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	345557	A. BUILDING _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZALEA HEALTH & REHAB CENTER	3800 INDEPENDENCE BOULEVARD WILMINGTON, NC 28412

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E 000	Initial Comments An unannounced recertification survey and complaint investigation was conducted onsite 03/25/24 through 03/28/24. Additional information was provided on 04/02/24 therefore the exit date was 04/02/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #6TJD11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted onsite from 03/25/24 through 03/28/24. Additional information was obtained on 04/02/24. Therefore, the exit date was changed to 04/02/24. Event ID# 6TJD11. The following intakes were investigated: NC00215038 NC00212584 NC00206953 NC00205637 NC00211669 NC00214361 NC00209687 NC00209825 NC00213090 NC00214387 NC00215013 10 of the 43 complaint allegations resulted in deficiency.	F 000		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing	F 582		4/23/24

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

Electronically Signed | 04/23/2024

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F 582	Continued From page 1	F 582		

facility and when the resident becomes eligible for Medicaid of-
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or

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F 582	Continued From page 2 discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (form 10055) prior to discharge from Medicare Part A skilled services (Resident #18 and Resident #66) and failed to provide a Centers for Medicare and Medicaid Services (CMS) Notice of Medicare Non-Coverage (form 10123) prior to discharge from Medicare Part A skilled services (Resident #324) for 3 of 3 residents reviewed for beneficiary protection review. The findings included: 1. Resident #18 was admitted to the facility 9/26/23 and admitted to Medicare Part A services. Resident #18's Medicare Part A skilled services ended on 10/22/23 and she remained in the facility. The SNF ABN reviewed revealed Resident #18's name, the date services were to end, and the estimated cost of the services. There were no options checked for the decision made about continuing Medicare Part A services.	F 582	On 4/19/2024 the Nurse Practitioner was notified that the facility failed to provide a Centers for Medicare and Medicaid Services Skilled Nursing Facility Advanced Beneficiary Notice prior to discharge from Medicare Part A skilled services for resident #18 and resident #66 and failed to provide a Centers for Medicare and Medicaid Services Notice of Medicare Non Coverage prior to discharge from Medicare Part A skilled services for resident #324. On 4/19/2024 the Social Worker reviewed all residents projected to discharge between 4/19/2024 and 4/21/2024 to ensure the facility provided a Centers for Medicare and Medicaid Services Skilled Nursing Facility Advanced Beneficiary Notice prior to discharge from Medicare Part A skilled services or provided a Centers for Medicare and Medicaid Services Notice of Medicare Non Coverage prior to discharge from Medicare Part A skilled services. No issues were identified. Education was provided to the	

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F 582	Continued From page 3 An interview was conducted with the facility Social Worker on 3/27/24 at 2:51 PM who stated she neglected to have Resident #18's Resident Representative choose an option for the decision made regarding continuing Medicare Part A skilled services. The facility Social Worker stated her normal process is to contact the Resident's Representative and let them know Medicare Part A services are ending and provide them with the CMS form 10123. If the resident wishes to remain in the facility, she provides the SNF-ABN form. The facility Social Worker stated she either meets with the Resident Representative in person or contacts the Resident Representative over the telephone and mails the forms. Attempts to contact the resident and Resident Representative were unsuccessful. An interview was conducted with the facility Administrator on 3/28/24 at 10:56 AM who stated the SNF ABN should have been completed with Resident #18's Resident Representative's decision made regarding continued Medicare Part A skilled services. 2. Resident #66 was admitted to the facility on 1/17/24. She was admitted to Medicare Part A skilled services on 1/17/24. Resident #66's Medicare Part A skilled services ended on 2/5/24 and she remained in the facility. The SNF ABN reviewed revealed Resident #66's name, the date services were to end, and the estimated cost of the services. There were no options checked for the decision made about continuing Medicare Part A services. The CMS	F 582	Interdisciplinary Team by the Facility Administrator on 4/22/2024 on ensuring ABN and NOMNC are being provided accurately and timely. The Facility Administrator will review all residents that are projected to discharge 5x week for 12 weeks to ensure ABN and NOMNC have been provided accurately and timely. The Quality Assurance Performance Improvement Committee will review the audits monthly for 3 months. The Quality Assurance Performance Improvement Committee may change the corrective action or extend the audits to ensure ongoing compliance.	

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F 582	Continued From page 4	F 582		

form 10123 revealed the facility Social Worker had a conversation on 2/2/24 with Resident #18's Resident Representative regarding Medicare Part A skilled services ending.

An interview was conducted with the facility Social Worker on 3/27/24 at 2:51 PM who stated she did not check an option for the decision made about continuing Medicare Part A services. She indicated an option should have been reflected on the SNF ABN. The facility Social Worker stated her normal process is to contact the Resident's Representative and let them know Medicare Part A services are ending and provide them with the CMS form 10123. If the resident wishes to remain in the facility, she provides the SNF-ABN form. The facility Social Worker stated she either meets with the Resident Representative in person or contacts the Resident Representative over the telephone and mails the forms.

Attempts to contact the resident and Resident Representative were unsuccessful.

An interview was conducted with the facility Administrator on 3/28/24 at 10:56 AM who stated that if a conversation was held with Resident #66's Resident Representative it should have been documented on the SNF ABN.

3. Resident #324 was admitted to the facility on 11/21/21 and admitted to Medicare Part A services.

Resident #324's Medicare Part A skilled services ended on 12/6/23. He was discharged to the community on 12/7/23.

Record review revealed Resident #324, nor his

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F 582	Continued From page 5 Resident Representative were given the CMS form from 10123. An interview was conducted with the Social Worker on 3/27/24 at 2:51 PM who stated she was out of the facility on leave during the time of Resident #324's discharge and was unable to locate the completed forms. She reported the facility Business Manager was assisting with this task during her absence. The facility Social Worker stated her normal process is to contact the Resident's Representative and let them know Medicare Part A services are ending and provide them with the CMS form 10123. If the resident wishes to remain in the facility, she provides the SNF-ABN form. The facility Social Worker stated she either meets with the Resident Representative in person or contacts the Resident Representative over the telephone and mails the forms. During an interview with the facility Business Manager on 3/27/24 at 2:55 she indicated she completed the forms for Resident #324 but was unable to locate the facility copies.	F 582		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments.	F 640		4/23/24

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(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:

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F 640	Continued From page 7 Based on record review and staff interviews the facility failed to complete discharge Minimum Data Set (MDS) assessments for 3 of 3 residents reviewed for discharge. (Resident #63, Resident #13, and Resident #52). The findings included: 1. Resident #63 was admitted to the facility on 9/22/23 and discharged to the hospital on 10/2/23. Review of Resident #63's MDS records did not include a discharge assessment for 10/2/23. An interview was conducted with the MDS Nurse on 3/26/24 at 1:50 PM who stated she was unsure the reason a discharge assessment was not completed. During an interview with the MDS Coordinator on 3/26/24 at 1:57 PM she stated she was unsure the reason the discharge assessment was overlooked. An interview was conducted with the Administrator on 3/28/24 at 10:56 AM who stated the discharge assessment should have been completed within the required timeframes. 2. Resident #13 was admitted to the facility on 10/9/23 and discharged to the community on 10/23/23. Review of Resident #13's MDS records did not include a discharge assessment for 10/23/23. An interview was conducted with the MDS Nurse on 3/26/24 at 1:50 PM who stated she was	F 640	The facility Minimum Data Set nurse completed the discharge MDS for resident #63, resident #13, and resident #52 on 3/26/2024. On 4/19/2024 the Minimum Data Set nurse audited all discharged residents since January 1, 2024 to ensure a discharge assessment was completed. Any missed discharge assessments will be completed by Minimum Data Set nurse by 4/24/2024. Education was provided to the Minimum Data Set nurses by the Regional Director of Clinical Services on 4/22/2024 on completing discharge Minimum Data Set assessments. The Facility Administrator or designee will audit the Electronic Medical Record of each discharged resident weekly for 12 weeks to ensure the discharge minimum data set is completed. The Quality Assurance Performance Improvement Committee will review the audits monthly for 3 months. The Quality Assurance Performance Improvement Committee may change the corrective action or extend the audits to ensure ongoing compliance.	

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F 640	Continued From page 8 unsure the reason a discharge assessment was not completed. During an interview with the MDS Coordinator on 3/26/24 at 1:57 PM she stated she was unsure the reason the discharge assessment was overlooked. An interview was conducted with the Administrator on 3/28/24 at 10:56 AM who stated the discharge assessment should have been completed within the required timeframes. 3. Resident #52 was admitted to the facility on 9/27/23 and discharged to the community on 10/16/23. Review of Resident #52's MDS records did not include a discharge assessment for 10/16/23. An interview was conducted with the MDS Nurse on 3/26/24 at 1:50 PM who stated she was unsure the reason a discharge assessment was not completed. During an interview with the MDS Coordinator on 3/26/24 at 1:57 PM she stated she was unsure the reason the discharge assessment was overlooked. An interview was conducted with the Administrator on 3/28/24 at 10:56 AM who stated the discharge assessment should have been completed within the required timeframes.	F 640		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		4/23/24

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F 641	Continued From page 9 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code the Minimum Data Set (MDS) assessment for 2 of 24 residents reviewed for MDS accuracy (Resident #38 and Resident #323). Findings included: 1. Resident #38 was admitted to the facility on 11/7/23 with diagnoses that included dementia and depression. Resident #38's significant change in status MDS assessment dated 2/24/24 revealed she was not assessed for cognition. The cognition section of the assessment had been dashed, indicating the assessment had not been completed. During an interview with the MDS nurse on 3/27/24 at 1:55 PM she stated the cognition section of the MDS assessment should have been completed by the facility social worker. An interview was conducted with the social worker on 3/27/24 at 3:09 PM who stated an assessment for cognition should have been completed for Resident #38. She reported she had been out of the facility, and the assessments were missed. During an interview with the Administrator on 3/28/24 at 10:56 AM she indicated she expected MDS assessments to be completed as specified by the Federal guidelines.	F 641	Resident #38 and #323 no longer reside in the facility. The facility Minimum Data Set nurse will audit all assessments scheduled after 4/15/2024 for current residents for Minimum Data Set section C to ensure it was completed. All other residents identified will be assessed with their next minimum data set. The Regional Director of Clinical Services will educate the facility Minimum Data Set nurses, the facility social worker and the speech therapist by 4/5/2024 on assessment completion and accuracy. The Director of Nursing or designee will audit all Minimum Data Set assessments prior to submission for 5 times a week for 12 weeks to ensure section C is completed and accurate. Any identified issues will be corrected before the Minimum Data Set is submitted. Audits will be reviewed by the Quality Assurance Performance Improvement Committee for 3 months and the committee may change the plan of correction or extend the audits to ensure ongoing compliance.	

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F 641	Continued From page 10 2. Resident #323 was admitted to the facility on 9/21/23 with diagnoses that included heart failure and depression. a. Resident #323's quarterly MDS assessment dated 10/17/23 revealed she was not assessed for cognition. The cognition section of the assessment had been dashed, indicating the assessment had not been completed. b. Resident #323's quarterly MDS assessment dated 10/17/23 revealed she was not assessed for mood. The mood section of the assessment had been dashed, indicating the assessment had not been completed. During an interview with the MDS nurse on 3/27/24 at 1:55 PM she stated the cognition and mood sections of the MDS assessment should have been conducted by the facility social worker. An interview was conducted with the social worker on 3/27/24 at 3:09 PM who stated the assessment for cognition and mood should have been completed for Resident #323. She reported she had been out of the facility, and the assessments were missed. During an interview with the Administrator on 3/28/24 at 10:56 AM she indicated she expected MDS assessments to be completed as specified by the Federal guidelines.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		4/23/24

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F 684	Continued From page 11	F 684		

facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff and Nurse Practitioner interviews the facility failed to administer a topical antibiotic ointment prescribed for treatment to the nasal area following a dermatology procedure and to administer antibiotic ophthalmic drops according to the physicians order for 2 of 2 residents (Resident #48, and Resident #43) reviewed for quality of care.

Findings included.

1.Resident #48 was admitted to the facility on 09/01/23 with diagnosis including malignant melanoma of the skin, and diabetes.

A physicians order dated 03/08/24 revealed Triple Antibiotic External Ointment (Neomycin-Bacitracin-Polymyxin). Apply to nose topically two times a day for Post-operative dermatology for 3 Days.

During an interview on 03/25/24 at 1:00 PM Resident #48 was observed lying in bed. He was alert and oriented to person, place, and time. He stated he had a recent procedure to remove a skin cancer on his nose and he continued to be followed by a dermatologist. He stated an antibiotic cream was prescribed to apply to his nose following the procedure earlier this month, but the antibiotic was not administered every day.

Provider was notified on 4/4/2024 that resident #48 did not receive his antibiotics as prescribed. The provider was notified on 4/23/2024 that resident #43 did not receive their antibiotics as prescribed. Resident #43 had no new orders.

On 4/22/24 the Regional Director of Clinical Services reviewed the Electronic Medication Administration Record for all residents that received an antibiotic since 4/1/2024 to ensure the antibiotics had been given as prescribed. All identified issues were reported to the provider and the antibiotics were extended to ensure the resident(s) received the prescribed number of administrations unless the Nurse Practitioner determined it unnecessary.

The Director of Nursing or designee will educate all nurses on following physician orders and reporting all missed doses of antibiotics to the provider for appropriate follow up. Education will be provided by 4/22/2024.

