan, last updated and revised on 4/22/22, included the resident was at risk for falls due to her dementia, cognitive loss, weakness, psychotropic medication use, polyarthritis to both knees, and no safety awareness. This had been originally added to the care plan on 7/8/2020 and remained an active problem on the resident's current care plan. Interventions, which had been initially added on 7/8/2020, included the following: Make sure room is free from clutter. Keep personal items and frequently used items within reach. Keep call light in reach at all times. Keep bed in lowest position with brakes locked whenever resident is in the bed. Ensure resident is wearing proper footwear when mobilizing in wheelchair. Anticipate and meet resident's needs. On 4/8/21 "bedside mat on floor beside bed whenever resident is in the bed. Mat to be put away when resident is out of bed" was added to the care plan. This remained	F 689	the good faith attempts by the provider to improve the quality of life of each resident. 1. Physician made aware of resident sleep pattern. New order for melatonin 9 mg daily at HS ordered effective 4/28. Sleep pattern is being monitored to determine the effectiveness of the new order. Effective 4/27/2022 resident was removed from the 3rd shift “get up list”. The resident care plan has been updated to indicate that resident will be offered and assisted to lay down in bed when resident is observed to be sleeping in her wheelchair. Resident care guide that is located in the resident room has been updated to reflect that resident is to be offered and assisted to lay down in bed when resident is observed to be sleeping in her wheelchair. 2. The director of nursing and interdisciplinary team has conducted a baseline audit of 100% of facility residents to identify any sleep pattern disturbances. No other residents were identified as having a sleep pattern disturbance at this time. 3. Resident sleep pattern concerns or issues identified by the nursing staff will be reported daily to the unit manager on the shift report. Each unit manager will bring any sleep pattern concerns to the daily clinical meeting to be addressed by the interdisciplinary team (IDT). All licensed nurses, including unit managers	

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F 689	Continued From page 2 part of her active care plan also. Resident # 1 's care plan noted her behavioral problem was wandering and yelling out and included interventions to address her behaviors also. A review of Resident # 1's current and past psychotropic medications revealed the following medications. Clonazepam .25 mg (mg) twice per day ordered since 6/25/21. Depakote Sprinkles 250 mg twice per day ordered since 4/21/21 Zoloft 75 mg daily ordered since 3/1/22. (The resident had been on 50 mg daily prior to 3/1/22). Resident # 1 had been prescribed 75 mg Risperdal every day from 8/12/20 until 1/7/22; at which time she was started on a gradual drug reduction and the medication was discontinued completely on 2/14/22. On 1/10/22 at 3:30 PM Nurse # 1 documented Resident # 1 was observed lying on the floor beside her wheelchair on her right side. She complained of some right arm pain. The physician was called and ordered x-rays of her right arm. On 1/11/22 the x-ray results showed no acute fracture or abnormality. Nursing notes on 1/11/22 reflected the resident was no longer complaining of pain and had no other injuries. On 1/11/22 the resident's care plan was updated to reflect she had fallen on 1/10/22 and staff were directed to monitor Resident for wheelchair safety. Nurse # 1 was interviewed on 4/24/22 at 4:35 PM and reported the following. The resident's fall had not been witnessed by anyone. The resident was	F 689	will be in-serviced by the director of nursing/designee on the new sleep pattern disturbance reporting process/protocol. Provider to be made aware of any sleep pattern disturbances to make any appropriate recommendations/orders. Identified sleep pattern disturbance will trigger further review of the residents' fall risk assessment during the clinical IDT meeting. 4. DON/designee to conduct an audit of the 24-hour shift reports to ensure sleep pattern disturbances are being documented and completed on the shift report, and that shift reports are being reviewed by the IDT during each clinical meeting. This audit will occur weekly x 4 weeks, then monthly x 3 months. Audit results to be reported to monthly QAPI committee meeting until a pattern of compliance is established. 5. Completion date: 5/20/2022	

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non-ambulatory and he thought she might have been trying to get up. She had been in the wheelchair. She had no head injury and appeared okay except for initially complaining of some arm pain.

Interview with the Director of Nursing (DON) on 4/28/22 at 10:50 AM revealed Resident # 1's 1/10/22 fall was the first fall she had sustained in over a year. The DON reported the resident had not fallen since October 2020 prior to the date of 1/10/22. At the time, the resident's care plan was updated to reflect the staff should monitor her for wheel-chair safety, but the facility's investigation had not been able to reveal with certainty how she had fallen because no one had been present.

