STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345119	A. BUILDING _____ B. WING _____	C 05/17/2024

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NORTHCHASE NURSING AND REHABILITATION CENTER	3015 ENTERPRISE DRIVE WILMINGTON, NC 28405

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E 000	Initial Comments An unannounced recertification survey and complaint investigation was conducted onsite 05/13/24 through 05/17/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # R0B411.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted onsite from 05/13/24 through 05/17/24. Event ID# R0B411. The following intakes were investigated: NC00215575, NC00214655 and NC00215985. 4 of the 10 complaint allegations resulted in deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580		6/24/24

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

Electronically Signed | 06/18/2024

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F 580	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and Nurse Practitioner (NP) interview the facility failed to notify the provider of significant weight gain greater than 3-pounds (lbs.) in 24-hours (hrs.), or 5-lbs. in a week, for a resident that required weight gain monitoring for possible cardiac fluid overload due to resident's history of Congestive Heart Failure (CHF). This deficient practice	F 580	F 580 Notify of Changes On 6/13/2024, the Director of Nursing (DON) reviewed Resident #20 weights from 5/1/24-6/7/24 with the physician and a new order was received for daily weights for 2 weeks then weekly, notify the provider of 3-pound weight gain in 24	

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F 580	Continued From page 2 occurred for 1 of 11 sampled residents reviewed for notification of change. (Resident #20) Findings included: Resident #20 was admitted on 4/28/24. His medical diagnoses included Congestive Heart Failure (CHF). A physician order written to start on 05/01/24 revealed daily weights times 2-weeks and notify provider of 3-lb. weight gain in 24-hours or 5-lbs. in a week, then weekly during day shift for CHF for 14-days, with start day 05/01/24. Review of Resident #20's Medical Administration Record (MAR) dated 05/01/24 through 05/14/24 revealed to obtain daily weights and report weight gain greater than 3-lbs. in 24-hours or 5-lbs. in a week (started 05/01/24). Recorded weights in Resident #20's MAR were recorded daily and signed off as completed as evidenced by nursing initials and a check mark daily up to 05/14/24. Review of Resident #20's daily weight: On 05/06/24 was 182.5 lbs. and his daily weight on 05/07/24 was 190-lbs. a weight gain of 7.5-lbs. in 1-day. On 05/09/24 was 189-lbs. and his daily weight on 05/10/24 was 191-lbs. a weight gain of 3-lbs. in 1-day. On 05/11/24 was 184-lbs. and his daily weight on 05/14/24 was 189.3-lbs. a weight gain of 5.3-lbs. in 3-days. Further review of the medical record for Resident #20 revealed there was no evidence the physician was notified of weight changes as ordered. An interview was conducted on 05/16/24 3:20 PM	F 580	hours or 5 pounds in 1 week. On 6/12/24, the Director of Nursing (DON), Assistant Director of Nursing (ADON), and unit manager initiated an audit of all residents with orders for daily weights to include resident #20 to ensure the provider was notified of significant weight gain greater than 3-pounds (lbs.) in 24-hours (hrs.), or 5-lbs. in a week, for a resident that required weight gain monitoring for possible cardiac fluid overload due to resident's history of Congestive Heart Failure (CHF) with documentation in the electronic record. The DON and/or the ADON will address all concerns identified during the audit to include but not limited to obtaining weight when indicated, notification of the physician of significant weight gain for further recommendations with documentation in the electronic record and education of staff. The audit will be completed by 6/24/24. On 6/10/24, the Staff Facilitator initiated an in-service with all nurses regarding Daily Weight Monitoring with emphasis on notification of the provider of significant weight gain greater than 3-pounds (lbs.) in 24-hours (hrs.), or 5-lbs. in a week, for a resident that required weight gain monitoring for possible cardiac fluid overload due to resident's history of Congestive Heart Failure (CHF) with documentation in the electronic record. The in-service will be completed by 6/24/24. After 6/24/24, any nurse who has not completed the in-service will complete	

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F 580	Continued From page 3 with the Nurse Practitioner (NP). The NP stated this was the first time she or MD had heard of Resident #20's one day weight gain of 7.5-pound from 05/06/24 through 05/07/24, and the three-day weight gain of 5.3-lbs. from 05/11/24 through 05/14/24, or the other 3 lb. one day weight gain 05/09/24 through 05/10/24. She stated no staff had reported to her any weight concerns. The NP expected the MD to be notified if Resident #20's daily weights were greater than 3-lbs. in one day or 5-lbs. in a week related to resident having a diagnosis of CHF. NP said she was not made aware or notified by nursing staff of resident's weight gain and should have. NP said Resident #20's weight gains had no health outcome, but could have, and she expected the MD to have been notified, per order, to treat the weight gain to determine if related to CHF, and if additional medication needed to be ordered or change in treatment adjusted. An interview on 05/16/24 at 4:30 PM with the Director of Nursing (DON) revealed it was her expectation that Resident #20's MD should have been notified of resident's greater than 3-lb. weight gain in a day or 5-lb. weight gain in a week, per physician's order. She said she did not know why the MD was not notified and should have per MD order.	F 580	it upon the next scheduled work shift. All newly hired nurses will be in-service during orientation by the Staff Facilitator regarding Daily Weight Monitoring. The Assistant Director of Nursing (ADON), Staff Facilitator (SF), and/or Quality Assurance (QA) nurse will review 10% of residents with orders for weight monitoring for possible cardiac fluid overload due to resident's history of Congestive Heart Failure (CHF) to include Resident #20, 3 times a week x 4 weeks then monthly x 1 month utilizing the Weight Audit Tool. This audit is to ensure weights were obtained per the physician order and the provider was notified of significant weight gain greater than 3-pounds (lbs.) in 24-hours (hrs.), or 5-lbs. in a week, for a resident that required weight gain monitoring for possible cardiac fluid overload due to resident's history of Congestive Heart Failure (CHF) with documentation in the electronic record. The Assistant Director of Nursing (ADON), Staff Facilitator and/or Quality Assurance (QA) nurse will address all areas of concern identified during the audit, including assessment of the resident, notification of the physician of significant weight gain for further recommendations with documentation in the electronic record and re-training of staff. The DON will review the Weight Audit Tool 3 x a week x 4 weeks, then monthly x 1 month to ensure all areas of concern are addressed. The DON will present the findings of the	

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F 580	Continued From page 4	F 580	Weight Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 582 SS=D	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 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	F 582		6/24/24

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F 582	Continued From page 5 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 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) prior to discharge from Medicare Part A skilled services for 2 of 3 residents reviewed for beneficiary protection notification who required the provision of the SNF-ABN form (Resident #126 and #129). Findings included: a. Resident #126 was admitted to the facility on 11/14/23.	F 582	F 582 Liability Notice On 6/11/24, the administrator completed Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) for Resident #126 and provided the written copy to the resident representative. On 6/11/24, the administrator completed Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) for Resident #129 and provided the written copy to the resident representative.	

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F 582	Continued From page 6 Review of Beneficiary Notices - "Residents Discharged Within the Last Six Months" form revealed Resident #126 Medicare Part A skilled services ended on 01/29/24. She remained in the facility with benefit days remaining, per Notice of Medicare Non-Coverage (NOMNC, Form CMS-10123). Record review revealed that Resident #126 was not given the CMS-10555 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN). b. Resident #129 was admitted to the facility on 01/04/24. Review of Beneficiary Notices - "Residents Discharged Within the Last Six Months" form revealed Resident #129 Medicare Part A skilled services ended on 02/12/24. She remained in the facility with benefit days remaining, per Notice of Medicare Non-Coverage (NOMNC, Form CMS-10123). Record review revealed that Resident #129 was not given the CMS-10555 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN). An interview was conducted on 05/15/24 at 11:50 AM with the Social Services Director (SW#1). The SW #1 indicated she or SW #2, who was new, should have provided Residents #126 and #129 with the CMS-10555 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) form, but was unable to provide documentation that they were provided. An interview was conducted on 05/16/2024 at 2:00 PM with the Administrator and she revealed	F 582	On 6/11/24, the administrator completed an audit of all Medicare “A” discharges for the past 30 days. This audit was to ensure a Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) was completed accurately, reviewed with and a written copy provided to the resident/resident representative prior to discharge. No additional concerns were identified. On 6/12/24, the clinical consultant completed an in-service with the Administrator, Business Office Manager, and/or Social Workers regarding Advance Beneficiary Notice of Non-coverage (ABN) with emphasis on providing appropriate notification related to non-coverage of Medicare “A” and reviewing form with the resident/resident representative prior to discharge. In-service will be completed by 6/24/14. After 6/24/14 any Administrator, Accounts Receivable and/or Social Workers who have not received the in-service will complete prior to the next scheduled work shift. All newly hired Administrator, Accounts Receivable and/or Social Workers will be in-serviced during orientation regarding Advance Beneficiary Notice of Non-coverage (ABN). 10% audit of all Medicare “A” discharges will be reviewed by the Assistant Administrator and/or administrator weekly x 4 weeks then monthly x 1 month utilizing the NOMNC-ABN Audit Tool to ensure the appropriate notification of medical non-coverage was reviewed and a written	