The Director of Nursing or designee will audit all EMARs for residents receiving antibiotic therapy 5x week for 12 weeks. Any missed doses will be reported to the

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F 684	Continued From page 12 He stated the area on his nose was healing well and he didn't have any complaints of pain or discomfort. The Minimum Data Set (MDS) quarterly assessment dated 03/27/24 revealed Resident #48 was cognitively intact. He had no rejection of care. Review of Resident #48's Medication Administration Record (MAR) dated March 2024 revealed Triple Antibiotic Ointment (Neomycin-Bacitracin-Polymyxin) was scheduled for administration beginning on 03/08/24 at 8:00 PM, then twice a day at 8:00 AM and 8:00 PM for a total of 6 treatments. Review of Resident #48's Medication Administration Record (MAR) dated March 2024 revealed Triple Antibiotic Ointment (Neomycin-Bacitracin-Polymyxin) was signed as administered on 03/09/24 and 03/10/24 at 8:00 PM. The medication was not administered on 03/08/24 at 8:00 PM, or 03/09, 03/10, and 3/11 at 8:00 AM. Resident #48 received 2 of the 6 treatments. Review of Resident #48's progress notes from 03/08/24 through 03/11/24 revealed no documentation as to why the antibiotic ointment was not administered. Attempts were made on 03/27/24 to contact Nurse #14 and Nurse #15 who were assigned to Resident #48 during the times the antibiotic ointment was scheduled for administration. There was no response.	F 684	provider immediately. The audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for 3 months. The committee may change the plan of correction or extend the audits to ensure ongoing compliance.	

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During an interview on 03/27/24 at 12:00 PM the Corporate Nurse Consultant stated the order for the antibiotic ointment for Resident #48 was entered into the electronic medical record on 03/08/24 and was not available from pharmacy on that date. She stated most likely it arrived from pharmacy the following day on 03/09/24 and the first dose was administered that evening at 8:00 PM. She stated the antibiotic ointment should have been available for administration for the remaining doses but there was no documentation that it was administered. She indicated Nurse #14 and Nurse #15 were agency staff and no longer employed by the facility.

During an interview on 03/27/24 at 3:30 PM the Director of Nursing stated Resident #48 should have received the full course of the antibiotic treatment. She indicted there was no documentation that the full course of treatment was administered.

During an interview on 03/27/24 at 4:30 PM the Nurse Practitioner stated Resident #48 should have been administered the full course of the antibiotic treatment. She indicated there was no outcome related to not receiving the missed doses.

2. Resident #43 was admitted to the facility on 12/07/20 with diagnosis including cerebral vascular accident (CVA) and dementia.

The Minimum Data Set (MDS) quarterly assessment dated 03/11/24 revealed Resident #43 had severely impaired cognition. He had no rejection of care.

A physicians order dated 02/05/24 for Resident

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#43 revealed Ciprofloxacin (antibiotic) ophthalmic solution 0.3%. Instill 2 drop in the left eye four times a day for episcleritis (inflammation of the sclera) for 5 days. (Total of 20 doses).

Review of Resident #43's Medication Administration Record (MAR) dated March 2024 revealed he received 15 of the 20 scheduled doses of the antibiotic ophthalmic drops. The 1st and 2nd dose were scheduled to be administered on 02/05/24 at 4:00 PM and 8:00 PM. The 3rd, 4th, and 5th doses were scheduled for administration on 02/06/24 at 8:00 AM, 12:00 PM, and 4:00 PM. The scheduled doses on 02/05/24 and 02/06/24 were not administered.

Attempts were made on 03/27/24 to contact Nurse #15 who was assigned to Resident #43 during the times the antibiotic ointment was scheduled for administration on 02/05/24 There was no response.

During a phone interview on 03/27/24 at 3:00 PM Nurse #10 stated she was assigned to Resident #43 on 02/06/24 and stated if she didn't administer the eye drops to Resident #43 then the medication was not available for administration. She stated she thought she would have made a note in Resident #43's progress notes regarding the medication not being administered.

Review of Resident #43's progress notes from 02/05/24 through 02/06/24 revealed no documentation as to why the antibiotic ophthalmic drops were not administered.

During an interview on 03/27/24 at 3:30 PM the Director of Nursing stated Resident #43 should

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F 684	Continued From page 15 have received the full course of the antibiotic treatment. She indicted there was no documentation that the full course of treatment was administered. During an interview on 03/29/24 at 4:00 PM the Corporate Nurse Consultant stated the order for Resident #43 for the antibiotic ophthalmic drops was entered into the electronic medical record on 02/05/24 and the medication was not received until the following night on 02/06/24. She stated the administration dates should have been adjusted in the electronic medical record and extended another day to reflect on the Medication Administration Record (MAR) so that the total number of prescribed doses would be administered. She stated education would be provided to nursing staff to make adjustments to the order dates once the medication was received for medications that were prescribed for a certain number of days or doses such as antibiotics. During an interview on 03/27/24 at 4:30 PM the Nurse Practitioner stated Resident #43 should have been administered the full course of the antibiotic treatment. She indicated there was no outcome related to not receiving the missed doses.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		4/23/24

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F 690	Continued From page 16 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to implement the treatment protocol for a newly acquired nephrostomy tube (a catheter surgically placed through the back and into the kidney to drain urine that is blocked). The treatment included monitoring the insertion site for signs and symptoms of infection, providing daily dressing changes to the insertion site, monitoring and recording urine output, and monitoring the tube	F 690	Order for nephrostomy tube care were entered into the EMR for resident #5 by the Director of Nursing on 3/28/2024. The NP was notified that the resident had not received nephrostomy tube care since admission on 3/29/2024 and documented in the electronic medical record. Resident no longer has a nephrostomy tube. The Director of Nursing, unit managers	

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F 690	Continued From page 17 for kinks or obstruction. This resulted in the nephrostomy tube and insertion site not being monitored for 8 days following hospitalization. There was no negative outcome. This occurred for 1 of 1 resident (Resident #5) reviewed for catheter care. Findings included. Resident #5 was initially admitted to the facility on 04/28/17. Resident #5 was readmitted on 03/19/24 following hospitalization with diagnoses including septic shock secondary to urinary tract infection, bacteremia (bacteria in the blood stream), and moderate to severe right hydronephrosis with nephrostomy tube placement. The Minimum Data Set (MDS) discharge assessment dated 03/10/24 revealed Resident #5 required extensive assistance with activities of daily living. She exhibited no rejection of care. She had no indwelling catheter at the time of assessment. Review of Resident #5's hospital discharge summary dated 03/19/24 revealed no orders for the care and treatment of the nephrostomy tube and to follow up with urology in two weeks. During an interview with Resident #5 on 03/27/24 at 2:15 PM she was observed lying in bed. She was oriented to person, place, and situation. She stated she was not certain if the dressing on her back covering the nephrostomy tube insertion site was being changed or not. She indicated she was uncertain if the urine collection chamber had been emptied. She stated she typically stayed in bed every day and preferred lying flat on her back	F 690	and wound nurse will complete a skin sweep on all residents by 4/8/2024 to ensure there are no other residents with an ostomy or device requiring care orders. The MD will be notified and care orders will be entered for any resident identified. The Director of Nursing will educate all nurses by 4/22/2024 on admission skin assessment process, caring for ostomy sites and tubes and entering care orders. The Director of Nursing will audit all new admissions to ensure care orders have been put into place for each resident with any type of drain tube 5x week for 12 weeks. The facility wound nurse or designee will do a skin inspection on each resident within 24 hours of admission x 12 weeks to ensure all drainage tubes have been identified. The audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for three months. The committee may change the plan of correction or extend the audits to ensure ongoing compliance.	

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and required staff assistance for turning and repositioning in bed. She stated she did have pain in her back but received medication that relieved her pain.

During an observation of the nephrostomy tube on 03/27/24 at 2:30 PM along with Nurse #3. Resident #5's nephrostomy tube was observed in place, there was no dressing covering the catheter insertion site on her right lower back. The old dressing was found in the bed with no date to determine when it was placed. The sutures were intact at the insertion site with no redness observed. The catheter tube was without kinks or obstruction. The urine collection chamber was positioned below the level of the kidneys. The nurse emptied 400 milliliters of clear urine. Nurse #3 applied a clean dry dressing to the insertion site. She indicted she was uncertain of how often the dressing was getting changed but thought it should be changed daily. Nurse #3 stated she was an agency nurse and had only worked in the facility 2-3 times.

Review of Resident #5's physician orders on 03/28/24 revealed no order in place for the care and treatment of the nephrostomy tube.

Review of Resident #5's Medication Administration Record (MAR) and Treatment Administration Record (TAR) on 03/28/24 revealed no orders and no documentation for the care and treatment of the nephrostomy tube.

During a phone interview on 03/28/24 at 3:45 PM with Nurse #6 she stated she was routinely assigned to Resident #5. She stated she most recently was assigned to her yesterday 03/27/24. She stated she was aware of the nephrostomy

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F 690	Continued From page 19 tube but stated "she didn't have to do anything with it." During an interview with the Director of Nursing (DON) on 03/28/24 at 2:30 PM she stated the facility had a protocol in place for care of nephrostomy tubes that should be followed. The protocol included monitoring the insertion site every shift and changing the dressing daily and as needed. It also included monitoring and recording urine output every shift including the amount and color. She stated she was not aware that Resident #5 did not have treatment orders in place or that the protocol for care of the nephrostomy tube was not implemented following her return from the hospital on 03/19/24. She stated when Resident #5 returned from the hospital the admitting nurse should have implemented the procedures for nephrostomy care and this did not occur. During a phone interview on 04/02/24 at 2:30 PM the Minimum Data Set (MDS) nurse stated she implemented a care plan today that included care of the nephrostomy tube. The interventions included in part; to assess and document urine output, pain or discomfort, signs, and symptoms of infection, and monitor the tube for kinks or obstruction every shift, and to change the dressing to the insertion site daily.	F 690		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 692		4/29/24

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comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, staff, Registered Dietician, and Nurse Practitioner interviews the facility failed to obtain physician ordered weights for 7 of 7 residents (Resident #274,#5, #31, #24,#47, #48, #26) and provide a nutritional supplement for 1 of 1 resident (Resident #274) reviewed for nutrition.

Findings included.

1.a) Resident #274 was admitted to the facility on 03/15/24 with diagnoses including in part; protein calorie malnutrition, and congestive heart failure.

A physicians order dated 03/15/24 for Resident #274 revealed to obtain daily weights for congestive heart failure.

A care plan dated 03/16/24 revealed Resident #274 was nutritionally impaired and was at risk for dehydration and weight fluctuations related to

Weight was obtained by the Director of Nursing or designee for resident #5, #31, #24, #48 and #26 on 4/3/2024. Weight was obtained by the Director of Nursing or designee for resident #47 on 4/4/2024. Resident #274 no longer resides in the facility. Provider notified of missing weights and not administered supplement on 4/26/2024.

The Director of Nursing/Designee obtained a baseline weight for each resident by 4/5/2024. Weight orders were reviewed by the IDT team on 4/18/2024 to ensure orders are appropriate for each resident. On 4/26, all residents receiving supplements from the dietary department during meal times were audited to ensure supplements were in place.

The Director of Nursing/Designee will

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F 692	Continued From page 21 recent surgical correction of gastric volvulus, congestive heart failure, feeding tube placement, variable oral intake, diuretic use, obesity, chronic obstructive pulmonary disease, and edema. Interventions included in part; to monitor weights per order. The Minimum Data Set (MDS) admission assessment dated 03/21/24 revealed Resident #274 was cognitively intact. She required moderate assistance with activities of daily living. She had no rejection of care. Review of Resident #274's electronic medical record revealed the following weights recorded as of 03/26/24. 3/27/2024 the recorded weight was 329 lbs. (pounds) 3/26/2024 the recorded weight was 329 lbs. 3/23/2024 the recorded weight was 331 lbs. 3/22/2024 the recorded weight was 331 lbs. 3/20/2024 the recorded weight was 331 lbs. 3/19/2024 the recorded weight was 330 lbs. 3/15/2024 the recorded weight was 331 lbs. Review of Resident #274's progress notes from 03/15/24 through 03/26/24 revealed no other weights recorded. During an interview on 03/27/24 at 09:29 AM Nurse Aide #4 stated she had worked at the facility for 12 years. She stated the wound nurse, and the Director of Nursing (DON) put together a notebook to record weights in and a notebook was kept at each nurses station. She stated the nurse would inform the nurse aides which residents needed weights each day, or the nurse	F 692	educate all nurses by 4/22/2024 on following physician's orders as it relates to obtaining weights and scheduling weekly weights on Wednesdays. In addition, the dietary department will be educated on 4/26/2024 by the Dietary Manager on placing supplements directly to the tray before they are sent out of the kitchen and ensuring tray card accuracy. Weights will be reviewed 5x week for 12 weeks by the Director of Nursing or designee to ensure the weights were obtained per MD order. If the weight was not obtained, the weight will be obtained immediately and re-education will be completed with the responsible staff member. Tray cards will be audited 10 trays a week x 12 weeks to ensure tray card accuracy including supplements. The audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for three months. The committee may change the plan of correction or extend the audits to ensure ongoing compliance.	

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aide would look in the notebook to determine which residents needed to be weighed. She stated once the weight was obtained by the nurse aide the nurse was supposed to sign the sheet which showed the recorded weight, and the sheet would be placed back into the notebook. She indicated there was a lot of agency staff working currently in the facility and indicated that could be why the weights were not getting done consistently. She indicated the wound nurse was in charge of reviewing the weight books to ensure weights were getting done.