On 2/12/2022 at 6:18 AM, Nurse # 4 documented Resident # 1 had an echymotic (bruise) spot to her right outer eye. The nurse described it as "purplish/red" and without any signs of swelling. Nurse # 4 further documented she asked the resident how it had occurred and the resident could not recall.

Review of facility records revealed the facility investigated the 2/12/22 eye bruise and reported it as an injury of unknown origin to the state agency. The investigation summary contained the following information. "On 2/14/22 while investigating the incident it was observed by me and (Nurse # 2) the resident was laying her head down, on the right side of her face on her bed side table. This was also reported by several staff members that the resident lays her face down on her bedside table throughout the day. She was then observed on 2/16/22 to have her face lying down on the bed side table with her hand balled up under her right eye." The investigation

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documentation included that the bedside table would be padded to further reduce risk of injury in the future.

On 3/8/22 at 12:32 PM, Nurse # 3 documented Resident # 1 had a bruise under her left eye. There was no swelling noted or pain. The nurse noted the resident's bruise was exactly in the area where she rested her hand.

The ADON (Assistant Director of Nursing) and Unit Manager were interviewed on 4/26/22 at 11:05 AM and reported the right eye bruise, which was sustained on 2/12/22, was very small; "at the most the size of a quarter" and was in a half moon shape. The ADON stated she had been the one to investigate the bruise and the resident had a habit of leaning her head on her propped- up hand. When another bruise occurred under the opposite eye, she was again observed resting that area of her head in her hand and they did not do an entire new investigation into the left eye. They felt the left eye was from the compression of her head in her hand as the first bruise was and it was very small. They also reported the resident used to wear glasses, which she no longer used, and the areas could have come from some compression from the frames as she rested her head. The resident was also known to rest her head on the bedside table and the facility had padded the bedside table with a mat after the 2/12/22 right eye bruise.

On 3/23/22 at 2:50 AM, Nurse # 4 documented the following in the record. Resident # 1 was heard yelling from her room. When the Nurse Aide checked on her, the resident was found on the floor beside her bed with her right leg on the bed. She was found to have a large contusion

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(bruise) to her right forehead and small abrasion to the right side of her occipital head with scant bleeding. The nurse assessed the resident's neurological status, found the resident's pupils to be equal and reactive to light, checked the resident's vital signs, applied ice to the contusion, and notified the physician. Nurse # 4 noted she would continue to monitor the resident.

Nurse # 4 was interviewed on 3/23/22 at 11:10 PM and again on 4/28/22 at 11:35 AM and reported the following. The resident was assessed. She felt the resident might have hit her head on the bed frame. According to Nurse # 4, the resident had fallen out towards the side of the bed near her window. There was a wardrobe beside that side of the bed, but it did not appear that she had hit the wardrobe. There was no blood on it nor the floor. The floor mat had been in place on the opposite side of the bed because that was the side from which the resident generally tried to get up. She continued to check on the resident throughout the night and she seemed okay.

On 3/23/22 at 12:26 PM, Nurse # 3 documented the following. At 8:45 AM the resident was then complaining of pain in addition to having the hematoma and the laceration. The resident's vital signs were assessed and Resident # 1's Responsible Party (RP) was notified that the resident needed to be evaluated at the emergency room. The Nurse practitioner was also called.

Nurse # 3 was interviewed on 4/25/22 at 2:33 PM and reported the following. Nurse # 4 had assessed Resident # 1 when she fell out of bed on 3/23/22. She (Nurse # 3) then came on duty

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and, when she assessed Resident # 1, she felt at that time it was better to have the resident checked at the hospital. She contacted the RP, who agreed.

According to hospital Emergency Department records for 3/23/22, the resident was "alert and disoriented; well-appearing and in no acute distress" on initial assessment. She was assessed to have a hematoma to the forehead and to the back of the head with a scabbed over laceration on the back of her head. A CT scan showed no acute abnormality. She was diagnosed with a contusion of the forehead, a concussion, and a scalp laceration which did not require sutures. The resident was transferred back to the facility on 3/23/22 after evaluation.