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F 582	Continued From page 7 it was her expectation that the residents at the facility or Responsible Party (RP) should be provided appropriate notices prior to being discharged from Medicare.	F 582	copy provided to the resident/resident representative prior to discharge. The Assistant Administrator and/or administrator will address all areas of concern identified during the audit to include completion, review and providing a written copy of the SNF-ABN to the resident/resident representative and re-training of staff. The Administrator will review the NOMNC-ABN Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Administrator will forward the NOMNC-ABN Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the area of nutrition for 4 of 11 residents whose MDS assessments were reviewed for nutrition (Residents #107, #12, #19, # 69).	F 641	F 641 Accuracy of Assessments On 5/16/24, the Minimum Data Set (MDS) Coordinator completed a modification of assessment dated 4/12/24 comprehensive assessment for Resident #107 to reflect accurate coding for a	6/24/24

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F 641	Continued From page 8 Findings included: 1. Resident #107 was admitted on 10/5/22 with diagnosis which included adult failure to thrive and diabetes. Review of Resident #107's electronic health record revealed the following weights were recorded: 10/2/2023- 207.3 pounds (Lbs.) 11/10/2023- 205.1 Lbs. 12/5/2023- 194.2 Lbs. 1/19/2024- 181.8 Lbs. 1/30/2024- 177.1 Lbs. 2/9/2024- 172.5 Lbs. 3/26/2024- 147.6 Lbs. 4/2/2024 1:14 PM- 152.3 Lbs. 4/10/2024 2:35 PM- 158.1 Lbs. Review of Resident #107's weights recorded revealed resident had a 47.1-pound weight loss in180 days (22.92 percent). Review of Resident #107's 4/12/24 quarterly Minimum Data Set (MDS) indicated resident had a mild cognitive impairment. Resident #107's weight was 158 pounds and resident was coded as had no weight loss or weight gain of 5 percent in the past 30 days or 10 percent in the past 180 days. An interview was conducted on 5/16/24 at 3:15 PM with MDS Coordinator #1. MDS Coordinator #1 stated the MDS Coordinator was responsible for the completion of the nutrition section of the MDS assessments. MDS Coordinator #1 stated Resident #107's 4/12/24 quarterly MDS should have been coded for a significant weight change.	F 641	significant weight loss. On 5/16/24, the Minimum Data Set (MDS) Coordinator completed a modification of assessment dated 3/26/24 comprehensive assessment for Resident #12 to reflect accurate coding for a significant weight loss. On 5/16/24, the Minimum Data Set (MDS) Coordinator completed a modification of assessment dated 4/11/24 comprehensive assessment for Resident #19 to reflect accurate weight of resident with no significant weight change. On 5/16/24, the Minimum Data Set (MDS) Coordinator completed a modification of assessment dated 3/29/24 comprehensive assessment for Resident #69 to reflect accurate coding for a significant weight gain. On 6/11/24, the MDS Coordinator under the oversight of the MDS Consultant initiated an audit of the most recent comprehensive, significant change assessments and/or quarterly MDS assessment section “K” for all residents to include Resident #107, Resident #12, Resident #19 and Resident #69 to ensure all MDS’s assessments completed are coded accurately for significant weight changes. The DON will address all concerns identified during the audit to include updating assessment when indicated and education of the MDS nurse. The audit will be completed by 6/24/14.	

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F 641	Continued From page 9 MDS Coordinator #1 further revealed the computer usually gave a warning when a resident had a significant weight change but it had not been giving the warnings so that may have contributed to the error. MDS Coordinator #1 indicated she was aware of how to calculate a weight change per the Resident Assessment Instrument (RAI) manual, but she had not done it. An interview was conducted on 5/16/24 at 4:35 PM with the Director of Nursing (DON). The DON stated she expected that the MDS assessments would be coded accurately, that the weight changes would be calculated, and she did not know why the resident had lost weight. An interview was conducted on 5/17/24 at 1:50 PM with the Administrator. The Administrator stated she expected the MDS assessments to be completed accurately. The Administrator further stated it was important for the MDS assessments to be accurate for the resident care plans to be accurate and reflect the resident's current condition. 2. Resident #12 was admitted on 12/20/21 with diagnosis which included in part end stage renal disease. Review of Resident #12's electronic health record revealed the following weights were recorded: 9/28/23- 224 pounds (Lbs.) 2/27/24- 222.2 Lbs. 3/26/24- 199.1 Lbs. Review of Resident #12's weights recorded revealed resident had a 23-pound weight loss in 30 days (10.4%) and 25-pound weight loss in 180	F 641	On 6/11/24, the MDS Consultant completed an in-service on MDS Assessments and Coding with all MDS nurses and MDS Coordinator regarding proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately for significant weight changes. All newly hired MDS Coordinator or MDS nurses will be in-service regarding MDS Assessments and Coding during orientation. 10% audit of newly completed MDS assessments- section “K”, to include assessments for Resident #107, Resident #12, Resident #19 and Resident #69 utilizing the MDS Accuracy Audit Tool will be reviewed by the MDS consultant and/or Director of Nursing weekly x 4 weeks then monthly x 1 month to ensure accurate coding of the MDS assessment for significant weight changes. All identified areas of concern will be addressed immediately by the MDS consultant and/or DON to include retraining of the MDS nurse and completing necessary modification to the MDS assessment. The DON will review the MDS Accuracy Audit Tool weekly x 4 weeks and then monthly x 1 month to ensure any areas of concerns have been addressed. The DON will forward the results of MDS Accuracy Audit Tool to the Quality	

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F 641	Continued From page 10 days (greater than 10%). Review of Resident #12's 3/26/24 quarterly Minimum Data Set (MDS) assessment revealed the resident had severe cognitive impairment. Resident #12 was coded as having a weight of 199 pounds with no weight loss or weight gain of 5 percent in the past 30 days or 10 percent in the past 180 days. An interview was conducted on 5/16/24 at 3:15 PM with MDS Coordinator #1. MDS Coordinator #1 stated the MDS Coordinator was responsible for the completion of the nutrition section of the MDS assessments and Resident #12's MDS should have been coded for a significant weight change. MDS Coordinator #1 revealed the computer usually gave a warning when a resident had a significant weight change but it had not been giving the warnings so that may have contributed to the error. MDS Coordinator #1 indicated she was aware of how to calculate a weight change per the Resident Assessment Instrument (RAI) manual but she had not done it. An interview was conducted on 5/16/24 at 4:35 PM with the Director of Nursing (DON). The DON stated she expected that the MDS assessments would be coded accurately. An interview was conducted on 5/17/24 at 1:50 PM with the Administrator. The Administrator stated she expected the MDS assessments to be completed accurately. The Administrator further stated it was important for the MDS assessments to be accurate for the resident care plans to be accurate and reflect the resident's current condition.	F 641	Assurance and Performance Improvement (QAPI) Committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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3. Resident #19 was admitted to the facility on 11/29/23 with diagnosis which included diabetes and hypertension.

Review of Resident #19's electronic health record revealed the following weights were recorded:

11/29/2023- 156.5 pounds (Lbs.)
12/1/2023- 156.5 Lbs.
12/5/2023- 150.7 Lbs.
12/12/2023- 148.4 Lbs.
12/21/2023- 143.7 Lbs.
12/29/2023- 143.0 Lbs.
1/11/2024- 147.3 Lbs.
1/30/2024- 142.2 Lbs.
2/9/2024- 140.0 Lbs.
3/7/2024- 141.6 Lbs.
3/12/2024- 135.0 Lbs.
4/9/2024- 178.0 Lbs.
4/9/2024 incorrect documentation
4/9/2024- 178.0 Lbs.