During an interview on 03/27/24 at 1:32 PM the wound care nurse stated she had recently been assigned to review the weight books to ensure weights were getting documented and recorded. She indicated she or the assigned nurse would record the weights in the residents electronic medical record. She reported that if weights weren't recorded in the residents electronic medical record, then they weren't done. She stated she reviewed the notebooks weekly, but she was currently acting as the unit manager and was the wound nurse. She indicated if daily or weekly weights weren't done then it was an oversight. She indicated the nurse aide and the residents assigned nurse should be making sure the weights were getting done according to the physicians order.

During an interview on 03/27/24 at 04:18 PM Resident #274 was alert and oriented to person, place, and time. She stated she had not refused weights.

During an interview on 03/28/24 at 2:00 PM the Registered Dietician stated obtaining resident weights had been an issue, but she thought the

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process had improved since they now had one staff member in charge of reviewing weights. She stated weights should be followed per the physicians order. She stated Resident #274 should be receiving daily weights for congestive heart failure and her weight was stable.

During an interview on 03/28/24 at 2:31 PM the Director of Nursing (DON) stated the facility protocol for weights included obtaining an admission weight, then weekly weights for 4 weeks, then monthly weights unless the physician ordered a residents weight to be done more frequently. She stated weights should be obtained according to the physicians order and documented in the notebook which was kept at each nurses station and then recorded in the residents medical record. She stated she made the notebooks for weights to be recorded in and the nurse aid was responsible for obtaining the weight, then the nurse was to sign off on the weight sheet, and any refusals would be documented by the nurse. The sheet would be placed back into the notebook and the wound nurse would review and document the weights in the residents medical record. She indicated the wound nurse was recently assigned to review the weight book to ensure weights were getting done. She stated she thought the system seemed to be improving at this point and was not aware weights were getting missed. She indicated they currently employed a lot of agency staff, and more education was needed.

During an interview on 03/28/24 at 4:00 PM the Nurse Practitioner stated weights should be obtained according to the physicians order and documented in the residents medical record. She stated current weights were needed for Resident

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#274 to determine nutritional status and she expected the weights to get done.

1.b) A dietary note dated 03/21/24 at 10:35 AM for Resident #274 revealed resident at risk for nutritional decline, dehydration, and weight fluctuations related to diagnosis of COPD, Lupus, diuretic use, and edema. Nutrition interventions include to continue non-therapeutic diet, with the resident desire to keep supplements between meals, and to provide nutritional shakes with meals.

A physician's order dated 03/22/24 for Resident #274 was to give a house supplement two times per day, regular diet regular texture thin consistency, with 4-ounce nutritional shake with every meal.

Observations of Resident #274's lunch tray was observed on 03/25/24 at 1:15 PM, breakfast on 03/26/24 at 9:15 AM, lunch on 03/26/24 at 1:15 PM, dinner on 03/26/24 at 5:45 PM, breakfast on 03/27/24 at 8:30 AM, and lunch on 03/27/24 at 1:15 PM, with no 4-ounce nutritional shake supplement was on the meal trays. The standing orders: 4-ounce nutritional supplement shake were listed on the meal tray tickets.

An observation and interview were conducted with Resident #274 (200-hall) on 03/26/24 at 9:15 AM. She stated she was eating the breakfast she had ordered; except she was missing the nutritional shake. She said she let nursing and dietary know about not getting the nutritional shake on her meal tray, but they never provided her with one.

An interview was conducted on 03/26/24 at 1:20

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PM with Medication Aide (MA) #1. The MA said she gave medications to Resident #274 throughout the day without difficulty. The MA stated she was not the one who delivered resident's lunch tray, but confirmed there was no 4-ounce nutritional shake on the resident's meal tray. She also read the resident's meal tray slip, with standing orders: 4-ounce nutritional shake on tray for each meal. She then instructed a Nursing Aide (NA) to go to the kitchen and get a 4-ounce nutritional shake for the resident, which the NA did.

An interview was conducted on 03/27/24 at 4:00 PM with the DM. He reviewed Resident #274's meal ticket and stated there should be a nutritional 4-ounce shake on her meal tray at breakfast, lunch, and dinner. He was unaware the nutritional shake had been missing from the meal trays. The DM added that 4-ounce supplement shakes were in stock and there were no issues with having it available. He stated the kitchen dietary aide was responsible for putting these items on the tray when the meals were being plated. And stated the kitchen dietary aides "just forgot" to put the shake on the meal tray for Resident #274, and it was her expectation that each meal ticket should be reviewed at the time of plating to ensure that items are not forgotten.

During an interview on 03/28/24 at 7:55 AM with the Director of Nursing (DON) revealed that the nurse aide that was setting up the tray for Resident #274 should be checking the ticket on the tray to ensure it was correct.

During an interview on 03/28/24 at 8:00 AM with the Administrator revealed that she had been made aware of Resident #274 not receiving the

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4-ounce nutritional supplement. The Administrator said that there were several staff who should be checking the ticket. The first being the kitchen staff and Dietary Manager. Then the nurse aide should also be checking the ticket to make sure it was correct.

During an interview on 03/28/24 at 1:34 PM with the Registered Dietician revealed that she did not think that the missing 4-ounce nutritional shake supplement is a routine missed item. The registered Dietician stated that Resident #274 was not currently losing weight, but she expected the kitchen to put the nutritional shake on the tray when the meals were being plated.

2. Resident #5 was readmitted to the facility on 03/19/24 with diagnoses including septic shock, heart failure and diabetes.

The Minimum Data Set (MDS) discharge assessment dated 03/10/24 revealed Resident #5 required extensive assistance with activities of daily living. She exhibited no rejection of care.

A physicians order dated 03/18/24 for Resident #5 revealed to obtain daily weights and to notify the physician if weight increase was greater than 3 lbs. (pounds) per day or 5 lbs. in one week.

A care plan dated 03/21/24 revealed Resident #5 was at risk for nutritional decline, dehydration, and weight fluctuations related to recent sepsis and diagnosis of type 2 diabetes, chronic kidney disease, congestive heart failure, the need for a therapeutic diet, diuretic use, variable oral intake, history of weight fluctuations, edema, and dysphagia. Interventions include in part: to monitor weights per order.

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Review of Resident #5's electronic medical record revealed the following weights recorded:

03/28/2024 05:23 the recorded weight was 212.4 lbs.
03/27/2024 05:54 the recorded weight was 212.5 lbs.
03/26/2024 05:30 the recorded weight was 212.5 lbs.
03/24/2024 05:39 the recorded weight was 212.3 lbs.
03/23/2024 05:29 the recorded weight was 212.2 lbs.
03/20/2024 05:39 the recorded weight was 211.8 lbs.

Review of Resident #5's progress notes from 03/18/24 through 03/26/24 revealed no other weights recorded.

During an interview on 03/28/24 at 11:44 AM Resident #5 was observed lying in bed. She was oriented to person, place, and situation. She stated she would not refuse weights as long as the mechanical lift was used.

During an interview on 03/28/24 at 4:00 PM the Nurse Practitioner stated weights should be obtained according to the physicians order and documented in the residents medical record. She indicated Resident #5 was recently readmitted and was ordered daily weights due to congestive heart failure. She indicated Resident #5's weights were stable at this time.

3. Resident #31 was admitted to the facility on 10/03/23 with diagnosis including severe protein calorie malnutrition, chronic obstructive

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pulmonary disease, and oxygen dependence.

The Minimum Data Set (MDS) quarterly assessment dated 01/02/24 revealed Resident #31 was cognitively intact. She required limited assistance with activities of daily living (ADLs.

A care plan dated 10/10/23 revealed Resident #31 had impaired nutritional status and was at risk for dehydration and weight fluctuations due to respiratory failure, malnutrition, osteoporosis, emphysema, and weight gain trend. Interventions included in part: to monitor weights per order.

A physicians order dated 10/03/23 for Resident #31 revealed to obtain daily weights and notify the physician of weight gain over 3 lbs.

03/20/2024 the recorded weight was 90.2 Lbs.

03/17/2024 the recorded weight was 90.3 Lbs.
03/16/2024 the recorded weight was 90.2 Lbs.

03/15/2024 the recorded weight was 89.1 Lbs.
03/14/2024 the recorded weight was 92.3 Lbs.
03/06/2024 the recorded weight was 91.0 Lbs.
03/04/2024 the recorded weight was 90.8 Lbs.
03/03/2024 the recorded weight was 91.0 Lbs.

03/02/2024 the recorded weight was 90.4 Lbs.
02/25/2024 the recorded weight was 88.8 Lbs.
02/17/2024 the recorded weight was 94.6 Lbs.

02/14/2024 the recorded weight was 91.8 Lbs.
02/11/2024 the recorded weight was 94.8 Lbs.

02/09/2024 the recorded weight was 99.3 Lbs.
02/07/2024 the recorded weight was 99.6 Lbs.
02/05/2024 the recorded weight was 100.0 Lbs.

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02/03/2024 the recorded weight was 98.9 Lbs.
01/28/2024 the recorded weight was 99.2 Lbs.
01/21/2024 the recorded weight was 99.4 Lbs.

01/20/2024 the recorded weight was 99.4 Lbs.

01/19/2024 the recorded weight was 99.6 Lbs.
01/14/2024 the recorded weight was 98.8 Lbs.
01/13/2024 the recorded weight was 98.8 Lbs.
01/07/2024 the recorded weight was 99.6 Lbs.

01/06/2024 the recorded weight was 99.7 Lbs.

01/04/2024 the recorded weight was 100.0 Lbs.
12/31/2023 the recorded weight was 98.4 Lbs.
12/30/2023 the recorded weight was 98.6 Lb.
12/27/2023 the recorded weight was 99.0 Lb.

12/24/2023 the recorded weight was 96.4 Lbs.
12/23/2023 the recorded weight was 96.0 Lbs.
12/22/2023 the recorded weight was 96.0 Lbs.

12/17/2023 the recorded weight was 97.6 Lbs.
12/16/2023 the recorded weight was 97.6 Lbs.
12/15/2023 the recorded weight was 97.0 Lbs.
12/11/2023 the recorded weight was 97.6 Lbs.

12/07/2023 the recorded weight was 103.6 Lbs.
12/06/2023 the recorded weight was 103.6 Lbs.

12/03/2023 the recorded weight was 104.2 Lbs.
12/02/2023 the recorded weight was 104.0 Lbs.
12/01/2023 the recorded weight was 104.6 Lbs.

11/26/2023 the recorded weight was 104.9 Lbs.

11/25/2023 the recorded weight was 104.6 Lbs.
11/22/2023 the recorded weight was 105.0 Lbs.

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F 692	Continued From page 30 11/21/2023 the recorded weight was 105.0 Lbs. 11/19/2023 the recorded weight was 105.0 Lbs. 11/18/2023 the recorded weight was 104.6 Lbs. 11/15/2023 the recorded weight was 105.2 Lbs. 11/12/2023 the recorded weight was 108.2 Lbs. 11/11/2023 the recorded weight was 108.0 Lbs. 11/07/2023 the recorded weight was 108.2 Lbs. 10/29/2023 the recorded weight was 107.6 Lbs. 10/26/2023 the recorded weight was 110.8 Lbs. 10/25/2023 the recorded weight was 111.0 Lbs. 10/24/2023 the recorded weight was 110.2 Lbs. 10/23/2023 the recorded weight was 110.2 Lbs. 10/21/2023 the recorded weight was 109.6 Lbs. 10/17/2023 the recorded weight was 109.8 Lbs. 10/15/2023 the recorded weight was 110.2 Lbs. 10/05/2023 the recorded weight was 106.8 Lbs. 10/03/2023 the recorded weight was 107.8 Lbs. During an interview on 03/27/24 at 10:06 AM Nurse Aide #4 stated Resident #31 was oriented to person, place, and time. She was independent with activities of daily living (ADLs). Her appetite was getting better, and she ate 50% of most of	F 692		

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her meals and ate a lot of snacks.

During an interview on 03/28/24 at 11:23 AM Resident #31 was oriented to person, place, and situation. She stated she had never refused weights.

During an interview on 03/28/24 at 4:00 PM the Nurse Practitioner stated weights should be obtained according to the physicians order and documented in the residents medical record. She stated current weights were needed to determine nutritional status and she expected the weights to get done.

4.. Resident #24 was admitted to the facility on 01/07/20 with diagnoses including heart failure, and chronic obstructive pulmonary disease.

A physicians order dated 10/31/23 for Resident #24 revealed to obtain weekly weights.

The Minimum Data Set (MDS) Quarterly assessment dated 02/11/24 revealed Resident#24 was severely cognitively impaired. She required extensive assistance with activities of daily living (ADLs). She had no rejection of care.

Review of Resident #24's electronic medical record revealed the following weights:

03/14/2024 the recorded weight was 97 lbs.
02/27/2024 the recorded weight was 98 lbs.
12/08/2023 the recorded weight was 104 lbs.
12/07/2023 the recorded weight was 95.8 lbs.
11/15/2023 the recorded weight was 100 lbs.
11/07/2023 the recorded weight was 101 lbs.

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10/23/2023 the recorded weight was 98 lbs.

Review of Resident #24s progress notes from 03/15/24 through 03/26/24 revealed no other weights recorded.

During an interview on 03/28/24 at 2:00 PM the Registered Dietician stated Resident #24 was currently receiving Hospice care and weekly weights were no longer needed. She stated the order should have been discontinued when the resident started Hospice services.