According to an interview with the DON on 4/26/22 at 1:40 PM, the fall mat was in place on the right side of the bed (where the wardrobe was not) when the resident fell. She fell towards the wardrobe area of the bed. Following the fall, they did intervene. They moved one side of her bed against the wall, and then the fall mat was placed by the one open side of the bed. They also placed a scoop mattress on the bed.

Review of the resident's care plan revealed it was updated on 3/28/22 to reflect the resident had a scoop mattress.

On 3/28/22 Resident # 1 was seen by the Psychiatric Nurse Practitioner (NP), who noted staff reported to her that the resident was more restless and awake at night. The Psychiatry NP ordered to change her evening dose of Clonazepam to 9 PM, which would be closer to her bedtime.

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On 4/12/22 at 7:33 AM, Nurse # 3 documented that at shift change staff were called to Resident # 1's room and she was found laying on the floor bleeding from the center of her forehead. The resident was alert, breathing, and complaining of pain to her head. Staff took measures to control the bleeding and EMS was called. The resident was transferred to the hospital for evaluation.

Review of emergency department records for 4/12/22 revealed Resident # 1 had a 4 centimeter laceration to her head which required seven sutures. She also had sustained a nondisplaced fracture through the floor of the left maxillary sinus. After her evaluation and laceration repair, she was transferred back to the facility on 4/12/22.

Nurse # 3 was interviewed on 4/25/22 at 2:33 PM and reported the following. It was near shift change when she had already come on duty for first shift that she was alerted by NA (Nurse Aide) # 1 that Resident # 1 was on the floor. The resident was found on the floor with her feet near the bathroom door. Nurse # 1 reported the resident could not stand up from her wheelchair, and so she was unsure how she fell. Nurse # 5 had come to assist and held pressure to the wound while she called EMS to respond. Nurse # 3 reported that third shift routinely got the resident out of bed and therefore Resident # 1 was already up when she came on duty. Nurse # 3 stated the night shift had been reporting that the resident was not sleeping at night. Nurse # 3 stated that at times staff would lay Resident # 1 in bed to rest and then she would want right back up.

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NA # 1 was interviewed on 4/25/22 at 2:50 PM and again on 4/26/22 at 9:10 AM. NA # 1 reported the following. He had worked a double shift beginning on 4/11/22 at 11:00 PM and through to 4/12/22 at 3:00 PM. NA # 1 reported Resident # 1 would routinely yell at night and would be awake around 12:00 midnight and could be awake for three or four hours. He stated that she slept more in the daytime than at night. He was not assigned to Resident # 1 on the night shift which began on 4/11/22, but knew that NA # 2 (her assigned NA) had gotten her up between 5:00 and 5:30 AM on 4/12/22. On the AM of 4/12/22 Resident # 1's assigned dayshift NA had been working with another resident and he had walked by Resident # 1's room and saw Resident # 1 by the bathroom door on the floor. He had gotten help immediately.

NA # 2, who had worked on 4/11/22 beginning at 11:00 PM, was interviewed on 4/25/22 at 4:45 PM and reported the following. Resident #1 had not been sleeping well since around December 2021. She thought they had changed her medication and it seemed to coincide with this. She was very anxious and would routinely be awake from 11:00 PM until around 3:00 AM. She then would get her up around 5:30 AM. On the morning of 4/12/22, she had gotten her up around that time and her shift was over when Resident # 1 fell. She later heard that she was found on the floor. NA # 2 reported the resident would yell at times and at other times she would get sleepy and lean in her wheelchair. She was afraid the resident would fall when she leaned in the wheelchair, and someone had told her to put the bedside table in front of her. She had been doing that. NA # 2 was interviewed regarding why she was getting Resident # 1 up around 5:30 AM if she was not

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going to sleep until 3:00 AM. NA # 2 responded that Resident # 1 was on the "get up list" for third shift along with her roommate. She would go into the room to first get Resident # 1's roommate up and when she turned on the light for the roommate, then Resident # 1 would start yelling. On the AM morning of 4/12/22, NA # 2 reported the resident was awake when she got her up.