Review of Resident #19's weight record revealed resident had a 43-pound weight gain in 30 days (24.16 percent) and a 21.5-pound weight gain in 180 days (13.74 percent).

Review of Resident #19's quarterly Minimum Data Set (MDS) assessment dated 4/11/24 indicated resident was coded as had a weight of 178 pounds. The MDS assessment indicated Resident #19 had no weight loss or weight gain of 5 percent in 30 days or 10 percent in 180 days.

An interview was conducted on 5/16/24 at 3:15 PM with MDS Coordinator #1. MDS Coordinator #1 stated the MDS Coordinator was responsible for the completion of the nutrition section of the MDS assessments. MDS Coordinator #1 stated

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Resident #19's 4/11/24 quarterly MDS should have been coded for a significant weight change. MDS Coordinator #1 further revealed the computer usually gave a warning when a resident had a significant weight change but it had not been giving the warnings so that may have contributed to the error. MDS Coordinator #1 indicated she was aware of how to calculate a weight change per the Resident Assessment Instrument (RAI) manual. MDS Coordinator #1 stated she had not calculated the weight change and the computer populated the assessment with the weight, so she had not checked it. MDS #1 stated maybe she should have questioned the weight that entered on Resident #19's assessment and reviewed the weights more carefully.

An interview was conducted on 5/16/24 at 4:35 PM with the Director of Nursing (DON). The DON stated she expected that the MDS assessments would be coded accurately, and the weight change would be calculated.

An interview was conducted on 5/17/24 at 1:50 PM with the Administrator. The Administrator stated she expected the MDS assessments to be completed accurately. The Administrator further stated it was important for the MDS assessments to be accurate for the resident care plans to be accurate and reflect the resident's current condition.

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F 641	Continued From page 13 4. Resident #69 was admitted to the facility on 09/10/23 with diagnoses that included: End stage renal disease, mild protein calorie malnutrition, dependence on renal dialysis, and Type 2 Diabetes Mellitus. Review of the MDS assessment for Resident #69 dated 03/29/24 documented he had intact cognition. He weighed 169 pounds. He had no weight gain in six months. Review of the recorded weights for Resident #69 revealed he weighed 135.3 pounds on 09/29/23 and 169 pounds on 03/29/24 showing a weight gain of 24.91 percent. In an interview with the DON and the Administrator on 05/16/24 at 8:45 AM they both stated they expected the MDS assessment to be coded correctly to reflect that Resident #69 had a weight gain during the six month assessment look back period. In an interview with MDS Nurse #1 on 05/16/24 at 13:51 PM she stated the MDS assessment dated 03/29/24 was coded incorrectly documenting the resident did not have a 10% or more weight gain in the previous six months because he did have a weight gain of 24.91 percent during this period. She did not know why the assessment had been coded incorrectly.	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		6/24/24

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F 657	Continued From page 14 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews, the facility failed to update the comprehensive care plan to reflect changes in care interventions in the areas of mobility and nutrition. This was for 3 of 11 residents whose care plans were reviewed (Resident #107, Resident #12, and Resident #19). Findings included: 1.Resident #107 was admitted on 10/5/22 with diagnosis which included: stroke with hemiparesis, adult failure to thrive and diabetes.	F 657	F 657 Care Plan Timing and Revision On 5/15/24, the Minimum Data Set (MDS) Nurse updated the care plan for Resident #107 to accurately reflect the residents current state of nourishment; less than body requirement to include measurable goals and interventions. On 5/17/24, the MDS Nurse updated the care plan for Resident #107 to accurately reflect the resident's mobility status and non-compliance with splint use. On 5/16/24, the MDS Coordinator updated the care plan for Resident #12 to	

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F 657	Continued From page 15 a. Review of Resident #107's nutrition care plan last revised on 1/31/2024 revealed a problem of state of nourishment more than body requirement characterized by weight gain, obesity, excessive appetite related to: increased caloric and fat intake, and sedentary lifestyle. The goal indicated the resident would adhere to a prescribed diet, would eat food only from their own plate, and would eliminate snacking between meals. The care plan did not include a goal of a desired weight to be achieved. Interventions included avoiding using food as a reward, using other means of positive encouragement, and referring to the dietitian for evaluation/recommendations. Review of Resident #107's record revealed the following weights and physician orders were recorded: 10/2/23- 207.3 pounds (lb.) 11/10/23-205.1 lb. 12/5/23- 194.2 lb. 1/19/24- 181.8 lb. 1/26/2024 a physician order was written for [brand name] nutritional supplement three times per day with meals and regular diet with enriched meals for Resident #107 due to weight loss. 1/30/24- 177.1 lb. 2/9/24- 172.5 lb. 3/26/24- 147.6 lb. 3/26/24 a physician order for Resident #107 to have weekly weights measured. 4/2/24- 152.3 lb.	F 657	accurately reflect the resident's current state of nourishment and potential for weight fluctuations related to hemodialysis to include measurable goals and interventions. On 5/15/24, the MDS Nurse updated the care plan for Resident #19 to accurately reflect the resident's current state of nourishment; less than body requirement to include measurable goals and interventions. On 6/11/24, the Director of Nursing (DON) the initiated an audit of care plans for all residents to include Resident #107, Resident #12, and Resident #19 to ensure the care plan accurately reflects the resident's current state of nourishment with measurable goals and interventions, residents' mobility status, and use of splints/braces. The DON will address all concerns identified during the audit to include updating the care plan when indicated and education of staff. The audit will be completed by 6/24/24. On 6/11/24, Staff Development Coordinator (SDC) initiated an in-service with all nurses regarding Care Plans. With emphasis is on ensuring the care plan is updated timely and accurately with all aspects of resident care to include but not limited to nutritional and mobility status and use of splints/braces. In-service will be completed by 6/24/14. After 6/24/14, any nurse who has not completed the in-service will complete in-service upon the next scheduled work shift. All newly hired nurses will be in-service during orientation regarding Care Plans. The Assistant Director of Nursing, Staff	

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F 657	Continued From page 16 4/10/24- 158.1 lb. Review of Resident #107's quarterly Minimum Data Set (MDS) dated 4/12/24 noted her weight was 158 pounds and had no weight loss or weight gain. An interview was conducted on 5/15/24 at 11:30 AM with the Registered Dietitian (RD). The RD revealed she was in the position since January 2024, her role was to complete a clinical review of the nutritional status of the residents, and she was not involved in the care planning process. The RD stated she was aware Resident #107 was not eating well and had lost a significant amount of weight. An interview was conducted on 5/16/24 at 3:10 PM with MDS Coordinator #1. MDS Coordinator #1 stated she was responsible for updating resident care plans and it was an error that Resident #107's care plan was not revised to reflect the weight loss and current interventions. She explained this had been an oversight. An interview was conducted on 5/17/24 at 1:50 PM with the Administrator. The Administrator stated she expected the care plans would be accurate and up to date, including current information and interventions. b. Review of Resident #107's quarterly Minimum Data Set (MDS) assessment dated 4/12/24 indicated she had impaired range of motion of the upper and lower extremities on one side, required extensive assistance with transfers, was noted as dependent for wheelchair mobility, and walking was coded as not applicable.	F 657	Facilitator and/or Quality Assurance Nurse (QA) will review care plans for 10% of residents to include resident # 107, resident #12 and resident #19 weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure care plans are updated timely and accurately for residents' nutritional and mobility status and use of splints/braces. The Assistant Director of Nursing (ADON), Staff Facilitator, and/or Quality Assurance Nurse (QA) will address all concerns identified during the audit to include updating care plans and/or re-training of staff. The Director of Nursing will review the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns identified. The Director of Nursing will forward the results of the Care Plan Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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A review of Resident #107's mobility care plan last reviewed on 4/26/24, included a focus of requires assistance for potential to restore or maintain maximum function of self-sufficiency for mobility characterized by the following functions: positioning, locomotion and ambulation related to at risk for limitation of range of motion in upper and lower extremities. The goal indicated resident will walk 50 feet with a hemi walker (a walker for a resident with the use of only 1 hand or arm) and left ankle brace through next review. Interventions included providing verbal cues and minimal assist of 1 person for ambulation of 50 feet with hemi walker and left ankle brace.