5.Resident #47 was admitted to the facility on 10/11/23 with diagnosis including cerebral vascular accident (CVA), and dysphagia (difficulty swallowing).

A physicians order dated 10/11/23 for Resident #47 revealed weigh on admission and then weekly for 4 weeks.

The Minimum Data Set (MDS) admission assessment dated 01/17/24 revealed Resident #47 was severely cognitively impaired. He required extensive assistance by staff with activities of daily living (ADLs). He exhibited no rejection of care. He had no weight loss and had a feeding tube in place.

A care plan dated 10/19/23 revealed Resident #47 was at risk for nutritional decline, dehydration, and weight fluctuations related to CVA, anemia, dementia, history of aspiration pneumonia, dysphagia with NPO (nothing by mouth) status, and 100% reliance on tube feedings with a history of intolerance to tube

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feedings. Interventions included in part to; monitor weight per order, and report 5% weight loss or gain to the physician and Registered Dietician.

Review of Resident #47's electronic medical record revealed the following weights recorded as of 03/26/24.

03/07/2024 the recorded weight was 191 lbs.
02/17/2024 the recorded weight was 193 lbs.
10/23/2023 the recorded weight was 186.2 lbs.

Review of Resident #47's progress notes revealed no other weights recorded.

During an interview on 03/28/24 at 4:00 PM the Nurse Practitioner stated weights should be obtained according to the physicians order and documented in the residents medical record. She stated current weights were needed to determine nutritional status and she expected the weights to get done.

6.Resident #48 was admitted to the facility on 09/01/23 with diagnosis including diabetes with left below knee amputation.

A physicians order dated 09/01/23 for Resident #48 revealed to weigh on admission and then weekly for 4 weeks.

The Minimum Data Set (MDS) quarterly assessments dated 12/26/23 revealed Resident #48 was cognitively intact. He had no rejection of care and received a therapeutic diet.

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A care plan dated 03/26/24 revealed Resident #48 was at risk for nutritional decline, and weight fluctuations related to diagnosis of type 2 diabetes, heart failure, chronic kidney disease with a need for a therapeutic diet of low concentrated sweets and no added salt. Interventions included in part; to monitor weight per order.

Review of Resident #48's electronic medical record revealed the following weights recorded as of 03/26/24.

03/08/2024 the recorded weight was 245 lbs.
01/05/2024 the recorded weight was 241 lbs.
12/11/2023 the recorded weight was 235 lbs.
09/01/2023 the recorded weight was 265 lbs.

Review of Resident #48's progress notes revealed no other weights recorded.

During an interview on 03/26/24 at 1:00 PM Resident #48 was alert and oriented to person, place, and time, and stated he received a regular diet. He indicated he wasn't certain how often he was weighed since his admission. He stated he did not and would not refuse weights.

During an interview on 03/28/24 at 1:43 PM the Registered Dietician stated Resident #48's weight was stable since January 2024. She stated weight orders should be followed and recorded in the residents medical record.

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7. Resident #26 was admitted to the facility on 7/24/15 with diagnoses which included in part: dysphagia (impaired swallowing) following a stroke and presence of a feeding tube.

Review of Resident #26's 1/6/24 quarterly Minimum Data Set (MDS) assessment indicated resident had severe cognitive impairment and had a feeding tube present. The assessment indicated resident's weight was 154 pounds with no weight loss or gain and resident received 51-100% of total calories through a feeding tube.

Review of the facility weight protocol indicated residents were to be weighed on admission, weekly for four weeks and then monthly or per physician order.

Review of Resident #26's care plan revealed a 1/7/24 focus which indicated resident was at risk of nutritional decline due to nothing by mouth status and 100% reliance on tube feeding for nutrition and hydration with history of weight fluctuations. Interventions included monitoring weight per protocol.

Review of the weight log in Resident #26's electronic health record revealed the following:
12/7/23 154.2 pounds
1/9/24 157.6 pounds
No weight was recorded for February 2024.
3/6/24 150.2 pounds

Review of a 2/29/2024 Registered Dietician (RD) progress note revealed in part resident with current body weight of 154.2 pounds as of 12/7/23. Resident with history of weight discrepancies. Resident continues with nothing by mouth status with 100% reliance on tube feeding

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for nutrition and hydration. Weigh per policy (monthly) and monitor for tolerance of tube feeding regimen.

Review of a 3/7/2024 RD progress note revealed a weight note regarding significant weight loss over 2 months with a weight change of 4.7%. Resident continues with nothing by mouth status and 100% reliance on tube feeding for nutrition and hydration: Reweigh resident to verify new weight as no changes noted with tube feeding. The note indicated medications were reviewed and Resident #26 was not receiving a diuretic. The RD recommended to add weekly weights for 4 weeks to monitor closely.

Review of Resident #26's electronic health record revealed a 3/7/24 physician order to weigh resident in the morning every Wednesday for weight monitoring for four weeks.

Review of Resident #26's electronic health record revealed a weight of 144.6 pounds was recorded on 3/13/24 and on 3/14/24 resident's weight was 150.4 pounds.

Review of Resident #26's electronic health record revealed a weight change note dated 3/14/24 due to weight loss. Tube feeding was increased from three times per day to four times per day for weight stability. Resident to be weighed frequently to monitor closely.

An interview was conducted with the Unit Manager on 3/27/24 at 2:20 PM. The Unit Manager revealed the weekly and monthly weights were completed by the Nursing Assistant assigned to the resident. The monthly weights were to be completed on the 1st through the 7th

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F 692	Continued From page 37 of the month. The Unit Manager stated there were issues with obtaining weights due to staffing problems. An interview was conducted with the Director of Nursing (DON) on 3/27/24 at 9:30 AM. The DON revealed she was in the position as a Unit Manager since the end of November and the interim DON position since the end of February. The DON stated she was aware there were problems with obtaining residents weights. The DON stated she was working on improving the system for obtaining weights. The DON stated she expected resident weights to be obtained and recorded per facility protocol. An interview was conducted with the Registered Dietician (RD) on 3/28/24 at 1:00 PM. The RD indicated the facility had issues with not obtaining the weights per protocol and questionable weights recorded. The RD stated that at minimum monthly weights were required for a resident receiving tube feeding. The RD indicated monthly weights were essential for monitoring the nutritional status of each resident. The RD revealed she was aware that Resident #26 had not been weighed in February and she did not know why a weight was not obtained. An interview with the Administrator on 3/28/24 at 3:30 PM revealed she expected that resident weights be obtained and recorded for the residents monthly or as ordered by the physician.	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes,	F 693		4/23/24

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F 693	Continued From page 38 both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff, Registered Dietician and Nurse Practitioner interviews, the facility failed to follow a physician order for the method of administration of the enteral feeding (nutrition taken through a tube directly into the stomach) and the calculated amount of water flush. 2) Implement the enteral feeding tube policy upon admission resulting in the residents gastrostomy tube not being flushed every six hours when not in use with 30 milliliters of water for 4 days following admission. This occurred for 2 of 2 residents (Resident #26, and Resident #274) reviewed for management of enteral feeding tubes. Findings included:	F 693	Nurse Practitioner was notified on 3/29/2024 that resident #26 did not receive the bolus feeding or the appropriate amount of water on 3/26/2024. The order was reviewed by the Registered Dietician on 4/22/2024 and enteral tube order was changed to Isosource 1.5- 250ml bolus via PEG with 150ml water flushes before and after each bolus three times a day. Resident #274 no longer resides in the facility. A skin sweep was done on 4/5/24 by the Director of Nursing, unit managers and the wound care nurse to ensure each resident with a gastric tube had been identified and had appropriate flush	

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F 693	Continued From page 39 1.) Resident #26 was admitted to the facility on 7/24/15 with diagnoses which included in part: dysphagia (impaired swallowing) and aphasia (impaired communication) following stroke. In addition, Resident #26 had gastrostomy status listed as a diagnosis. Review of Resident #26's 1/6/24 quarterly Minimum Data Set (MDS) assessment indicated resident had severe cognitive impairment. The assessment indicated resident had a feeding tube and received 51-100 % total calories were received through a feeding tube. In addition, the resident was coded as having received 501 cubic centimeters (cc's) or more of fluid intake through a feeding tube. Review of Resident #26's revised 1/7/24 care plan revealed a problem of at risk for output exceeding input related to altered intake process with interventions which included administer tube feeding as ordered. The care plan further indicated resident was at risk for nutritional decline dehydration, weight fluctuations related to diagnosis of epilepsy, history of stroke, and dysphagia requiring nothing by mouth status, 100% reliance on tube feeding for nutrition and hydration, and history of weight fluctuations. The goal indicated the resident would be free from aspiration and dehydration through next review. Interventions included: check for tube placement and gastric contents, administer tube feeding and water flushes per physician orders, assess for signs of dehydration (skin turgor, dry mouth, cracked lips) and Registered Dietician consult. A 3/14/24 physician order indicated Resident #26 was to receive enteral feeding four times a day	F 693	orders. On 4/24/2024 the Director of Nursing reviewed the electronic medical record to ensure each resident receiving enteral feeding had appropriate orders that include water flush amounts. On 4/24/2024 the unit manager did an enteral tube observation on each resident receiving enteral feeding to ensure the resident received the enteral feeding and flush according to the order. The Director of Nursing/Designee will educate all nurses by 4/5/2024 on following physician's orders (specifically as it relates to enteric feeding) and ensuring all residents with gastric tubes have flush orders. The Director of Nursing will audit all new admissions to ensure flush orders have been put into place for each resident with gastric tubes 5x week for 12 weeks. In addition, the Director of Nursing will observe 3 enteric feedings per week for 12 weeks to ensure it is done according to the MD/NP order. The audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for tree months. The committee may change the plan of correction or extend the audits to ensure ongoing compliance.	

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for nutrition and hydration. Administer Isosource 250 milliliters bolus via pump over 1 hour with 150 milliliters water flush before and after each bolus.

Review of Resident #26's March 2024 Medication Administration Record (MAR) revealed the following entries:

Enteral Feed Order four times per day for nutrition/hydration Isosource 250ml bolus via pump over 1 hour with 150ml water flush before and after each bolus. Start date 3/14/24.

A tube feeding administration observation was conducted with Nurse #1 on 3/26/24 at 12:15 PM. Resident #26 was sitting up in a recliner chair in her room. Nurse #1 explained to Resident #26 that she was going to administer the tube feeding. Resident #26 nodded understanding by moving her head up and down. The observation revealed Nurse #1 using a new 2-ounce syringe inserted the tip of the syringe into the port of the resident's feeding tube, opened the clamp on the tube and pulled back on the plunger. There was no return of stomach contents. Nurse #1 then poured approximately half of a 4-ounce plastic drinking cup into the syringe and held the syringe up to gravity to flow into the feeding tube. The water immediately flowed through the feeding tube. Nurse #1 then poured 250 milliliters of tube feeding formula into the syringe connected to the feeding tube. Nurse #1 held the syringe up and the immediately flowed through the feeding tube. No signs of discomfort observed. Nurse #1 then poured the remainder of the cup of water into the syringe and held the syringe up for the water to flow through via gravity. When the water had run in through the syringe, Nurse #1 closed the clamp

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on the tube and disconnected the syringe from the port of the feeding tube.

An interview was conducted with Nurse #1 on 3/26/24 at 12:30 PM. Nurse #1 revealed she always administered the tube feeding using a syringe via gravity. Nurse #1 stated she started working at the facility in November 2023 and was oriented to administer the tube feeding using a syringe via gravity. Nurse #1 stated she had not observed a feeding pump for Resident #26 since she began working at the facility in November. Nurse #1 stated she estimated the amount of water and did not measure the amount according to the order.

An interview was conducted on 3/26/24 at 3:45 PM with the Nurse Practitioner (NP). The NP indicated the enteral feeding should be administered as ordered. The NP stated there was potential for complications related to not following the physician order for the feeding method and amount of water.

An interview was conducted with the Director of Nursing (DON) on 3/28/24 at 9:30 AM. The DON revealed she was in the position as interim DON since the end of February. DON stated she was aware Resident #26 had a physician order for bolus tube feeding. DON stated she was not sure why the enteral feeding was administered via syringe via gravity instead of through a pump. DON stated since she started at the facility at the end of November, Resident #26 had not had a feeding pump to administer her tube feeding. The DON stated she expected the physician orders to be followed as written. DON stated she expected the placement of the tube to be verified prior to administration and she expected the

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ordered amount of water to be administered.

An interview was conducted with the Registered Dietician on 3/28/24 at 1:15 PM revealed not providing the correct amount of water had the potential to cause dehydration. The water flush impacts the hydration calculations. The RD stated she calculated the amount of water specific to the resident's hydration needs. The RD stated that administering the tube feeding via gravity rather than by pump had the potential to cause vomiting, cramping and abdominal discomfort. The RD stated she expected the order for the enteral feeding to be followed as written.

An interview was conducted with the Regional Nurse Consultant on 3/28/24 at 3:40 PM. The Regional Nurse Consultant indicated she expected the physician orders for tube feeding to be followed as written including the method of delivery and the calculated amount of water flush.

An interview with the Administrator on 3/28/24 at 3:35 PM revealed she expected physician orders for tube feeding to be followed as written.

2.) Resident #274 was admitted to the facility on 03/15/24 with diagnoses including in part; protein calorie malnutrition, and gastric volvulus (abnormal rotation of the stomach).

A care plan dated 03/16/24 revealed Resident #274 had actual impaired skin integrity related to a surgical wound from the gastrostomy tube insertion. The goal of care was for the gastrostomy tube to be maintained without complications. Interventions included administering medications and treatments as

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ordered and to notify the physician of adverse effects.