During the interview with Nurse # 4 on 4/25/22 at 11:10 PM and again on 4/28/22 at 11:35 AM, Nurse # 4 also reported Resident # 1 did not sleep well at night. Nurse # 4 reported the resident had "no good sleep pattern at all," and this had been a problem since some medication changes. Her sleep was sporadic. The staff would put Resident # 1 in bed at night, but she called out repetitively to "get me up-get me up." Then the staff got her up early and she was still sleepy at times. Nurse # 4 reported that Resident # 1 and her roommate had been on the "get up list" for third shift since she had started working around November 2021. She knew both residents tended to yell in the AM to get up when they awakened and the "get up list" had never been adjusted since Resident # 1 had been falling. Nurse # 4 reported that she thought it was a possibility Resident # 1 may have fallen asleep in the wheelchair when she fell on the AM of 4/12/22, but she could not say for sure because no one was present. Nurse # 4 reported she had worked the nightshift which began on 4/11/22 and had been present at shift change when Resident # 1 was found at shift change on 4/12/22. Nurse # 4 reported she had last seen Resident # 1 around 6:00 AM and she was up in her wheelchair, awake at that time, and okay.

Review of Resident # 1's care plan revealed it

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was updated following the fall of 4/12/22 to reflect that the resident would have a therapy evaluation. On 4/26/22 at 12:10 PM this was confirmed with the Rehab director to have been done. The resident had been ordered a smaller wheelchair to see if that would help decrease her falls and a wedge cushion had also been ordered. The rehab director reported all therapy disciplines were continuing to work with Resident # 1 as of 4/26/22.

A review of the care plan did not reveal the resident's sleep disturbances and habits were addressed on the care plan as possibly contributing to her falls.

Interview with the MDS care plan nurse on 4/26/22 at 2:00 PM revealed no one had mentioned to her about addressing the resident's altered sleep pattern in conjunction with the current schedule of getting her up on third shift, and therefore a new planned schedule had not been re-evaluated.

Resident # 1 was initially observed on 4/24/22 at 1:37 PM in her room. The resident was leaning forward in her wheelchair and had her head face-down onto a pillow which was on a padded bedside table. The bedside table was in front of her wheelchair and appeared in a stable position to the extent the resident was not falling further forward out of the wheelchair. She appeared to be asleep. Resident # 1 was observed in this same position on 4/24/22 at 2:19 PM, and again at 3:15 PM. During the 1:37 PM observation, NA # 3 was interviewed about the resident sleeping while leaning over on her bedside table. NA # 3 responded that they let her sleep in her chair; otherwise if they put her in bed, then she would

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be trying to get up. Nurse # 6 was also interviewed at this time about the resident sleeping with her head on the bedside table and responded that sometimes she does that. At 5:00 PM, Resident # 1 was observed awake and yelling in the hall for the nurse to help her. The resident was observed to be able to maneuver her wheelchair unassisted and roll herself. Staff were observed to try to talk and calm the resident. The resident appeared very anxious.

Resident # 1's RP was interviewed on 4/24/22 at 3:30 PM and reported the staff were not consistent in whether they laid the resident down if she was sleeping in the chair. She noted she had been in earlier that afternoon and spoken to the staff about finding her sleeping in the chair and they didn't lay her down. During a follow up interview with the RP on 4/25/22 at 12:30 PM the RP reported she had been the one to put the pillow under the resident's head on the afternoon of 4/24/22 because staff were letting her sleep on the bedside table and did not lay her down.

Another NA (NA # 4), who cared for Resident # 1 was also interviewed about what they do when the resident falls asleep in the chair. NA # 4 was interviewed on 4/25/22 at 2:20 PM regarding this and responded that she put the resident to bed if she was sleeping in her chair.

Interview with the Director of Nursing on 4/26/22 at 10:15 AM revealed the facility had tried to look into the resident's falls and address each fall or incident to minimize Resident # 1's risk for injury as indicated in their care plan updates. None of the falls were witnessed and therefore they were unable to say what had actually occurred. The DON had not been aware the resident was not

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sleeping well at night and that staff were getting her up around 5:30 AM. The DON stated there were certain residents, for staff accountability purposes, that were assigned to certain shifts to be assisted out of bed; but Resident # 1's schedule of being on night shift to get up had not been brought to his direct attention as something to evaluate. Resident # 1's routine of getting out of bed early had not been reassessed after her falls. The observations of Resident # 1 sleeping on her bedside table on 4/24/22 at 1:37 PM, 2:19 PM, and 3:15 PM were shared with the DON during the interview. The DON stated if a resident was sleeping for that length of time in their chair, then it would have been a reasonable expectation to assist her to lie down.