An interview on 5/16/24 at 10:15 AM with the Rehabilitation Director revealed Resident #107 last received therapy from January 2024 through April 2024 to address mobility, positioning, and transfers. The Rehabilitation Director stated Resident #107 was non-compliant with splints, was non-ambulatory, and did not progress well with therapy.

An interview was conducted on 5/16/24 at 3:10 PM with MDS Coordinator #1. MDS Coordinator #1 stated she was responsible for updating resident care plans and it was an error that Resident #107's care plan was not revised to reflect her current non ambulatory status. She explained this had been an oversight.

An interview was conducted on 5/17/24 at 9:35 AM with Nurse #1. Nurse #1 indicated she was assigned to Resident #107 frequently and was familiar with her care. She explained Resident #107 had not walked or worn a leg brace for a long time.

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An interview was conducted on 5/17/24 at 1:50 PM with the Administrator. The Administrator stated she expected the resident care plans to be revised to reflect changes in condition and interventions.

2. Resident #12 was admitted on 12/20/21. Resident's diagnoses included in part end stage renal disease and dependence on renal dialysis.

Review of Resident #12's nutrition care plan last revised on 1/24/23 indicated a problem for state of nourishment related to diagnosis of obesity, diabetes mellitus, increased protein needs and on therapeutic diet. Interventions indicated cardiac diet, regular texture, supplement as ordered, monitor weight, and notify physician as indicated.

The resident had actual weight loss, received a renal carbohydrate-controlled diet and was on dialysis which was not updated/included in this nutrition care plan.

Review of Resident #12's record revealed the following weights were recorded:

9/28/23- 224 pounds (lb.)
2/27/24- 222.2 lb.
3/26/24- 199.1 lb.

Review of the weights recorded revealed resident had a 23-pound weight loss in 30 days (10.4%) and 25-pound weight loss in 180 days (greater than 10%).

Review of Resident #12's 3/26/24 quarterly Minimum Data Set (MDS) assessment revealed Resident #12 was coded as having a weight of 199 pounds with no weight loss or weight gain

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and received a therapeutic diet.

Review of Resident #12's record revealed a physician order dated 3/29/24 for renal carbohydrate-controlled diet regular texture.

Review of Resident #12's record revealed a 4/19/24 Registered Dietitian (RD) progress note which indicated resident's nutritional status was reviewed due to dialysis. The note indicated resident received a renal carbohydrate-controlled diet with regular texture and thin liquids and had a weight decrease of 14.5# (6.7 percent) over 30 days.

An interview was conducted on 5/15/24 at 11:05 AM with the Registered Dietitian (RD). The RD stated she had been in the position since January 2024 and was following Resident #12 regarding the significant weight change. The RD stated she was not involved with the resident care plans.

An interview was conducted on 5/16/24 at 3:10 PM with MDS Coordinator #1. MDS Coordinator #1 stated she was responsible for updating resident care plans and it was an error that Resident #12's care plan was not revised to reflect her current nutritional status. She explained this had been an oversight.

An interview was conducted on 5/17/24 at 1:50 PM with the Administrator. The Administrator stated she expected the resident care plans would be accurate, person centered and revised as needed.

3. Resident #19 was admitted to the facility on 11/29/23 with diagnosis which included diabetes.

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Review of Resident #19's record revealed the following weights were recorded:
11/29/2023- 156.5 pounds (lb.)
12/5/23- 150.7 lb.

Review of Resident #19's current nutrition care plan indicated a problem last revised on 12/11/23 which indicated state of nourishment more than body requirement characterized by weight gain, obesity, excessive appetite related to overweight, diabetes, and heart disease. The goals indicated Resident #19 would adhere to the prescribed diet, would eat food only from her own plate, would eliminate snacking between meals and total intake would meet resident's nutritional needs as evidenced by weight stability. Interventions included avoiding using food as a reward, using other means of positive reinforcement, consistent carbohydrate/no added salt diet, regular texture, refer to dietitian for evaluation/recommendations, and weigh per facility protocol.

Review of Resident #19's record revealed the following weights were recorded:

12/12/23- 148.4 lb.
1/11/24- 147.3 lb.
2/9/24- 140.0 lb.
3/7/24- 141.6 lb.
3/12/24- 135.0 lb.
4/9/24- 178.0 lb.

A 4/12/24 physician order indicated Resident #19 received a consistent carbohydrate diet pureed texture with nectar consistency liquids.

Review of Resident #19's quarterly Minimum Data Set (MDS) assessment dated 4/11/24 noted a weight of 178 pounds with no weight loss or

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weight gain and they received a mechanically altered diet.

A review of Resident #19's electronic health record revealed a 4/11/24 physician order for daily weights for 2 weeks then weekly due to 43-pound weight gain in 1 month.
4/12/24- 138.4 lb.
4/19/24- 132.4 lb.

A 4/19/24 physician order indicated Resident #19 was to receive [brand name] nutritional supplement one time a day for additional calories and protein and a regular diet.

5/14/24- 129.7 lb.

A 5/14/24 Nurse Practitioner progress note indicated Resident #19 was evaluated due to unintentional weight loss. The note indicated Resident #19's diet was advanced to regular diet to increase intake.

An interview was conducted with the Registered Dietitian (RD) on 5/15/24 at 11:10 AM. The RD stated she was in the position since January 2024, her role was to complete clinical reviews of the residents' nutrition and she was not involved in the care planning process. The RD indicated Resident #19 had significant weight loss.

An interview was conducted on 5/16/24 at 3:10 PM with MDS Coordinator #1. MDS Coordinator #1 stated it was an error that Resident #19's care plan was not updated regarding the weight loss and current interventions. She explained she was responsible for the completion of the nutrition focus in the care plan and Resident #19's care plan should have been revised when she began

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F 657	Continued From page 22 losing weight. MDS Coordinator #1 also explained that the previous RD who left in December updated and revised the nutrition care plans but the new RD did not. An interview was conducted on 5/17/24 at 1:50 PM with the Administrator. The Administrator stated she expected the resident care plans would be accurate and revised to reflect changes in condition and interventions.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation,	F 676		6/24/24

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F 676	Continued From page 23 including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to provide tray set-up and assistance with eating to maintain resident's ability to feed themselves for 3 of 3 residents (Resident #112, #126, and #131) reviewed for activities of daily living (ADL). The findings included: 1. Resident #112 was admitted 11/28/22 with diagnoses that included: dysphagia, dementia, and mild protein calorie malnutrition. Resident #112 was receiving palliative care through hospice services. The resident's Quarterly Minimum Data Set (MDS) dated 03/26/24 indicated the resident had moderate to severe cognitive impairments and required supervision and set up only for meals during the assessment period. Resident #112's care plan dated 03/26/24 revealed a potential for fluid volume deficit related to anemia, with nourishment less than body requirement, inadequate intake, and decreased appetite.	F 676	F 676 Activities Daily Living (ADLs) On 6/11/24, the Director of Nursing (DON) updated the care plan/care guide for Resident #112 for partial/moderate assistance with meals to include tray set up. On 6/11/24, the DON updated the care plan/care guide for Resident #126 for set up/clean up assistance with meals to include cutting meats per resident preference. On 6/11/24, the DON updated the care plan/care guide for Resident #131 for set up/clean up assistance with meals to include cutting meats per resident preference. On 6/12/24, DON and administrator initiated an audit of meal delivery to include all meals for residents not able to report. This audit is to ensure staff provided appropriate assistance during mealtime to include tray set up and/or feeding assistance per care plan/care guide. The DON and administrator will	