The Minimum Data Set (MDS) admission assessment dated 03/21/24 revealed Resident #274 was cognitively intact. She required moderate assistance with activities of daily living. She had no rejection of care.

Review of the nursing progress notes for Resident #274 from admission on 03/15/24 until 03/19/24 revealed on 03/15/24 at 2:45 PM Nurse #3 the admitting nurse documented the gastrostomy tube was patent. There was no other documentation of the gastrostomy tube getting flushed.

A physicians order for Resident #274 dated 03/19/24 revealed to flush the gastrostomy tube every shift with 100 milliliters of water.

Review of Resident #274's Medication Administration Record (MAR) dated March 2024 revealed the gastrostomy tube was not flushed from 03/15/24 until the evening shift on 03/19/24. It was not flushed during the day shift on 3/20/24.

During an interview on 03/26/24 at 02:18 PM Resident #274 stated she was admitted to the facility 11 days ago. She was admitted with the gastrostomy tube in place. She stated her gastrostomy tube was not in use and she was prescribed a regular diet. She stated she was concerned about her gastrostomy tube getting "stopped up" due to it not being flushed today. She stated the gastrostomy tube was not flushed for the first few days following admission. She stated the tube had been getting flushed over the last week but indicated it was not getting flushed

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every shift.

During an observation on 03/27/24 at 4:30 PM Registered Nurse #3 was observed flushing the gastrostomy tube with 100 milliliters of water. The tube was patent and flushed easily. There were no concerns identified. The dressing covering the insertion site was clean, dry, and intact.

During an interview on 03/28/24 at 12:10 PM Registered Nurse #2 reported that she was the admitting nurse when Resident #274 admitted on 03/15/24. She stated she did flush the gastrostomy once on the day of admission. She stated typically the unit manager, or the Director of Nursing entered the admission orders. She reviewed Resident #274's medical record and confirmed that the flush order was not entered until 03/19/24.

During an interview on 03/28/24 at 2:30 PM the Director of Nursing (DON) stated the facility protocol for management of gastrostomy tubes included to flush with 30 milliliters of water every 6 hours for patency. She indicated this should have been entered into the electronic medical record on the day of admission by the admitting nurse. She indicated she was not aware the order to flush Resident #274's gastrostomy tube was not entered on admission.

During an interview on 03/28/24 at 4:00 PM the Corporate Nurse Consultant stated the order for the gastrostomy tube flush for Resident #274 was never entered into the electronic medical record on admission causing it to be missed. She indicated flush orders were to be entered on admission by the admitting nurse for residents with feeding tubes. She indicated that education

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F 693	Continued From page 45 would be provided.	F 693		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the staff, Administrator and Regional Nursing Consultant, the facility failed to prevent the Director of Nursing (DON) from having a resident care assignment including working on the medication cart with a facility census of greater than 60 residents for 7 of 7 days reviewed. Findings included: Review of the facility assignment sheets for 11/8/23 on the 3:00 PM-11:00 PM shift for 200 hall the Director of Nursing was assigned. Review of the facility assignment sheet for 1/1/24 on the 3:00 PM-11:00 PM shift on the top of the 100 hall the Director of Nursing was assigned.	F 727	On 4/19/2024 the facility administrator informed the medical director that the facility failed to prevent the Director of Nursing from having a resident care assignment including working on the medication cart with a facility census greater than 60 on 11/8/23, 1/1/24, 1/12/24, 1/23/24, 1/30/24, 3/4/24 and 3/15/24. On 4/2/2024 the Administrator reviewed the April nursing schedule to ensure the Director of Nursing was not schedule to have a resident care assignment or to work a cart. Education will be provided to the Licensed Nursing Home Administrator, the Director	4/23/24

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F 727	Continued From page 46 Review of the facility assignment sheet for 1/12/24 on the 11:00 PM to 7:00 AM shift for the 100 hall the Director of Nursing was assigned. Review of the facility assignment sheet for 1/23/24 on the 7:00 AM to 7:00 PM shift on the top of the 100 hall the Director of Nursing was assigned. Review of the facility assignment sheet for 1/30/24 on the 3:00 PM to 11:00 PM shift for the 100 hall the Director of Nursing was assigned. Review of the Medication Administration Record (MAR) for residents on the 100 hall for 3/4/24 at 08:00 AM and 12:00 revealed the DON's electronic signature for administration of medications. Review of the Medication Administration Records (MAR) for residents on the 200 hall for 3/15/24 at 8:00 PM and 10:00 PM revealed DON's electronic signature for administration of medications. Interview with the Administrator on 3/27/24 at 8:30 AM revealed the census was above 60 residents on the above dates. The Administrator stated she was not aware of the DON working the medication cart, but she might have. The Administrator stated she was not sure if the previous or current DON had worked the medication cart. The Administrator stated the previous DON's last day was 2/21/24 and the current interim DON was in the position as of 2/22/24. An interview with the interim Director of Nursing on 3/28/24 at 09:30 AM revealed she was hired at the end of November 2023 as a unit manager	F 727	of Nursing and the facility scheduler by the Regional Director of Clinical Services on staffing requirements by 4/22/2024. The schedule will be reviewed by the Facility Administrator of Designee 5x week for 12 weeks to ensure the Director of Nursing is not being utilized as a charge nurse or staff nurse. Any open shifts will be filled by agency staff unless other facility nurses are available to work. Audits will be reviewed by the Quality Assurance Performance Improvement committee monthly for 3 months. The committee may change the plan of correction or extend the audits to ensure ongoing compliance.	

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and became the interim DON at the end of February. The DON indicated she was not sure if she had worked a full shift on the medication cart since she became the interim DON, but she did work it for several hours when a nurse was late. The DON stated she was in the on-call rotation for the facility and was informed that if there was a call out or the schedule was short, she was to come in and work the shift. The DON stated she was informed when she became interim DON that if she was needed to work doing resident care she was expected to work. The DON was unaware of a regulation regarding the DON being a full time DON and not performing patient care.

An interview was conducted on 3/28/24 at 11:30 AM with the facility scheduler. The scheduler revealed the Director of Nursing (DON) had worked on the medication cart in the previous six months. The scheduler stated the prior DON and the current interim DON had worked the medication carts when there was an open position for a shift that could not be filled or when there was a call out that was not replaced. The scheduler stated she was unaware that the DON was not to work on a patient care assignment. If there was a call out whoever was on the on-call rotation for that day was to work the shift if unable to obtain coverage. The DON is in the on-call rotation and does work doing patient care when needed.

An interview was conducted on 3/28/24 at 11:35 AM with the Regional Nursing Consultant. The Regional Nursing Consultant indicated she came to the facility for a site visit in December and the Director of Nursing was working on the medication cart. The Regional Nursing Consultant was informed in December that the

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F 727	Continued From page 48 DON was having to work the medication cart frequently due to nurses leaving suddenly. The Regional Nursing Consultant stated the facility recently switched to a different human resources system for hiring new staff and renewed the contracts with temporary agencies to replace nurses that had left. The Regional Nursing Consultant stated she was aware the interim DON had worked some shifts since she came into the position at the end of February. An interview with the Administrator on 3/28/24 at 3:40 PM revealed she expected that the Director of Nursing would not work the medication cart and that the facility would be adequately staffed to ensure the DON did not work on a patient care assignment.	F 727		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data	F 732		4/23/24

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F 732	Continued From page 49 specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to post accurate nurse staffing information for 15 of 84 days for daily nursing posted staffing data reviewed. This included nursing and unlicensed nursing staff. Findings included: Review of the daily posted staffing from January 2024 through March 24, 2024, revealed the daily posted staffing sheets were blank. Staffing sheets for 2/23/24, 2/24/24, 2/25/24, 2/26/24,2/27/24, 2/28/24, 2/29/24, 3/7/24, 3/8/24,3/9/24, 3/10/24, 3/11/24, 3/12/24, 3/13/24, and 3/16/24 were completed with the date. There was no indication of the number of licensed and unlicensed staff members working for each shift, the hours worked, and resident census in the	F 732	The scheduler corrected the staff postings on 4/19/2024 for 2/23/24,2/24/24, 2/25/24, 2/26/24, 2/27/24, 2/28/24, 2/29/24, 3/7/24, 3/8/24, 3/9/24, 3/10/24, 3/11/24, 3/12/24, 3/13/24 and 3/16/24 The Staffing Coordinator will review all assignment sheets since 1/1/2024 to ensure the staff numbers and hours worked were accurate, will attach a copy of the assignment sheet to the staff postings and separate them by the month by 4/5/2024. The Director of Nursing or designee will educate all nurses, including the staffing coordinator by 4/5/2024 on ensuring the daily staff posting is adjusted throughout	

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F 732	Continued From page 50 facility for any of the dates. An interview was conducted with Unit Manager #1 who stated he was responsible for completing the daily posted staffing. He reported on the dates the staffing information was not completed he was not in the facility. Unit Manager #1 stated he was unsure who was responsible for completing the daily posted staffing when he was not in the facility. An interview was conducted with the Administrator on 3/28/24 at 10:56 AM who stated Unit Manager #1 was assigned the duty of posting the staffing information and a back-up person was not assigned for the days he was not in the facility.	F 732	the day to reflect actual staff hours and the number of residents. The Director of Nursing or designee will educate the facility scheduler by 4/5/2024 on the daily staff postings and storage requirements. The daily staff posting will be reviewed and audited by the Director of Nursing or designee 5x week for 12 weeks to ensure each once reflects the number of residents and any adjusted staffing. Any issues identified will be corrected and re-education will be provided to the staff member(s) responsible. The audits will be reviewed by the Quality Assurance Performance Improvement committee monthly for 3 months. The plan of correction may be changed or audits extended to ensure ongoing compliance.	
F 761 SS=D	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.	F 761		4/23/24

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F 761	Continued From page 51 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, and staff, Corporate Nursing Consultant and Administrator interviews the facility failed to: store an opened bottle of lorazepam in the locked box of the medication refrigerator and label a bottle of lispro insulin with an opened date for 1 of 1 medication storage rooms observed for medication storage (Hibiscus Pharmacy Room). 1. An observation of the Hibiscus Pharmacy Room (Medication Storage Room on 100 hall) with Nurse #12 in attendance revealed the nurse unlocked the room. In the Pharmacy Room there was a refrigerator which was unlocked. An unlocked box was observed in the refrigerator. The box contained two 30 milliliter bottles of lorazepam concentrate 2 milligrams per milliliter labeled for Resident # 53. One of the bottles was sealed. The other bottle was opened with liquid observed in the bottle. An interview on 3/25/24 at 3:30 PM with Nurse #12 revealed the box should be locked but it was not. Nurse #12 attempted to lock the box and discovered the key was broken in half with one half in the lock and the other half on the key ring. Nurse #12 stated she was not informed by the off going nurse that the key was broken, and the box	F 761	The refrigerated narcotics were transferred to another hall by the Regional Director of Clinical services on 3/25/2024 where they could be secured appropriately. The lock box was installed on 3/29/2024. The opened undated insulin was removed from the refrigerator by the Regional Director of Clinical Services on 3/26/2024. On 3/25/2024 the other narcotic lock box in the facility was checked by the Regional Director of Clinical Services and function appropriately. All other medication refrigerators and medication carts were checked by the Director of Nursing or designee by 4/5/2024 to ensure there are no additional undated opened insulins. All insulin opened and undated were discarded. All nurses and medication aides will be educated by the Director of Nursing or designee on Medication Storage, to include narcotic medication securement, by 4/22/2024. The Director of Nursing or designee will	

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F 761	Continued From page 52 could not be locked. Nurse #12 stated the off going nurse showed her the medications in the refrigerator when they counted, and she assumed that the other nurse opened and then locked the box. Nurse #12 stated she did not check that the box was locked after they counted the medication. An interview on 3/25/24 at 3:35 PM with the Corporate Nurse Consultant revealed that narcotics were to be double locked. The Corporate Nurse Consultant further indicated that the box that contained the bottles of lorazepam should have been locked, and the medication room was to be locked. The Corporate Nurse Consultant stated that it should have been reported immediately that the key to the box was broken. An observation on 3/25/24 at 3:40 PM revealed the Corporate Nurse Consultant immediately removed the bottles from the unlocked box and brought them to the Magnolia Pharmacy Room (Medication Storage Room on 200 hall) where they were to remain until a new locked box could be obtained. An interview on 3/25/24 at 3:45 PM with the Administrator revealed she expected the narcotics to be double locked. The Administrator stated it should have been reported immediately that the key to the lock for the narcotic box was broken and the medication should not have been left in the unlocked box. An interview on 3/25/24 at 3:50 PM with the Unit Manager revealed he was unaware the key to the narcotic box was broken. The Unit Manager stated the narcotics were to be double locked,	F 761	audit the medication room refrigerators 3x week for 12 weeks to ensure all locks are functioning properly and medications are stored properly. In addition, all medication rooms and medication carts will be audited 3x week for 12 weeks to ensure all opened insulins are dated appropriately. Audits will be reviewed by the Quality Assurance Performance Improvement committee monthly for the duration of the audits. The QA team may extend the audits or change the plan of correction to ensure ongoing compliance.	

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and the nurses should have reported that the lock to the box was broken.