Interview with the Unit Manager and the ADON on 4/26/22 at 11:05 AM revealed they were unaware Resident # 1 was not sleeping until around 3:00 AM and the staff were continuing to turn on the light to get the roommate up and then also get Resident # 1 up around 5:30 AM. The Unit Manager stated if the resident was sleeping in her wheelchair during the day, it would be a reasonable expectation to lay her down.

Resident # 1's physician was interviewed on 4/24/22 at 11:50 PM and reported the following. Resident # 1 was very frail, had no fat padding due to her far advanced age, and could very easily bruise with minimal pressure. The resident used to be on Risperdal to help with agitation but her RP wanted it discontinued because the RP felt it was contributing to sedation and the Clonazepam did not help with her agitation as well. The RP was hesitant to add medication. Changes made in her Zoloft on 3/1/22 usually took 4 to 6 weeks to see a difference. She did

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F 689	Continued From page 13 feel as if the staff were watching the resident and trying to keep her from falling, but that the resident had her days and nights mixed up. It had been difficult to address this because of the RP's hesitancy about medication, which in the physician's opinion, had been helping the resident. The physician did feel the lack of sleep could potentially contribute to falls but over all she felt the facility staff were trying to address her falls. The physician noted the resident was far advanced in age and could fall asleep where ever she was. Resident # 1's psychiatric Nurse Practitioner was interviewed on 4/26/22 at 12:45 PM and reported Resident # 1 had a lot of anxiety and agitation. She constantly was asking staff to take her home and the Risperdal had helped with that. Resident # 1 was calm while her RP was visiting and therefore the RP did not often see the behaviors and was hesitant to have the Risperdal continued. The psych NP stated she did think that the resident's anxiety and restlessness had contributed to her falls, and she had instructed the staff to change the second dose of Clonazepam to later in the evening to try to help with that and on 3/1/22 the resident had an increase in her Zoloft. Although the Psych NP was aware the resident was restless at night, she was not aware the resident was not going to sleep until around 3:00 AM and not aware the staff were getting her up around 5:30 AM. The NP did feel as if there were ways to possibly help improve the resident's sleep cycle.	F 689		
F 806 SS=E	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink	F 806		5/20/22

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F 806	Continued From page 14 Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview and staff interview the facility failed to assure a system was in place for food preferences and choices to be met for five (Residents # 2, # 3, # 4, # 5, and # 6) of five residents reviewed for food choices. The findings included: Review of dietary menus for Sunday (4/24/22) through Saturday (4/30/22) revealed the following menu for Sunday lunch on 4/24/22: baked chicken, garden rice, mixed vegetables, roll, and fruited Jello. The alternate for the meal was listed as soup and sandwich. Available sandwiches were listed as : ham, turkey, bologna, grilled cheese, peanut butter and jelly. Review of the menu revealed that everyday the alternate meal was for soup and the same sandwiches mentioned above. There was no mention of salads as an alternative. There was no mention of the planned soups available for each meal. 1 a. Resident # 4 was admitted to the facility on 8/5/16. Some of the resident's diagnoses included aphasia and dysphagia.	F 806	F806 Resident allergies, preferences, substitutes This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. 1. Food preferences for residents #2, #3, #4, #5 and #6 have all been identified through resident interview and added to each individual residents “meal tracker” ticket and are receiving foods according to their preferences. 2. The dietary manager has conducted a facility-wide audit to identify any other residents affected by the deficient practice. All residents identified as not	