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F 676	Continued From page 24 A nursing note dated 05/10/24 at 10:41 AM for Resident #112 revealed the resident had triggered a 110% weight loss over the last 180-days. The Resident's Health Care Provider and Responsible Party (RP) was notified with no new orders at that time. The resident continued Hospice services and continued to receive Med-Pass (a nutritional supplement) 120 mL by mouth twice per day, and enriched meals with staff encouragement. A Registered Dietitian (RD) note dated 05/10/24 at 1:37 PM for Resident #112 revealed the resident continued to receive hospice care, with mechanical soft texture diet and thin liquids. Her by mouth intake reflects 50-75%, occasionally more, with added med-pass supplement two times per day. An interview and observation were conducted on 05/14/24 at 8:45 AM with Resident #112. She said her breakfast tray was not set up and should have been. She was observed trying to punch a hole into her juice container with a plastic straw and failed to puncture the aluminum lid and dropping the broken straw onto the floor. She said with only one hand she was not able to open her mighty shake, milk carton, or juice, or cut her sausage or French toast. An interview was conducted on 05/14/24 at 9:15 AM with the Rehabilitation Director. She said all resident meal trays should be set-up by facility staff if the residents were not independent. She said Resident #112 was in Hospice and needed tray set-up assistance with meals. On 05/14/24 at 12:40 PM Resident #112 was	F 676	address all concerns identified during the audit to include providing assistance/tray set up when indicated and education of staff. The audit will be completed by 6/24/14. On 6/11/24, the Admission Director initiated questionnaires with all alert and oriented residents regarding assistance with meals to include (1) do staff assist you with setting up your meal tray to include opening drinks or food items and (2) Do staff cut up food per preference? The Social Worker will notify the DON of all concerns identified during the audit. The questionnaires will be completed by 6/24/14. On 6/11/24, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Quality Assurance Nurse, and unit managers initiated an audit of all resident's care plan/care guides to ensure the care plan/care guide accurately reflects assistance needed during mealtime. The DON and ADON will address all concerns identified during the audit to include updating the care plan when indicated. The audit will be completed by 6/24/14. On 6/11/24, the Staff Facilitator initiated an in-service with all nurses nursing assistants (NA) regarding Meal Delivery with emphasis on setting up meal tray to include opening food items and drinks, inserting straws when indicated, cutting up food per resident preference, and providing feeding assistance/cues when indicated. The in-service included a return	

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observed sitting up in bed with her lunch tray in front of her. The Nursing Aide (NA) was not present. Resident #112 made several attempts to put a straw in the lid of a juice cup and was unsuccessful. She was observed trying to grasp and open her milk carton with her fingers and failed.

An interview was conducted on 05/15/24 at 11:30 AM with the Registered Dietitian. She said all residents' meal trays should be set up unless they specifically requested to set-up their meal tray themselves.

An interview was conducted on 05/15/24 at 2:06 PM with the Director of Nursing. She said all residents who needed partial/moderate assistance with meals means tray set-up and additional help if needed. She further stated Residents' meal trays should be set up unless they specifically requested to set-up their meal tray themselves.

An interview was conducted on 05/16/24 at 3:20 PM with the Nurse Practitioner. She expected most of the resident meal trays to be set up by the NAs, unless the resident specifically requested to set-up their own meal tray. She said it is good nursing practice to do so, by improving meal intake, encouraging eating, and by getting to know residents likes and dislikes, and time to offer alternates.

An interview was conducted on 05/17/24 at 9:45 AM with Nursing Aide (NA#2). NA#2 stated, she only worked part-time and could not remember which residents on the 500-hall (the hall where Resident #112 resided) needed their meal trays to be set-up or not. She was not aware Resident

demonstration on where to find feeding assistance required on the iPad prior to providing care. The in-service will be completed by 6/24/14. After 6/24/14, and NA who has not completed the in-service will complete it upon the next scheduled work shift. All newly hired NAs will be in-service during orientation regarding Meal Delivery.

The Unit Managers, admissions director, social worker, medical records, accounts payable, and scheduler will complete 10 meal observations to include all meals twice weekly x 4 weeks then monthly x 1 month utilizing the Resident Care Audit-Meal Delivery. This audit is to ensure staff provided appropriate assistance during mealtime to include tray set up and/or feeding assistance per care plan/care guide. The Unit Managers, admissions director, social worker, medical records, accounts payable, scheduler, and ADON will address all concerns identified during the audit to include providing assistance/tray set up when indicated and re-training of staff. The Administrator and/or Director of Nursing will review the Resident Care Audit-Meal Delivery Tool twice weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed.

The Director of Nursing will forward the Resident Care Audit-Meal Delivery Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 2 months for review to determine trends and/or issues that may need

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#112 received assistance with her meals. She said she rarely worked on the 500-hall and wasn't told which residents needed meal tray set-up or assistance with feeding. She said she could not remember anything about that day.

2. Resident #126 was admitted to the facility on 10/12/18 with diagnoses that included diabetes, congestive heart disease, adult failure to thrive, and anemia.

Resident #126's Minimum Data Set (MDS) dated 04/30/24 revealed resident had had no cognitive impairments and needed supervision with eating.

Resident #126's care plan dated 04/30/24 revealed: Potential for or Actual fluid volume deficit due to: 1500ml fluid restriction, daily diuretic use. State of nourishment; more than body requirement characterized by weight gain. Ms. Warren required assistance with the activities of Daily Living/Personal Care due to weakness, adult failure to thrive and congestive heart failure. Interventions included: Eating (oral intake): Set-up/clean-up assistance.

An interview and observation were conducted on 05/14/24 at 8:50 AM with Resident #126. She said her breakfast tray was not set up and should have been. She was observed holding up a fork with a round sausage patty stuck to the end, eating around the edges of the sausage. She was also observed not able to open her milk or juice container and was unable to use the knife and fork together to cut her French toast into smaller pieces which would have been easier to eat.

An interview was conducted on 05/14/24 at 9:15

further interventions put into place and to determine the need for further frequency of monitoring.

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AM with the Rehabilitation Director. She said all resident meal trays should be set-up by facility staff if the residents were not independent. She said Resident #126 was receiving Physical Therapy (PT) in her room and needed tray set-up assistance with meals.

An interview was conducted on 05/17/24 at 9:45 AM with Nursing Aide (NA#2). NA#2 stated, she only worked part-time and could not remember which residents on the 500-hall (the hall where Resident #126) needed their meal trays to be set-up or not. She was not aware #126 received assistance with her meals. She said she rarely worked on the 500-hall and wasn't told which residents needed meal tray set-up or assistance with feeding. She said she could not remember anything about that day.

3. Resident #131 was admitted 04/02/24 with diagnoses that included hemiplegia, dysphagia, cerebral infarction (stroke), and diabetes.

The resident's Minimum Data Set (MDS) dated 04/08/24 indicated the resident had no cognitive impairments and needed supervision with eating.

Resident #131's care plan dated 04/08/24 revealed a potential for fluid volume deficit related to anemia, with nourishment less than body requirement, inadequate intake, and decreased appetite. Interventions included: Provide assistance with meal as indicated, with set-up/clean-up assistance, due to hemiplegia/hemiparesis following cerebral infarction affecting left non-dominant side.

An interview was conducted on 05/14/24 at 8:15 AM with Resident #131. She said her breakfast

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F 676	Continued From page 28 tray was not set up and should have been. She said with only one hand she was not able to open her mighty shake, milk carton, or juice, or cut her sausage or French toast. An interview was conducted on 05/14/24 at 8:30 AM with Nurse #3. She said Resident #131 could only use her right hand due to a stroke and needed Nursing Aides (NAs) to set-up her tray and assist with her meals. The nurse said she did not know why the NAs did not set up Resident #131 meal tray.	F 676		
F 684 SS=E	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 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 observations, record review, staff, and the Nurse Practitioner interviews the facility failed to 1.) obtain blood pressure readings or heart rate prior to administering the antihypertensive medication Metoprolol which had parameters to hold the medication if the systolic blood pressure was less than 110 mmHg (millimeters of mercury) or heart rate less than 60 beats per minute. (Resident #17) and 2.) obtain physician ordered weekly weights for a resident with congestive heart failure. (Resident #44). This occurred for 2 of 2 residents (Resident #17, Resident #44)	F 684	F 684 Quality of Care On 6/1/24, the hall nurse assessed Resident #17 blood pressure (BP) and pulse. The BP and pulse did not exceed parameters for administration of blood pressure medication per physician orders. The electronic medication administration record (eMAR) was updated to include assessing BP and pulse prior to administering medication.	6/24/24