An interview on 3/27/24 at 4:20 PM with Nurse #8 revealed she worked on 3/25/24 on the 100 hall on the 7-3 shift. Nurse #8 indicated the lock on the narcotic box was broken on 3/25/24 when she received the keys when she came on for her shift and when she went off duty at the end of her shift. Nurse #8 further revealed the refrigerator was not locked, only the door to the medication room was locked. Nurse # 8 stated she worked at the facility for the past month and the lock on the narcotic box was broken the entire time she worked here. Nurse #8 stated she had not reported to anyone that the lock on the narcotic box was broken and that the nurses all were aware. Nurse # 8 indicated she did not know if anyone had reported to maintenance or administration that the lock on the box was broken. Nurse # 8 stated she thought it was okay that the lock on the box was broken since the door to the medication room was locked and the resident whose medication was in the lock box did not use the medication very often. Nurse # 8 stated both nurses that worked on the 100 hall had keys to the medication storage room.

An interview on 3/27/24 at 4:45 PM with Nurse #6 revealed she worked on the medication cart on the top of the 100 hall. Nurse #6 stated the medication cart on the top of the 100 hall and the medication cart for the bottom of the 100 hall both had keys to the Medication Storage Room on 100 hall. Nurse #6 stated only the nurse on the medication cart for the bottom of the 100 hall had a key to the locked box in the refrigerator. Nurse #6 stated she heard the lock on the box in the refrigerator was broken for a while, but she did

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F 761	Continued From page 54	F 761		

not report it since the narcotic box was the responsibility of the nurse assigned to the other 100 hall medication cart.

An interview was conducted on 3/28/24 at 09:30 AM with the Director of Nursing (DON). The DON revealed she had been in the position of DON since the end of February and prior to that was a Unit Manager at the facility. The DON indicated she was the one who broke the key in the narcotic box several weeks ago. The DON stated she reported to the previous DON that the key to the box broke in the lock, and the box was not locked. The DON stated she left the two bottles of lorazepam in the unlocked box. She revealed she was not instructed to move the bottles of lorazepam to the other locked box in the other medication storage room. She further revealed she called the pharmacy to report the key was broken and that it was not possible to lock the box. The DON stated initially the pharmacy stated they would send a technician to fix the box and later she was informed the box should be replaced by the facility maintenance director. The DON stated she reported to the maintenance director that a new locked box was needed. The DON stated when the key to the box broke, she did not move the narcotics to the locked narcotic box on the other unit as she did not think it was a problem leaving them unlocked. The DON acknowledged the narcotics were not kept in a double locked system and that the open box containing 2 bottles of liquid narcotic was kept in an unlocked refrigerator.

An interview was conducted on 3/28/24 at 2:30 PM with the Maintenance Assistant. The Maintenance Assistant stated he worked at the facility since November 2023. He stated the

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F 761	Continued From page 55 facility Maintenance Director no longer working in the facility as of last week. The Maintenance Assistant stated he had not been informed until this week that the locked box for the narcotics on the 100 hall was broken and was told it was being ordered. An interview with the Regional Nursing Consultant on 3/28/24 at 3:45 PM revealed she expected narcotics would be handled and stored appropriately under the two-lock system. An interview with the Administrator on 3/28/24 at 3:48 PM revealed she expected that medications would be stored properly. 2. An observation of the Hibiscus Pharmacy Room (Medication Storage Room on 100 hall) on 3/25/24 at 3:30 PM revealed an open vial of Lispro insulin for Resident #40 with no opened date observed. An interview with Nurse #12 revealed insulin was to be dated when opened. The nurse stated an opened vial with no opened date should be discarded. An interview was conducted with the DON on 3/28/24 at 9:40 AM. The DON stated she expected insulin would be dated when opened. An interview with the Administrator on 3/28/24 at 3:48 PM revealed she expected medications would be stored properly.	F 761		
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing	F 802		4/29/24

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F 802	Continued From page 56 The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to have sufficient dietary staff to ensure meals were delivered at the posted mealtimes. This failure had the potential to impact 74 of 74 residents who received oral nutrition. The findings included: An interview was conducted with the Dietary Manager (DM) on 03/25/24 at 11:45 AM. He stated that two of his kitchen staff called out that morning, leaving one kitchen aide and himself to prepare both breakfast and lunch, as well as clean-up. He revealed he was struggling to obtain and maintain staff, due to other facilities paying more. The DM disclosed having an understaffed kitchen staff meant meals were not served on time according to the schedule, but	F 802	On 3/25 staffing was an issue so the dietician assisted in getting the remaining meals out timely. Provider notified by the Administrator on 4/19/2024 that dietary staffing had been affecting meal delivery times. On 4/8/2024 the facility administrator reviewed staffing sheets to ensure sufficient dietary staffing until the end of April. On 4/22 a contract dietary manager was put into place and the administrator met with the administrative team to determine who had kitchen experience in case additional hands were needed in the kitchen. Education provided to dietary staff	

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F 802	Continued From page 57 dietary staff were doing the best they could. An interview was conducted on 03/25/24 at 12:43 PM with the Dietary Manager (DM). He stated due to kitchen budget cuts he was having to schedule the kitchen staff short, months in advance, which he said, "it is what it is". He stated that the dietary department needed staff, which was why there was only 1 dietary aide and himself preparing breakfast that morning, and that one dietary aide usually comes around 12:00 PM and a cook comes in the afternoon to complete the evening cooking. A dining room observation was conducted on 03/25/24 at 1:00 PM with an alert and oriented resident, who stated he was waiting like everyone else for his lunch to be served, which was often served late; but there was nothing he could do about it but wait. A lunch observation was conducted with Resident #274 (200-hall) on 03/25/24 at 1:15 PM, revealed no nutritional shake on resident's lunch tray per meal tray standing order slip, which read: 4-ounce nutritional shake. An observation and interview were conducted with Resident #274 (200-hall) on 03/26/24 at 9:15 AM. She stated she was eating the breakfast she had ordered; except she was missing the nutritional shake. She said she let nursing and dietary know about not getting the nutritional shake on her meal tray, but they never provided her with one. She also stated meal trays were never delivered at a consistent time, except when you are here. Resident #274 stated she usually receives her breakfast tray around 10:00 AM and the lunch tray around 1:00 PM to 1:30 PM, and	F 802	regarding call out policy by the CDM on 4/22/2024 and appropriate staffing levels reviewed with Dietary Manager. Education provided to administrative team on 4/26/2024, by the Administrator on assisting with meal preparation and on call schedule in the event of a dietary call out. Administrator will be alerted of all call outs and will ensure administrative staff are available to assist. On 4/26/2024 Administrator verified that all open positions were posted on Apploi. Open interviews are now being conducted 5 days a week. The Administrator/designee will review staffing 7 days a week x 12 weeks and review call outs to ensure sufficient staffing. The QA team will review monthly for three months. The QA team may extend the audits or alter the POC to ensure ongoing compliance.	

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her dinner trays did not arrive until 7:00 PM to 10:00 PM.

A lunch observation was conducted with Resident #274 (200-hall) on 03/26/24 at 1:15 PM, revealed no nutritional shake on her lunch tray per meal tray slip standing order: 4-ounce nutritional shake.

An interview was conducted on 03/26/24 at 1:20 PM with Medication Aide (MA) #1. The MA revealed mealtimes were erratic. The MA stated the mealtime inconsistency was related to very few staff in the kitchen. The MA stated mealtimes were often erratic, and that the inconsistency was related to very few staff in the kitchen. The MA confirmed that Resident #274 did not have a 4-ounce nutritional shake on her lunch meal tray as she should have per standing order.

An interview was conducted on 03/27/24 at 3:50 PM with Kitchen Cook #1. He stated the kitchen was often short staffed with 3 or less staff per shift. He stated it takes 3 Kitchen Aides and 1 Kitchen Cook to prepare meals, deliver trays timely, and clean-up. He stated the kitchen needed 3 Kitchen Aides, 1 cook, and the DM to run their kitchen and feed 74 residents, He stated the kitchen had been short staffed for over 6 months, and upper management knows about it.

An interview was conducted on 03/27/24 at 3:55 PM with Kitchen Cook #2. He stated the kitchen had been short staffed a lot of the time, which required him working long hours, often two shifts. He stated resident meals were often late because they were short staffed.

An interview was conducted on 03/27/24 at 3:58

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PM with Kitchen Cook #3. She stated the kitchen had been short-staffed for about a year. She stated there had been times when she and the DM were the only staff to prepare meals and cleanup for 74 residents, impossible. She said with 4 staff it is doable, 2 and 3 very difficult, and 1 impossible. She said the Administrator was aware of their situation, but nothing seems to be done about it.

An interview was conducted on 03/27/24 at 4:00 PM with the DM. He stated he did not have sufficient staff as some of the dietary staff had quit and his staffing budget was cut. The DM stated staffing the kitchen with 1 to 2 kitchen cooks or aides is not enough to be efficient or provide resident meals timely. He stated on Monday there was no cook in the morning as a result he was responsible for cooking breakfast and lunch for the residents. He further stated he had only two kitchen staff who assisted him with cleaning and other kitchen jobs.

A follow-up interview was conducted with the Dietary manager on 03/27/24 at 4:30 PM. He stated the dietary department did not have adequate staff and he stepped in as a cook when there was no cook or any call outs.

An interview was conducted on 03/28/24 at 7:55 AM with the Administrator. The Administrator stated she was hired as the Administrator 5 months ago, and since then been aware the kitchen needed more staff, and she has been actively recruiting since then. The Administrator stated the Dietary Manager's primary function has been to manage, cook, and fill in, until the facility has adequate dietary staff.

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F 802	Continued From page 60 A review of the dietary staff schedules from 12/24/23 - 03/25/24 (93-day total) revealed: " 4-days there were 1-kitchen staff scheduled for the whole day. " 13-days there were only 2-kitchen staff scheduled for the whole day. " 34-days there were only 3-kitchen staff scheduled for the whole day. " 44-days there were only 4-kitchen staff scheduled for the whole day. Meal schedule mealtimes provided by the Dietary Manager. " Breakfast - 8:00 AM -200 Hall, 8:45 AM-Dining Room, 8:45 AM-100 Hall. " Lunch - 12:00 PM -200 Hall, 12:45 PM-Dining Room, 12:45 PM-100 Hall. " Dinner - 6:00 PM -200 Hall, 6:45 PM-Dining Room, 7:00 PM-100 Hall.	F 802		
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, staff, Registered Dietician, and Nurse Practitioner interviews the facility failed to provide physician ordered low concentrated sweets therapeutic diets to 2 of 2 diabetic residents (Resident #34	F 808	Based on observations, record review, staff, Registered Dietician, and Nurse Practitioner interviews the facility to provide physician ordered low concentrated sweets therapeutic diets to 2	4/29/24

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F 808	Continued From page 61 and Resident #48) reviewed for nutrition. Findings included. Resident #34 was admitted to the facility on 10/16/23 with diagnosis including diabetes and long-term insulin use. A physicians order for Resident #34 dated 10/16/23 revealed LCS (Low Concentrated Sweets) diet. Regular texture with thin consistency. A care plan dated 10/27/23 revealed Resident #34 was at risk for impaired nutritional status in part due to type 2 diabetes. Interventions included to encourage compliance with dietary guidelines, encourage a healthy lifestyle and provide diet according to the physicians order. The Minimum Data Set (MDS) quarterly assessment dated 01/19/24 revealed Resident #34 was cognitively intact. She had no rejection of care and received a therapeutic diet. During an interview on 03/26/24 at 1:00 PM Resident #34 stated she was told on admission that the facility didn't provide diabetic diets. She stated she received regular foods with regular portion sizes. She stated she was provided regular snacks such as peanut butter and jelly sandwiches, crackers, and cookies. An observation on 03/26/24 at 1:00 PM revealed Resident #34's lunch meal included chicken with gravy, mashed potatoes, green beans, and blueberry cobbler with regular portion sizes. An observation on 03/27/24 at 9:30 AM revealed	F 808	of 2 diabetic residents (Resident #34 and Resident #48) reviewed for nutrition. Provider notified by Administrator on 4/19/2024 that low concentrated were not provided to resident #34 and #48. On 4/24/24 the Administrator observed each tray including tray card for resident #34 and resident # 48, for low concentrated sweets that were prepared and delivered from the kitchen to ensure trays were prepared correctly. Education provided to dietary department on 4/23/24 regarding low concentrated sweets diet requirements by dietary manager. The dietary manager or designee will audit tray card accuracy for 10 residents weekly for 12 weeks for residents receiving low concentrated sweets diet, to ensure compliance with Saber diet descriptions. The Quality Assurance Performance Improvement team will review monthly for 3 months. The Quality Assurance Performance Improvement team may extend the audits or alter the plan of correction to ensure ongoing compliance.	

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Resident #34 was served bacon, oatmeal, toast with jelly, and cranberry juice.

During an interview on 03/27/24 at 1:30 PM the Regional Dietary Manager stated the facility provided "liberalized" diets to residents. She stated residents that received low concentrated sweets received the same foods as "liberalized" diets but with smaller portion sizes. She stated for example the resident would receive 2 ounces of dessert instead of 4 ounces of dessert.

During an interview on 03/27/24 at 2:30 PM the Dietary Manager stated he followed a spreadsheet which showed the meals being served each day. The spreadsheet had an "X" by the food that residents could be served who were to receive low concentrated sweets, a renal diet (low in sodium, potassium, protein, and phosphorus) or a no added salt diet. He stated they offered smaller portion sizes of sugar foods to residents on low concentrated sweet diets such as 2 ounces of dessert instead of 4 ounces. He stated regarding no added salt diets that he didn't cook with salt. Residents that received a renal diet would get food substitutes such as serving chicken instead of pork if a substitute was available. He stated staffing was low in the kitchen and they tried to follow diet orders as much as they could.