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F 806	Continued From page 15 The resident's current diet order, initially dated 10/26/21, was for a low concentrated sweets diet with a mechanical soft consistency. Resident # 4's care plan, last revised on 3/16/22, directed staff to honor the resident's food preferences. Resident # 4 was initially observed on 4/24/22 at 12:58 PM. A lunch tray was before her but she was no longer eating. She had eaten the fruited Jello. She had not eaten the chopped chicken, mixed vegetables, or rice. Review of her diet card revealed a notation that the resident did not like steamed rice or carrots. The mixed vegetables observed on the plate included many carrots. The resident was asked if she was still hungry and nodded her head to signify that she was. At the time, her roommate had already finished her meal. On 4/24/22 at 1:01 PM, Nurse # 7 was interviewed about the resident's tray card and the items on her tray. Nurse # 7 stated she would check with dietary to see if they could obtain an alternate meal. On 4/24/22 at 1:23 PM Dietary Aide (DA) # 1 was observed to bring an alternate tray for Resident # 4 which had a sandwich and soup on it. DA # 1 confirmed Resident # 4 should not have been served the mixed vegetables with the carrots or the rice because of her preferences not to have them. DA # 1 stated that soup and sandwich were the only alternate for the meal that day. On 4/24/22 at 1:34 PM, Resident # 4 was observed eating the sandwich and nodded her head that she like the sandwich.	F 806	having food preferences listed on their meal tracker ticket have been interviewed for their likes and dislikes. Their preferences have been added to the meal tracker system. 3. Dietary manager and lead cook have been re-educated on the requirement that “each resident is to receive and the facility is to provide food that accommodates resident allergies, intolerances, and preferences; 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”. Dietary manager and lead cook have been re in-serviced to conduct a meal preference interview, identifying likes and dislikes upon admission and quarterly for each resident. All dietary staff have been re in-serviced to verify meal trays do not contain food items that are on the resident dislike list. The new process requires that at least two dietary personnel check the meal tray against the meal ticket each meal to ensure food preferences are honored. 4. Dietary manager/designee to conduct a random audit of 10 resident (to include new admissions) meal tracker tickets for preferences weekly x 4 weeks, then monthly x 3 months to ensure each resident meal ticket contains resident preferences. Dietary manager/designee to conduct meal tray audits weekly x 4 weeks, then monthly x 3 months to verify no food items from the dislikes list is on the tray and preferences are being honored. Audit results to be reported to monthly QAPI committee meeting until a	

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F 806	Continued From page 16 1 b. Resident # 3 was initially admitted to the facility on 11/8/21 and had a diagnosis of dysphagia. Resident # 3's quarterly MDS, dated 2/4/22, revealed he had mild cognitive impairment. The resident's current diet order was for a low concentrated sweets diet with a mechanical soft consistency and for two cartons of whole milk to be delivered each meal. Review of the resident's current care plan, revised on 4/25/22, revealed meal preferences would be honored. Resident # 3 was observed on 4/24/22 at 12:20 PM. The resident had his lunch tray before him. He complained of a lack of food variety. The resident pointed to the mixed vegetables on his tray and said he did not like mixed vegetables. He loved salad though. A review of the resident's meal tray card revealed it had no likes or dislikes listed on his meal tray card. Resident # 3 was again observed on 4/25/22 at 12:35 PM. The resident had no milk on his tray. The resident stated he loved milk and used to have his own cows for fresh milk but the facility did not send milk. The resident also had green beans and he stated he did not like those either. The resident's tray card still did not denote any likes or dislikes for the resident. 1c. Resident # 5 was last admitted to the facility on 6/28/21. The resident had a diagnosis of dysphagia. The resident's annual assessment, dated 3/31/22, coded the resident as cognitively intact. The resident had a diet order, dated 7/1/21, for a No Added Salt diet with a mechanical soft consistency. Resident # 5's care	F 806	pattern of compliance is established. 5. Completion date: 5/20/2022	

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plan, last revised on 4/22/22, noted to honor the resident's food preferences.

Resident # 5 was observed on 4/24/22 at 1:06 PM to have her lunch tray before her. The resident was very upset about her food. She stated she did not like the chicken and the mixed vegetables on her tray. She stated the previous day (4/23/22) they had served her fish at lunch and she did not like it either. It took them a very long time to get her a meal replacement the previous day and she ended up drinking a protein drink and making some peanut butter crackers which she had in her room. NA # 3 came into the room while the resident was talking and said they had gotten the resident soup and sandwich the previous day and they would get her another bowl of soup and a sandwich again. NA # 3 stated the resident liked that. Review of Resident # 5's tray card revealed it had no dislikes or likes listed on the tray card.

1 d. Resident # 2 was admitted to the facility on 8/3/17. The resident's quarterly MDS assessment, dated 5/6/22, coded the resident as cognitively intact. The resident's diet order, dated 8/17/21, was for a No Added Salt/ Low concentrated Sweets diet.