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F 684	Continued From page 29 reviewed for quality of care. Findings included. 1.) Resident #17 was admitted to the facility on 04/04/22 with diagnoses including hypertension, and end stage renal disease. A care plan dated 02/10/23 with a target date of 06/18/24 revealed Resident #17 had end stage renal disease, received hemodialysis and was at risk for complications. Interventions included to monitor vital signs. A physician's order dated 04/02/24 for Resident #17 revealed Metoprolol Succinate extended release 50 milligrams (mgs). Give one tablet by mouth daily for hypertension. Hold for systolic blood pressure less than 110 mmHg or heart rate less than 60 beats per minute. Review of Resident #17's Medication Administration Record (MAR) dated April 2024 revealed Metoprolol Succinate extended release 50 milligrams was scheduled for administration daily at 8:00 AM. The medication was signed as administered on the following dates with no corresponding blood pressure or heart rate recorded. 04/19/24 at 8:00 AM with no blood pressure or heart rate recorded. 04/20/24 at 8:00 AM with no blood pressure or heart rate recorded. 04/21/24 at 8:00 AM with no blood pressure or heart rate recorded. 04/22/24 at 8:00 AM with no blood pressure or heart rate recorded. 04/24/24 at 8:00 AM with no blood pressure or	F 684	On 6/12/24, the Director of Nursing reviewed Resident #44 weights from 6/1/24 to 6/12/24 and the resident was assessed with no signs or symptoms of fluid overload or weight gain. Weight was obtained weekly per physician's order. On 6/11/24, the Assistant Director of Nursing (ADON) initiated an audit of all residents' orders for anti-hypertensive medication with parameters for administration to include but not limited monitoring of blood pressure and pulse. This audit is to ensure the nurse followed physician orders to include obtaining vital signs prior to administering medications when indicated and/or holding medications when vital signs exceed parameters, notification of the medical provider when vital signs exceed parameters with documentation in the electronic record. The ADON will address all concerns identified during the audit to include assessing the resident, obtaining vitals and notification of the provider when indicated with documentation in the electronic record and education of staff. The audit will be completed by 6/24/14. On 6/12/24, the DON and ADON initiated an audit of all residents' orders for weight monitoring to include Resident #44 and residents with the diagnosis of congestive heart failure (CHF). This audit is to ensure the facility is obtaining weights per physician orders to include residents that required weight gain monitoring for possible cardiac fluid overload due to resident's history of Congestive Heart	

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F 684	Continued From page 30 heart rate recorded. 04/26/24 at 8:00 AM with no blood pressure or heart rate recorded. 04/28/24 at 8:00 AM with no blood pressure or heart rate recorded. 04/29/24 at 8:00 AM with no blood pressure or heart rate recorded. Review of Resident #17's progress notes dated 04/19/24 through 04/29/24 revealed no blood pressure or heart rate recordings that corresponded to the Metoprolol administration time. Review of Resident #17's Medication Administration Record (MAR) dated May 2024 revealed Metoprolol Succinate extended release 50 milligrams was scheduled for administration daily at 8:00 AM. The medication was signed as administered on the following dates with no corresponding blood pressure or heart rate recorded. 05/03/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/04/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/05/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/08/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/10/24 at 8:00 AM with no blood pressure or heart rate recorded. 05/12/24 at 8:00 AM with no blood pressure or heart rate recorded. Review of Resident #17's progress notes dated 05/03/24 through 05/12/24 revealed no blood	F 684	Failure (CHF) with documentation in the electronic record. The ADON, Staff Facilitator, Quality Assurance Nurse, and unit managers will address all concerns identified during the audit to include but not limited to obtaining weight when indicated, notification of the physician of significant weight gain for further recommendations with documentation in the electronic record and education of staff. The audit will be completed by 6/24/14. On 6/10/24, the Staff Facilitator initiated an in-service with all nurses regarding Following Physician's Orders with emphasis on obtaining vitals and/or blood sugar prior to administering medications with designated parameters, holding medications when vitals/blood sugar exceeds parameters, obtaining weights per physician orders for residents that required weight gain monitoring for possible cardiac fluid overload due to resident's history of Congestive Heart Failure (CHF), and notification of the physician with vitals, blood sugars or weight gain exceeds designated parameters with documentation in the electronic record. The in-service will be completed by 6/24/14. After 6/24/14, and nurse who has not completed the in-service will complete it upon the next scheduled work shift. All newly hired NAs will be in-service during orientation regarding Following Physician's Orders. The Assistant Director of Nursing, staff facilitator and/or Quality Assurance nurse	

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pressure or heart rate recordings that corresponded to the Metoprolol administration time.

The Minimum Data Set (MDS) quarterly assessment dated 04/19/24 revealed Resident #17 had moderately impaired cognition. She had no rejection of care and received hemodialysis.

A progress note documented by the Nurse Practitioner dated 05/15/24 revealed in part; Resident #17 was alert and oriented to person, place, and time. She was sitting in her wheelchair at the nurses station in no distress. She was appropriate and not drowsy. Her blood pressure was 116/76 (systolic/diastolic), pulse rate was 88 beats per minute. The cardiovascular exam indicated Resident #17 was at her baseline.

During an interview on 05/17/24 at 12:45 PM Resident #17 was observed in her wheelchair in the hallway. She was alert and oriented to person, place, and time. She was pleasant and easily engaged in conversation. She stated she was doing okay today and voiced no concerns. She indicated that she had no concerns with her medications and was not aware of the times her medications were scheduled for administration.

During an interview on 05/17/24 at 2:00 PM the Director of Nursing stated Nurse #4 and Nurse #5 who administered the Metoprolol on the dates with no blood pressures or heart rate recorded were not available for interview. She stated Nurse #4 was away on vacation and she made attempts today to contact Nurse #5 and there was no response. She stated the Medical Director was unavailable for interview due to a family emergency. She indicated a blood pressure and

will review 10% of residents with orders for weight monitoring for possible cardiac /fluid overload due to resident's history of Congestive Heart Failure (CHF) to include resident #44, 3 times a week x 4 weeks, then monthly x 1 month, utilizing the Weight Audit Tool. This audit is to ensure weights were obtained per the physician order and the provider was notified of significant weight gain greater than 3-pounds (lbs.) in 24-hours (hrs.), or 5-lbs. in a week, for a resident that required weight gain monitoring for possible cardiac fluid overload due to resident's history of Congestive Heart Failure (CHF) with documentation in the electronic record. The Assistant Director of Nursing, staff facilitator and/or Quality Assurance nurse will address all areas of concern identified during the audit, including assessment of the resident, notification of the physician of significant weight gain for further recommendations with documentation in the electronic record and re-training of staff. The DON will review the Weight Audit Tool 3 x a week x 4 weeks then monthly x 1 month to ensure all areas of concern are addressed.

The Interdisciplinary Team to include Quality Assurance (QA) Nurse, Staff Facilitator, and Assistant Director of Nursing will review 10% of resident orders for anti-hypertensive medications with parameters for administering medications to include blood pressure/pulse monitoring 3 times a week x 4 weeks then monthly x 1 month utilizing the

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F 684	Continued From page 32 heart rate should have been obtained and recorded prior to administering the Metoprolol. She acknowledged there were no corresponding blood pressures and heart rate recorded in Resident #17's medical record during the time the medication was administered for the dates listed. She indicated education would be provided to nursing staff regarding medication administration and monitoring blood pressures and heart rate. During a phone interview on 05/17/24 at 3:30 PM the Nurse Practitioner stated she routinely evaluated Resident #17 and last examined her on 05/15/24. She indicated she was not aware that Resident #17 was not having her blood pressure taken prior to Metoprolol administration. She stated the Metoprolol was prescribed to Resident #17 to control high blood pressure and her blood pressure reading on 05/15/24 was 116/76 (systolic/diastolic). She stated her blood pressures have been okay. She indicated Resident #17 received hemodialysis and her blood pressures fluctuated at times which was why parameters were in place to hold the medication if the blood pressure or heart rate was low. She stated there had been no reports to her regarding a change of condition and blood pressures and heart rate should be obtained prior to administering the medication. 2.) Resident #44 was admitted to the facility on 02/15/24 with diagnoses including congestive heart failure. A physician's order dated 02/16/24 for Resident #44 revealed Furosemide (diuretic) 40 milligrams (mgs). Give one tablet by mouth daily for congestive heart failure.	F 684	Parameters Audit Tool. This audit is to ensure the nurse followed physician orders to include obtaining vital signs prior to administering medications when indicated and/or holding medications when vital signs exceed parameter, notification of the medical provider when vital signs exceed parameters with documentation in the electronic record. The Interdisciplinary Team to include Quality Assurance (QA) Nurse, Staff Facilitator, and Assistant Director of Nursing will address all concerns identified during the audit to include assessing the resident, obtaining vitals and notification of the provider when indicated with documentation in the electronic record and re-training of staff. The DON will review the Parameters Audit Tool 3 x a week x 4 weeks then monthly x 1 month to ensure all areas of concern are addressed. The DON will present the findings of the Weight Audit Tool and the Parameters Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 684	Continued From page 33	F 684		

A physician's order dated 02/16/24 for Resident #44 revealed Aldactone (a potassium sparing diuretic) 25 milligrams (mgs). Give one tablet by mouth daily for hypertension.