During an interview on 03/28/24 at 1:43 PM the Registered Dietician stated many of the residents received liberalized diets and the residents on low concentrated sweets were served smaller portion sizes. She indicated residents who were ordered low concentrated sweets, renal, or no added salt diets should be provided with foods consistent with the dietary guidelines. She indicated moving

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forward diet orders would be reviewed and food preferences and dietary recommendations would be discussed with residents or their Responsible Party to determine dietary preference. She stated the diets would be discussed with the physician for approval.

During an interview on 03/28/24 at 1:45 PM Dietary Aide /Cook #4 stated she had only worked in the facility for a month. She stated her duties in the kitchen included to cook and to serve as a dietary aide. She stated she did plate the food for residents during meal preparation. She stated all residents were served the same foods, including the same amount of foods. She indicated she didn't know what specific guidelines were used for diabetic (low concentrated sweet) diets versus regular diets.

During an interview on 03/28/24 at 4:00 PM the Nurse Practitioner stated she was not aware that therapeutic diets such as low concentrated sweets, renal or no added salt diets were not being followed. She stated she expected diets to be provided according to the prescribed diet order.

2..Resident #48 was admitted to the facility on 09/01/23 with diagnosis including diabetes with left below knee amputation.

The Minimum Data Set (MDS) quarterly assessments dated 12/26/23 revealed Resident #48 was cognitively intact. He had no rejection of care and received a therapeutic diet.

A physicians order dated 09/01/23 for Resident #48 revealed low concentrated sweets and no

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added salt diet. Regular texture with thin consistency

A care plan dated 03/26/24 revealed Resident #48 was at risk for nutritional decline, and weight fluctuations related to diagnosis of type 2 diabetes, heart failure, chronic kidney disease with a need for a therapeutic diet of low concentrated sweets and no added salt. The goal of care was to meet his nutritional needs. Interventions included in part; to encourage compliance with diet guidelines, encourage a healthy lifestyle, and provide diet according to the physicians order.

During an interview on 03/26/24 at 1:00 PM Resident #48 was alert and oriented to person, place, and time, and stated he received a regular diet. He stated he was supposed to receive a low concentrated sweets diet, but he received regular foods. He stated he received foods such as jelly, syrup, and desserts with his meals. He stated snacks were provided to him, but they were not low sugar snacks.

An observation on 03/26/24 at 1:00 PM revealed Resident #48's lunch meal included chicken with gravy, mashed potatoes, green beans, blueberry cobbler with regular portion sizes.

An observation on 03/27/24 at 9:30 AM revealed Resident #48 was served bacon, toast with jelly, corn flakes, a cup of cranberry juice and milk.

During an interview on 03/28/24 at 1:43 PM the Registered Dietician indicated Resident #48 should receive foods consistent with the prescribed low concentrated sweets and no added salt diet.

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F 808	Continued From page 65 During an interview on 03/28/24 at 2:30 PM the Director of Nursing (DON) stated there had been a high turnover of staff in the kitchen and they were recruiting for additional kitchen staff. She indicated that was why the diet orders weren't consistently followed. She stated diets should be provided according to the physicians order. During an interview on 03/28/24 at 4:30 PM the Administrator stated she expected therapeutic diets to be provided according to the physician orders. She stated education would be provided.	F 808		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by:	F 809		4/29/24

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F 809	Continued From page 66 Based on resident, staff and Registered Dietician interviews, the facility failed to provide packed meals for a dialysis resident who left the facility at 6:30 AM and did not return until lunchtime three days a week for 1 of 1 resident reviewed, Resident #279. This deficiency had the potential to affect all five residents residing at the facility who received hemodialysis. Findings included: Resident #279 was admitted to the facility on 03/13/24 with diagnosis that included end stage renal disease and dependence on renal dialysis. Review of a Medicare 5 day Minimum Data Set (MDS) assessment revealed Resident #279 had intact cognition. He received hemodialysis and had a midline intravenous access line. Review of the care Plan dated 3/21/24 for Resident #279 revealed the following focus area: Resident at risk for nutritional decline, dehydration, and weight fluctuations related to, in part, end stage renal disease with hemodialysis. The goal was for Resident #279 to be free of signs and symptoms of dehydration, fluid overload, and electrolyte imbalance through the next review. One of the interventions was for the facility to provide a packed meal on dialysis days. In an interview with the Dietary Manager on 03/28/24 at 10:30 AM he stated the dietary staff sent a boxed lunch with the resident consisting of a sandwich, cookie, corn chips, juice and apple sauce. For residents who left early, a breakfast was prepared the night before and stored in the nourishment room for staff to give to residents in the early morning. He stated dialysis residents	F 809	The provider was notified on 3/29/2024 that resident #279 was not receiving breakfast prior to leaving the facility for dialysis. Resident #279 no longer resides in the facility The Administrator or designee interviewed all dialysis residents on 4/22/24 to ensure they were receiving meals appropriately despite their dialysis schedule Education will be provided to the dietary staff and clinical staff by the Director of Nursing or designee on ensuring dialysis residents receive breakfast prior to leaving for dialysis and on timely delivery of meals. Education will be completed by 4/22/2024 The Director of Nursing or designee will monitor all dialysis residents 3x week to ensure all meals are provided taking into consideration the dialysis schedule for each individual dialysis resident. The Quality Assurance Performance Improvement Committee will review the audits monthly for three months. The committee may change the plan of correction or extend the audits to ensure ongoing compliance.	

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F 809	Continued From page 67	F 809		

never left without a box lunch.

In an interview with the Nurse #2 on 03/28/24 at 8:30 AM she stated Resident #279 left the facility early in the morning for dialysis before her shift started. She did not know if he was provided with a boxed meal to take with him. She was not aware of bagged meals in the nourishment room. She noted staff did save his lunch tray for when he returned.

In an interview with Resident #279 on 03/28/24 at 1:54 PM he stated he did not get breakfast before he left in the mornings for dialysis. He explained he had to send a staff member to the kitchen to get him a bagged meal. He noted when he asked for a bagged meal to take with him, he usually got a peanut butter sandwich, apple sauce and some chips. He stated when he went from supper the previous night to when he returned from dialysis it was a span from 6:00 PM until 1:00 PM the next day when lunch arrived. He reported no breakfast was prepared for him unless he asked and he could not always find a staff member to go to the kitchen to get him one before he left.

In an additional interview with the Dietary Manager on 3/28/24 at 2:01 pm he stated he was not at the facility in the evening because he left at 5:00 PM each day. He was not aware bagged meals were not being prepared and placed in the nutrition room the night before for staff to give to dialysis residents who left before breakfast. He called a Dietary Aide and she stated over the speaker on the phone that she had given an aide a bag lunch that morning to give to Resident #279. She stated she was not aware of bagged meals in the nourishment room.

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F 809	Continued From page 68 In an interview with the Registered Dietician on 3/28/24 at 14:26 PM she stated it was preferred residents were provided 3 meals a day and if they are out of the building for dialysis, they should have a packed meal to take with them; otherwise, it was too many hours between meals. She explained residents were supposed to get 3 meals a day because residents who did not get 3 meals a day with protein were at risk for protein deficiency. In an interview with the Administrator on 3/28/24 at 2:58 PM she stated she expected dietary to provide bagged meals for dialysis residents to take with them without the residents having to ask for one. She was not aware the kitchen was not putting bagged lunches in the nourishment room the night before for staff to access.	F 809		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		4/29/24

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F 812	Continued From page 69 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of manufacturer's instructions, the facility failed to: 1) store the hand-held plastic scoops outside of 2 of 3 dry food bins holding flour and sugar 2) wash dishes in hot water and sanitize dishes in the facility's three-compartment sink per Food and Drug Administration Food Code recommendations in a quaternary sanitizing solution of at least 50-parts per million (ppm) and maintain sanitizing solutions used in the kitchen at the strength recommended by the manufacturer and maintain a clean and sanitized kitchen area for food preparation. These practices had the potential to affect 74 of 74 residents' food quality and kitchen sanitation safety. Findings included: 1. During the initial tour of the facility on 3/25/24 at 11:00 AM, an observation was made of the flour and two sugar bins. Hand-held plastic scoops were stored directly in the food items. An interview was conducted with the Dietary Manager (DM) on 03/25/24 at 11:10 AM. He stated it was his expectation that hand-held plastic scoops be stored in a closed container outside of each bin. An interview was conducted with the Administrator on 03/28/24 at 7:55 AM. She revealed it was her expectation that the dietary staff follow the sanitation guidelines taught by the	F 812	Based on observations, staff interviews and review of manufacturer's instructions, the facility failed to: 1) store the hand-held plastic scoops outside of 2 of 3 dry food bins holding flour and sugar 2) wash dishes in hot water and sanitize dishes in the facility's three-compartment sink per Food and Drug Administration Food Code recommendations in a quaternary sanitizing solution of at least 50-parts per million (ppm) and maintain sanitizing solutions used in the kitchen at the strength recommended by the manufacturer and maintain a clean and sanitized kitchen area for food preparation. These practices had the potential to affect 74 of 74 residents' food quality and kitchen sanitation safety. On 4/8/2024 the facility administration conducted a walk-through of the kitchen to ensure hand held plastic scoops were being stored outside of the dry food bins, and that dishes are being washed at the appropriate temperature with the appropriate sanitizing solution. Dietary staff educated on 4/23/24 as it pertains to proper storage of utensils and appropriate sanitizing solution and temperature to ensure resident food quality and kitchen sanitation safety.	

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F 812	Continued From page 70 facility. 2a. An observation of dietary assistant washing dishes (pots, sheet pans) in a three-compartment sink occurred on 03/25/24 at 11:15 AM. The water in the wash sink was warm to touch. The DM, using test strips, tested the concentration of the quaternary sanitizing solution which was less than 50-parts per million (ppm). Per Food and Drug Administration Food Code recommendations, the concentration of quaternary sanitizing solution should be at least 50-ppm. 2b. An observation on 03/25/24 at 11:20 AM revealed the kitchen's only red sanitizing bucket was dry and empty sitting under a food preparation area and was not being utilized to wipe down and sanitize the tops of the four stainless-steel food preparation tables. The DM stated he did not use the red bucket because he only had old test strips to check the strength of the quaternary sanitizing solution in the red bucket. Instead, he wiped down the food preparation areas with a store-bought bleach disinfectant spray. He also stated that he could not check the ppm effectiveness of the bleach sanitizing spray. A follow-up interview and kitchen observation were conducted on 03/26/24 at 12:00 PM with the DM. He said the quaternary solution in the red sanitizer bucket and three compartment dish washing sink needed to register 100 - 200 PPM when checked with the appropriate strips he picked up at a sister facility. He reported when the strength was less than this there was a chance that the surfaces being wiped down or dishes being washed were not properly	F 812	The Administrator/ Dietary manager will conduct audits 5x a week x 12 weeks to ensure proper dishwashing temperatures and proper storage of utensils. The QA team will review monthly for 3 months. The QA team may extend the audits or alter the POC to ensure ongoing compliance.	

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F 812	Continued From page 71 disinfected. He commented that the strength of the sanitizing solutions in the bucket and dish sink should be checked throughout the day and should not have registered 0-PPM. The DM was then observed to have filled the three compartments sink with sanitation solution and had placed a red bucket under each of the four stainless steel food preparation tables with sanitizing solution. After the replacements, he tested the four red buckets and three compartment sinks with appropriate test strips, with all registering appropriate 100-200 PPM. A follow-up interview was conducted on 03/27/24 at 3:55 PM with DM. The DM stated a filled red sanitation bucket should have been kept at each of the four food preparation areas for safety and sanitation reasons. He said kitchen staff were supposed to clean and wipe down the food preparation tables with sanitizing solution from one of the red sanitizing buckets and let it dry. The DM stated the food preparation tables needed to be consistently cleaned and sanitized to prevent mold or water borne pathogens from developing. An interview was conducted with the Administrator on 03/27/24 at 6:00 PM. He reported it was his expectation for the facility's kitchen staff to follow all regulatory guidelines for food and kitchen sanitation safety; wash and sanitize dishes per the manufacturer instructions, wipe down, test disinfectant solutions, and disinfect food preparation tables per guidelines.	F 812		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse	F 814		4/29/24

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F 814	Continued From page 72 properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure the area surrounding dumpsters remained free of garbage and debris and to close and/or replace all missing doors to the dumpsters that contained waste for 1 of 2 dumpsters reviewed. These failures had the potential to attract pests and rodents. Findings included: An observation of the dumpster area with the Dietary Manager (DM) on 03/26/24 at 12:20 PM revealed scattered debris, branches, and leaves around the sides and back area of the dumpster enclosure area. Both the right dumpster sliding door and the right half of the gate to the dumpster enclosure area were both missing, leaving trash contents and large amounts of debris to build-up around and behind the dumpsters, open to the elements, available to pests and rodents. An interview was conducted with the Dietary Manager on 03/26/24 at 12:30 PM. He stated it was the responsibility of the Environmental Services Department to keep the dumpster area clean and trash can lids closed. An interview was conducted with the Environmental Services Department -Assistant on 03/26/24 at 3:00 PM. He stated it was the responsibility of the assistant to ensure the area around the dumpsters was clean, free of debris, and in good repair. He stated the Environmental Services Department Director recently resigned and he as an assistant was left to manage the Environmental Services Department. He stated	F 814	An observation of the dumpster area with the Dietary Manager (DM) on 03/26/24 at 12:20 PM revealed scattered debris, branches, and leaves around the sides and back area of the dumpster enclosure area. Both the right dumpster sliding door and the right half of the gate to the dumpster enclosure area were both missing, leaving trash contents and large amounts of debris to build-up around and behind the dumpsters. Waste Management was contacted by the facility administrator on 3/29/2024 to report the broken dumpster and a request for a new dumpster was made. Education was provided to the facility administrator, director of maintenance, and central supply by the Regional Director of Clinical Services by 4/5/2024. The director of maintenance will assess the dumpster 5 days a week to ensure the doors are closing appropriately, waste is covered appropriately, and area around dumpster is free of debris. Any issues identified will be corrected as soon as possible. The audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for three months. The committee may change the plan of correction or extend the audits to ensure ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345557	A. BUILDING _____ B. WING _____	C 04/02/2024