Resident # 2 was observed on 4/25/22 at 1:05 PM with her lunch tray before her. One of the items was mashed potatoes. It was observed that Resident #2's tray card noted that she did not like mashed potatoes. Resident # 2 confirmed that she did not. Resident # 2 complained about the variety of food. Resident # 2 stated she did not like to eat a lot of bread and the only alternate to meals was soup and sandwich.

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1 e. Resident # 6 was admitted on 4/5/18. The resident's quarterly MDS assessment, dated 4/13/22, coded the resident has cognitively intact. The resident's current diet order, dated 7/5/21, was for a Low Concentrated Sweets diet of regular consistency.

Resident # 6 was interviewed on 4/24/22 at 2:48 PM and reported she really liked fresh fruit but the facility did not often have fresh fruit to offer them. The resident stated she disliked canned fruit. The resident reported that one time in the past three months, she had an apple and that was the only fresh fruit she had gotten in that time period.

The DM (Dietary Manager) was interviewed on 4/25/22 at 3:30 PM and reported the following. She was new to the facility and had been there for only a few weeks. Multiple dietary managers had been hired in the past year but had not stayed. She was trying to get everything in order. In regards to the residents who had food items on their trays that were listed as dislikes for them, the DM stated this should have been caught on the tray line and not served to them. The DM stated resident preferences should be obtained at time of admission and then updated during their care plan meetings. All residents should have their likes and dislikes listed on their tray cards so that the staff would know when the trays were being prepared. The DM reviewed the dietary department's meal tracker computer system during the interview. The DM found that Resident # 3 and Resident # 5, whose tray cards had not included dislikes and likes, had no information entered into the dietary's computer system about their likes and dislikes. The DM also could not find in their system that Resident # 3 was to have

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two cartons of milk with each of his meals. The DM stated that Resident # 3's clinical record, which contained the diet order and instructions to send milk, was not the same computer system in the dietary department. The DM reviewed the dietary computer system for Resident # 6 and found that it did include that she disliked canned fruit but made no mention that she liked fresh fruit. The DM stated when she began employment, the dietary department only had fresh apples for fresh fruit, and she was planning on trying to order different fruit; but currently apples were all she had in stock in the dietary department. In regards to Resident # 2's complaint that there was only soup and sandwich for an alternate and the resident did not like bread, the DM stated they did offer tuna salad and chicken salad sandwiches and this could be served without the bread as their entrée. According to the DM, alert residents were given the seven- day planned menu once a week and they could choose to have the soup and sandwich or the planned meal.

The RD (Registered Dietician) was interviewed on 4/27/22 at 12:52 PM and again at 2:01 PM and reported the following. The current DM was brand new and she was trying to do things correctly. There had been several DMs prior to the current one and they had not stayed for long periods of time. During the employment of the last two DMs, the facility had implemented a new dietary computer system; called Meal Tracker. The past two DMs were involved in getting training on the new system and implementing it. She knew that one of them had gone around to many residents to try to assess their preferences, but she could not find their notes and it appeared as if all of the information had not been entered into the new

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meal tracker system. Therefore, some of the residents' meal tray cards had no dislikes or likes listed although they should have been if the information had been put correctly in the new system. If the information had been put in the system, then it would be appearing on the tray cards to facilitate serving residents the foods they preferred. The RD also reported it had always been the facility's practice to offer a comparable alternate for their side vegetables, but she had just learned that day (4/27/22) from talking to the dietary staff that a few weeks ago they had stopped offering an alternative for the side vegetable. Therefore on 4/24/22 when mixed vegetables were served, there had been no comparable vegetable to offer. The RD stated staff had told her this was because of product availability and staff shortages. The RD did say the facility did make chef salads for residents who could eat the consistency of a salad and this should be listed on the menu; but it had not been. For residents, who did not like the entrée, then a salad would be a comparable meal and this had been conveyed to the residents who attended resident council, but it had not been transcribed to the menu so other residents would know it was a daily choice. The kitchen typically wanted to know by 10:00 AM if residents wanted a salad so they could prepare it. She confirmed that Resident # 3, who disliked the mixed vegetables and green beans he had been served, could have salads with some limitations of the salad items because of his diet consistency. The RD stated the menu, from which the alert residents were choosing each week, should have all the sandwich and soup options listed and it did not. The RD did feel as if offering more than just apples when seasonal fruit was in season was a reasonable option for the dietary department to

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