The Minimum Data Set (MDS) admission assessment dated 02/21/24 revealed Resident #44 was cognitively intact. She had no rejection of care.

A physician's order dated 03/20/24 for Resident #44 revealed to obtain weekly weights for congestive heart failure.

Review of Resident #44's electronic medical record from 03/20/24 through 05/17/24 revealed the following weights recorded:

03/27/24 the recorded weight was 196.1 Lbs. (pounds)
04/02/24 the recorded weight was 201.5 Lbs.
04/23/24 the recorded weight was 202.5 Lbs.
05/14/24 the recorded weight was 207.0 Lbs.

During an interview on 05/17/24 at 1:23 PM the Nurse Practitioner stated she was not aware Resident #44 was not getting weekly weights according to the order. She stated weekly weights were ordered to monitor fluid retention due to congestive heart failure. She stated Resident #44 had no change in condition and she expected weekly weights to get done according to the order.

During an interview on 05/17/24 at 1:48 PM Resident #44 was observed sitting in her wheelchair. She was alert, and oriented to person, place, and time. She stated weekly

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F 684	Continued From page 34 weights have not been done, but she did get weighed 2 or 3 days ago. She stated she did not refuse care and wanted her weight monitored. During an interview on 05/17/24 at 2:00 PM the Director of Nursing stated upon reviewing Resident #44's Medication Administration Record (MAR) the order for weekly weights was on the MAR but it had an "x" on the MAR each day and therefore it would not populate on the MAR to obtain a weekly weight. She indicated the error was due to the way the order was entered into the electronic medical record that prevented it from populating on the MAR to obtain the weight weekly. She indicated if it had shown on the MAR the nurse would have informed a nurse aide to obtain the weight. She stated it would be corrected immediately. She stated Resident #44 was weighed on 05/14/24 and was evaluated by the Registered Dietician on 05/15/24. She stated she expected weight orders to be entered into the electronic medical record correctly and education to nursing staff would be provided.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the	F 685		6/24/24

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F 685	Continued From page 35 provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and resident, staff and Nurse Practitioner interviews, the facility failed to obtain an appointment with an ophthalmologist for evaluation of vision for 1 of 1 resident (Resident # 22) reviewed for vision. Findings included: Resident # 22 was admitted to the facility on 10/7/20. Resident #22's medical diagnoses included cataracts and diabetes. Review of the facility grievance log revealed a grievance form dated 12/4/23 completed by Resident #22 was received by the Director of Nursing (DON) and the Assistant Administrator. The grievance was regarding Resident #22's request for a referral to an eye doctor for cataracts. Resident #22 stated the request had previously been made to the hall nurse. The outcome was that referrals and appointments were to be made. Findings of the grievance indicated that the DON stated Resident #22 sees the in-house eye care provider for her eye care and was last seen on 12/6/22. The grievance indicated an annual visit was tentatively scheduled for January 2024. The grievance further indicated Resident #22 would be placed on the list for the next in- house eye care visit. If the resident did not want to wait for the in-house provider, the grievance indicated will discuss an outside referral with the provider. The grievance resolution was issued to the resident on 12/6/23. Review of a 12/6/23 letter addressed to Resident #22 indicated resident requested a referral to see an eye doctor. The letter stated after an	F 685	F 685 Treatment/Devices to Maintain Hearing/Vision On 6/5/24, the transporter scheduled an eye appointment for Resident #22 for 7/8/24. The resident was notified of the scheduled appointment. On 6/14/24, the administrator and social worker completed an audit of all residents' most recent eye exams and referrals for ophthalmology. The audit was completed to ensure residents receive appropriate treatment and assistive devices to maintain vision and that requests and/or referrals for eye care services were completed timely per physician orders and/or resident preference. The assistant administrator and/or the social worker will address all concerns identified during the audit. The audit will be completed by 6/24/24. On 6/10/24, the Administrator completed an audit of grievances for the past 60 days. This audit is to identify any resident concerns related to requesting outside medical appointments to include but not limited to request for ophthalmology that had not been completed per resident preference/request. No additional concerns were identified during the audit. On 6/10/24, the Activity Director and social worker initiated resident questionnaires with all alert and oriented	

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F 685	Continued From page 36 appropriate investigation supervised by the grievance official, it was determined that the resident sees the in-house eye care provider for eye care for annual eye exams. The letter indicated the resident would be informed of the next visit with the eye care company. Review of a 2/14/24 physician progress note revealed Resident #22 was evaluated and requested an ophthalmologist appointment regarding cataracts. The physician progress note indicated an order was written for referral to an ophthalmologist. Review of Resident #22's 2/14/24 physician orders revealed an order for follow up with ophthalmology regarding cataracts. Resident #22's quarterly Minimum Data Set (MDS) dated 2/23/24 indicated the resident was cognitively intact, had impaired vision and did not have glasses. Review of Resident #22's electronic health record revealed a 2/26/24 Nurse Practitioner progress note which indicated the resident required a referral for ophthalmology. The progress note indicated an order was written for the referral. Review of Resident #22's Nurse Practitioner progress note dated 3/7/24 indicated resident was asking about the ophthalmology appointment which was previously requested. The progress note indicated awaiting the scheduling of the ordered appointment. Review of Resident #22's care plan revealed a focus last revised on 3/7/24 for impaired vision and risk for complications. The goal indicated	F 685	residents regarding Medical Appointments to identify any resident concerns regarding obtaining outside medical appointments per preference or appointments requested that have not been scheduled. The Social Worker and the Director of Nursing will address all concerns identified during the audit to include scheduling appointments when indicated and education of staff. The questionnaires will be completed by 6/24/14. On 6/12/24, the administrator initiated an in-service with the transportation scheduler, social worker, Director of Nursing and Assistant Director of Nursing regarding Requests for Medical Appointments with emphasis on ensuring residents receive proper treatment and assistive devices to maintain vision/hearing/dental and that requests and/or referrals for eye care/hearing/dental services were completed timely per physician order and resident preference to include referrals to outside providers when indicated. The in-service also includes notification of the provider, resident, and Administrator if an appointment cannot be scheduled for any reason, or the appointment cannot be scheduled in the requested time frame. The in-service was completed 6/17/24. All newly hired transportation/schedulers, social workers, DONs, and/or ADONs will be in-serviced during orientation regarding Requests for Medical Appointments. The Assistant Administrator and/or the	

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F 685	Continued From page 37 Resident #22 would use compensatory mechanisms for decreased vision through next review. Interventions indicated ensure eyeglasses are clean, appropriate and being worn by resident, and obtain eye exam consultation for resident to ensure appropriate medications and compensatory mechanisms are in place. An interview was conducted on 5/13/24 at 12:04 PM with Resident #22. Resident #22 stated she still had not received an eye doctor appointment. Resident #22 stated she thought her eyesight was getting worse and she was concerned since she had a diagnosis of diabetes and cataracts. A following up interview was conducted on 5/16/24 at 12:26 PM with Resident #22. Resident #22 stated no one had talked to her this week about her request to see an ophthalmologist. Resident indicated the Social Worker had not talked to her. Resident stated she was concerned about obtaining the appointments as she had not seen the eye doctor in over a year. Resident #22 stated she filed a grievance in December and still had not received the requested appointment. An interview was conducted on 5/15/24 at 12:10 PM with the Transportation Specialist. The Transportation Specialist stated she was responsible for scheduling appointments and transportation for the residents. She stated she was in the position for the past year. The Transportation Specialist stated she was informed of referrals by the nursing staff, family members and the providers. The Transportation Specialist stated she had not made any appointments lately for Resident #22. She stated she was informed a while back that Resident #22	F 685	social workers will review 10% of all new referrals for outside medical appointments and concerns related to medical appointment request per resident preference to include but not limited to request for eye care services weekly x 4 weeks then monthly x 1 month utilizing the Consult Audit Tool. This audit is to ensure residents receive proper treatment and assistive devices to maintain vision and that requests and/or referrals for eye care services were completed timely per physician order and resident preference to include referrals to outside providers when indicated. The Assistant Administrator and/or the social workers will address all concerns identified during the audit to include scheduling an appointment when indicated, notification of the provider, resident/resident representative of the appointment with documentation in the electronic record and re-training of staff. The DON will review the Consult Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will present the findings of the Consult Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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required an appointment with an ophthalmologist. The Transportation Specialist stated she was still working on arranging the appointment but had not recently tried. She stated when she had extra time, she called ophthalmologist offices to see if they would see the resident. She stated the last time she tried calling was a few weeks ago. The Transportation Specialist stated she did not have any notes indicating what offices she called, when and what the outcome was. The Transportation Specialist stated she was not sure how Resident #22 needed to be transported and it was difficult to obtain stretcher transportation. The Transportation Specialist stated she was not involved in the grievance that Resident #22 filed in December 2023 and was not made aware of the request to schedule the appointment in December 2023.