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F 814	Continued From page 73 the facility was trying to hire a new Environmental Services Department -Director; but until then he was falling behind in everything. An interview was conducted with the Administrator on 03/28/24 at 9:30 AM. She stated that they were in the process of interviewing for a new Environmental Services Department -Director, and she expected maintenance to keep the dumpster area clean and free of debris, and the side sliding doors of the dumpsters should be closed and not open to the elements available to pests and rodents.	F 814		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide effective leadership and implement effective systems to ensure the facility was able to obtain 60-gallon, 30-gallon, and 10-gallon plastic can garbage liners, toilet tissue, paper towels, and 30 ml. plastic medication cups to meet residents' needs. This failure result affected 74 of 74 residents reviewed for Administration. Findings included: Review of facility's grievances revealed an	F 835	Facility obtained necessary items from another Saber facility on 3/27/2024. Supply inventory was completed by central supply on 4/1 for trash bags, straws, medication cups, toilet paper and paper towels to ensure adequate amounts of each item. LNHA will educate the central supply on monitoring supply levels and ordering supplies by 4/5/2024. All staff will be educated on notifying administration of needed supplies and the supply order list	4/29/24

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F 835	Continued From page 74 anonymous grievance filed 09/05/23 regarding; "The facility ran out of supplies often. The workers were having to ration trash bags, straws, and medication cups due to the facility not obtaining the supplies. The complainant did not know what the facility was doing to obtain the supplies but said that staff had a difficult time finding supplies to work with." An interview was conducted on 03/26/24 at 3:00 PM with the Medical Records/Central Supply Manager (CSM). She stated the supply delivery truck comes once a week. CSM looks in each of the three supply rooms to assess the needs of the residents then asks the residents/staff as well as the department heads to see what supplies are needed for the following week. The CSM stated that since the Environmental Services Director resigned, she was also responsible for ordering supplies for housekeeping and maintenance, since the Environmental Service Director -Assistant does not know how to order supplies. The CSM stated they were currently very low on toilet paper and paper towels, and out of large 60-gallon and 30-gallon trash bags used for trash cans and soiled linen. She said she ordered housekeeping supplies on 03/20/24 (toilet tissue, paper towels, and 60-gallon trash bags) from their supplier, which delivery was still pending. A tour of the facility's main supply room on 03/26/24 at 2:00 PM revealed: No large/medium trash can liners, no toilet paper, no paper towels, and 800 - 30 ml. plastic medication cups. An interview was conducted on 03/26/24 at 3:55 PM with Nurse #8. She stated she was the day nurse on the 100-hall and that the large, soiled	F 835	by 4/5/2024. Central Supply or other designated person will interview 5 staff members weekly x12 weeks to ensure there are no issues with supply availability and complete weekly inventory using a master supply list. Any items identified will be ordered as soon as possible and supplies will be obtained from other sources if needed. The audits will be reviewed by the Quality Assurance Performance Improvement Committee monthly for three months. The committee may change the plan of correction or extend the audits to ensure ongoing compliance.	

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F 835	Continued From page 75	F 835		

utility bins located in the hall were not being utilized due to facility being out of the large 60-gallon and medium 30-gallon trash bags. She stated nursing, housekeeping, and laundry staff were trying to make do with the small can liners until the shipment of larger can liners arrived.

A facility tour on 03/26/24 at 6:05 PM revealed no large 60-gallon can liners were available for the soiled linen bins on the 100 or 200 halls.

An interview was conducted on 03/27/24 at 10:05 AM with Housekeeper #1. She stated yesterday she was the day housekeeper on the 100-hall and was out of the medium and large trash can liners and were rationing out what small bags they did have. She stated housekeeping was often low or out of supplies like paper towels, toilet paper, plastic bags of all sizes, as well as other supplies. She said she did not know why supplies were low or why the situation was not fixed and continued to be an ongoing issue.

An interview was conducted with the Director of Nursing (DON) on 03/28/24 at 7:55 AM. She stated we have had problems with getting supplies timely, measuring cups, straws, paper towels, garbage can liners, etc. But with the Environmental Service Director gone, existing staff have stepped up to order maintenance and housekeeping supplies and they are currently working hard to get the supplies ordered and to the residents without any problem. The DON further stated that it was her expectation that residents have the supplies that are needed.
An interview was conducted on 03/28/24 at 9:30 AM with the Dietary Manager (DM). He stated on 03/27/24 he went to one of their sister facilities and picked up 1-case each of small, medium,

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F 835	Continued From page 76 and large trash can liners, since the facility was out, and that the Environmental Service Director - Assistant ordered supplies for the wrong date. An interview was conducted with the Administrator on 03/28/24 at 10:50 AM. She stated she did not realize staff were having issues with getting supplies from the facility's current supply vendor. She stated, going forward, she expected staff to communicate when they were having difficulty obtaining supplies from the facility's vendor so they could obtain the items from another supplier.	F 835		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information	F 867		4/29/24

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F 867	Continued From page 77	F 867		

will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

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F 867	Continued From page 78 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI	F 867		

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F 867	Continued From page 79 program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) program failed to maintain implemented procedures and monitor interventions the committee put in place following a Focused Infection Control survey and complaint investigation completed on 06/23/23, a recertification survey and complaint investigation completed on 12/09/22, a Focused Infection Control survey and complaint investigation completed on 06/03/22, a recertification survey and complaint investigation completed on 09/23/21, and a revisit survey and complaint investigation completed on 04/28/21. This was for 5 deficiencies cited in the areas of Quality of Care (684), Nutrition/Hydration Status Maintenance (692), Labeling and Storing Drugs & Biologicals (761), Sufficient Dietary Support Personnel (802), and Food Procurement, Store, Prepare, and Serve (812). These deficiencies were subsequently recited during the recertification and complaint investigation survey of 04/02/24. The continued failure during six federal surveys of record shows a pattern of the facility's inability to sustain an effective QAPI program. Findings included.	F 867	Quality Assurance Performance Improvement meeting was held on 4/19/2024 to discuss the recent citations that were received. The discussion included 5 deficiencies that were cited previously: Quality of Care (684), Nutrition/Hydration Status Maintenance (692), Labeling and Storing Drugs and Biologicals (761), Sufficient Dietary Support Personnel (802), and Food Procurement (812) (684) On 4/22/24 the Regional Director of Clinical Services reviewed the Electronic Medication Administration Record for all residents that received an antibiotic since 4/1/2024 to ensure the antibiotics had been given as prescribed. (692) The Director of Nursing/Designee obtained a baseline weight for each resident by 4/5/2024. Weight orders were reviewed by the IDT team on 4/15/2024 to ensure orders were appropriate for each resident. (761) On 3/25/2024 the other narcotic lock box in the facility was checked by the Regional Director of Clinical Services and function appropriately. All other medication refrigerators and medication	

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F 867	Continued From page 80 This tag is cross-referenced to: F684: Based on record review, staff and Nurse Practitioner interviews the facility failed to administer a topical antibiotic ointment prescribed for treatment to the nasal area following a dermatology procedure and to administer antibiotic ophthalmic drops according to the physicians order for 2 of 2 residents (Resident #48, and Resident #43) reviewed for quality of care. During the revisit survey and complaint investigation on 04/28/21 the facility failed to assess and obtain orders for treatment of a right-hand skin tear and abrasion and follow the Nurse Practitioners order to obtain a urinalysis. During the recertification survey and complaint investigation on 12/09/22 the facility failed to complete neurologic assessments with vital signs and assessment of hand grasps and change in behavior. During the Focused Infection Control survey and complaint investigation on 06/23/23 the facility failed to administer topical antibiotics according to the physicians order. F692: Based on observations, record review, staff, Registered Dietician, and Nurse Practitioner interviews the facility failed to obtain physician ordered weights for 7 of 7 residents (Resident #274,#5, #31, #24,#47, #48, #26) and provide a nutritional supplement for 1 of 1 resident (Resident #274) reviewed for nutrition. During the recertification survey and complaint investigation on 12/09/22 the facility failed to	F 867	carts were checked by the Director of Nursing or designee by 4/5/2024 to ensure there are no additional undated opened insulins. (802) On 4/8/2024 the facility administrator reviewed staffing sheets to ensure sufficient dietary staffing until the end of April. (812) On 4/8/2024 the facility administration conducted a walk-through of the kitchen to ensure hand held plastic scoops were being stored outside of the dry food bins, and that dishes are being washed at the appropriate temperature with the appropriate sanitizing solution. (684) The Director of Nursing or designee will educate all nurses on following physician orders and reporting all missed doses of antibiotics to the provider for appropriate follow up. Education will be provided by 4/23/2024. (692) The Director of Nursing/Designee will educate all nurses by 4/23/2024 on following physician's orders as it relates to obtaining weights and scheduling weekly weights on Wednesdays. (761) All nurses and medication aides will be educated by the Director of Nursing or designee on Medication Storage, to include narcotic medication securement, by 4/22/2024. (802) Education was provided to dietary staff regarding call out policy by the CDM on 4/22/2024 and appropriate staffing levels reviewed with Dietary Manager. (812) Dietary staff were educated on the proper storage of utensils, appropriate sanitizing solution and temperatures to ensure resident food quality and kitchen sanitation safety. The regional Director of	

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F 867	Continued From page 81 obtain and record accurate weights and identify and verify the accuracy of weights. F761: Based on observation, staff, Corporate Nurse Consultant, and Administrator interviews the facility failed to store an opened bottle of Lorazepam in the locked bin of the medication refrigerator and label a bottle of Lispro insulin with an opened date for 1 of 1 medications storage rooms observed. During the recertification survey and complaint investigation on 09/23/21 the facility failed to discard expired medications in medication carts and the medication storage room and keep medication carts free of loose medications. During the recertification survey and complaint investigation on 12/09/22 the facility failed to remove expired insulin and keep unattended medications stored in a locked compartment. F802: Based on observations and interviews the facility failed to have sufficient dietary staff to ensure meals were delivered at the posted mealtimes. This failure had the potential to impact 74 of 74 residents who received oral nutrition. During the Focused Infection Control survey and complaint investigation on 06/03/22 the facility failed to employee sufficient dietary support staff to carry out the functions of food and nutrition services. F812: Based on observations, staff interviews and review of manufacturer's instructions, the facility failed to: 1) store the hand-held plastic scoops outside of 2 of 3 dry food bins holding flour and sugar 2) wash dishes in hot water and	F 867	Clinical services educated the facility administrator on 4/22/2024 on QAPI at a glance. The Regional Director of Clinical Services will educate the Facility Administrator and the Director of Nursing by 4/22/2024 on QAPI at a glance as well as the QAPI policy. To ensure ongoing compliance the Regional Director of Clinical Services or the Regional Vice President of Operations will participate in the monthly QA meeting for three months. The RDCS may extend the oversight process or change the corrective action to ensure ongoing compliance.	

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F 867	Continued From page 82	F 867		

sanitize dishes in the facility's three-compartment sink per Food and Drug Administration Food Code recommendations in a quaternary sanitizing solution of at least 50-parts per million (ppm) and maintain sanitizing solutions used in the kitchen at the strength recommended by the manufacturer and maintain a clean and sanitized kitchen area for food preparation. These practices had the potential to affect 74 of 74 residents' food quality and kitchen sanitation safety.

During the recertification survey and complaint investigation on 12/09/22 the facility failed to remove expired items from the dry goods storage and label and date items in the cooler, refrigerator, freezer, and the nourishment room.

An interview was conducted on 03/28/24 at 3:30 PM with the Administrator along with the Corporate Nurse Consultant. The Administrator stated that the repeat deficiencies were primarily related to increased staff turnover over the last several months and the use of agency staff. She indicated they were actively recruiting new staff. The Corporate Nurse Consultant stated continued education would be provided to staff to ensure they adhere to facility policies and procedures.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345557	A. BUILDING: _____ B. WING _____	4/2/2024

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 559	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to provide a written notification of a room change for 1 of 1 resident reviewed for notification of room changes (Resident #16). The findings included: Resident #16 was admitted to the facility on 3/6/21 with diagnoses that included vascular dementia. Resident #16's most recent Minimum Data Set (MDS) assessment dated 1/16/23 coded him as having a moderate cognitive impairment. A nursing progress note revealed Resident #16 changed rooms on 12/31/23. An interview was conducted with Resident #16 on 3/27/24 at 2:00 PM who could not remember his room change. Attempts to contact Resident #16's responsible party on 12/31/23 were not successful. An interview was conducted with the social worker on 3/27/24 at 2:51 PM who stated a written notice of room change was not given to Resident #16's responsible party. She stated she was not aware that written notification of a room change was required. During an interview with the Administrator on 3/28/24 at 10:56 AM she indicated she was not aware that written notification of a room change was required.

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

The above isolated deficiencies pose no actual harm to the residents