An interview was conducted on 5/15/24 at 12:30 PM with Social Worker (SW) #1. SW#1 stated she had been in the position since December 2023. SW #1 stated she arranged the ophthalmologist visits with the in-house provider. SW #1 stated the last in-house ophthalmologist visit at the facility was in August 2023. Resident #22 was not seen in August 2023. SW #1 indicated Resident #22 was not seen by the in-house eye care provider since December 2022. SW #1 did not know why Resident #22 was not seen in August 2023. SW #1 stated the in-house eye care provider should be seeing residents at the facility in August 2024. SW #1 stated if a resident had a concern or needed to be seen by an ophthalmologist sooner than the annual visit, she could reach out to the company and request a visit to be arranged sooner. SW #1 stated she was not informed Resident #22 had a physician order for a referral in February 2024

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to be seen by ophthalmology. SW #1 stated she went on maternity leave in February 2024, and she may have been gone when the referral was written in February. SW #1 stated she would talk to Resident #22 about obtaining a visit with the in-house ophthalmologist.

An interview was conducted on 5/15/24 at 12:40 PM with Social Worker (SW) #2. SW #2 stated she was new to the position having started in January 2024. SW# 2 stated she was not notified of the physician order written in February 2024 for Resident #22 to see the ophthalmologist.

An interview was conducted on 5/15/24 at 1:45 PM with the Unit Manager. The Unit Manager stated she was not aware of a physician order for a referral for Resident #22 to see the ophthalmologist written by the provider in February 2023. The Unit Manager further stated she was not aware of a grievance that was filed by Resident #22 in December 2023 regarding her request to see an ophthalmologist.

An interview was conducted on 5/16/24 at 3:30 PM with the Nurse Practitioner. The NP indicated a resident with a diagnosis of cataracts required evaluation at least annually. The NP stated the facility used a company that comes into the facility to provide ophthalmology care. The NP stated she expected to be notified if the facility did not complete a referral for an appointment.

An interview was conducted on 5/17/24 at 4:30 PM with the Director of Nursing (DON). The DON stated they should have arranged the appointments for Resident #22 but there was a problem with the resident's payor source.

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F 685	Continued From page 40 An interview was conducted on 5/17/24 at 12:20 PM with the Administrator. The Administrator stated Resident #22 expressed a concern about having an ophthalmology appointment scheduled. The Administrator stated Resident #22 was not eligible to be seen by the in-house ophthalmologist that came in August 2023 since it wasn't a year since her last exam. The Administrator stated she guessed they could have tried to obtain the appointment with an outside provider. The Administrator stated there had been a delay in finding a provider that would accept the resident's insurance, but 5 months was a long time and maybe they could have tried to obtain the appointment sooner. The Administrator stated it was her understanding the only reason the resident wanted the appointment with the ophthalmologist was so she could see her iPad.	F 685		
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 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	F 692		6/24/24

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F 692	Continued From page 41 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 record review, observations and staff, resident and Nurse Practitioner interviews, the facility failed to provide physician ordered nutritional supplements on meal trays and failed to obtain physician ordered weights for 2 of 10 residents reviewed for nutrition (Resident #107 and Resident #19). 1. .Resident #107 was admitted on 10/5/22. Resident's medical diagnosis included stroke, failure to thrive, protein calorie malnutrition and diabetes. Review of Resident #107's electronic health record revealed the following weights were recorded: 10/2/2023- 207.3 pounds (Lbs.) 11/10/2023- 205.1 Lbs. 12/5/2023- 194.2 Lbs. 1/19/2024- 181.8 Lbs. 1/30/2024- 177.1 Lbs. 2/9/2024- 172.5 Lbs. 3/26/2024- 147.6 Lbs. 4/2/2024- 152.3 Lbs. 4/10/2024- 158.1 Lbs. 4/16/2024- 158.0 Lbs. 4/23/2024 No weight recorded. 4/30/2024 No weight recorded. 5/7/2024- 161.3 Lbs. 5/14/2024- 157.8 Lbs.	F 692	F 692 Nutrition/Hydration Status Maintenance On 6/13/24, the administrator observed meal delivery for Resident #107 to ensure meal tray was accurate per physician order to include supplements and per resident preference with no identified concerns. Weights obtained from 5/28/24-6/11/24 with weight gain noted each week. On 6/13/24, the administrator observed meal delivery for Resident #19 to ensure meal tray was accurate per physician order to include supplements and per resident preference with no identified concerns. Weights obtained from 5/28/24-6/11/24 were reviewed with stable weights noted. On 6/13/24, dietary consultant, dietary manager, and administrator initiated an audit of all meal tray cards to meal trays to ensure meal trays were accurate per physician order to include supplements and per resident preference. The dietary consultant, administrator, and/or the Dietary Manager will address all concerns identified during the audit to include providing a meal tray that reflects an accurate diet to include supplements per	

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F 692	Continued From page 42 Review of Resident #107's electronic health record revealed a 1/26/2024 physician order for Mighty Shake nutritional supplement three times per day with meals and regular diet with enriched meals. A 3/12/24 Nurse Practitioner (NP) progress note indicated resident continued with decreased appetite with stable decline in weight. Review of Resident #107's electronic health record revealed a 3/26/2024 physician order for weekly weights. Review of Resident #107's 4/12/24 quarterly Minimum Data Set (MDS) indicated resident had a mild cognitive impairment. Resident #107's weight was 158 pounds and the resident was coded as had no weight loss or weight gain of 5 percent in past 30 days or 10 percent in past 180 days. A 4/24/24 NP progress note indicated resident was seen due to poor appetite and weight loss. The progress note indicated to continue with the enriched meal diet, nutritional supplement and encourage intake. The progress note did not indicate Resident #107 was receiving end of life care. Observation of Resident #107's lunch meal tray card on 5/13/24 at 12:40 PM revealed resident was to receive enriched meals, double vegetables, 2 bowls of soup, a peanut butter and jelly sandwich and a Mighty Shake nutritional supplement. The meal tray card further indicated disliked fish, spaghetti squash, zucchini, rice, pasta, and vegetables. Observation of the meal tray revealed Resident #107 did not receive	F 692	physician orders and resident preference and education of dietary staff. The audit will be completed by 6/24/14. On 6/12/24, the Director of Nursing (DON) initiated an audit of all residents' orders for weight monitoring to include residents #107 and #19. This audit is to ensure the facility is obtaining weights per physician orders for monitoring of residents with significant weight changes. The DON and/or the Assistant Director of Nursing (ADON) will address all concerns identified during the audit to include but not limited to obtaining weight when indicated, notification of the physician of significant weight loss for further recommendations with documentation in the electronic record and education of staff. The audit will be completed by 6/24/14. On 6/13/24, the administrator and dietary manager initiated an in-service with the dietary staff regarding Preparing Meal Trays with emphasis on ensuring the meal tray is accurate with the meal tray card per physician's order to include supplements and per resident preference. The in-service also includes the dietary staff must notify the Dietary Manager for any instance that the meal tray cannot meet the physicians order to include supplements or resident preferences. The in-service will be completed by 6/24/14. After 6/24/14, any dietary staff who has not completed the in-service will complete it upon the next scheduled work shift. All newly hired dietary staff will be in-service during orientation regarding Preparing	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 43 double vegetables, soup, a sandwich, or a Mighty Shake nutritional supplement on the meal tray. Resident #107's meal tray consisted of 2 chicken tenders, a single serving of macaroni and cheese and a single serving of coleslaw. Observation of Resident #107's lunch meal tray on 5/14/24 at 12:40 PM revealed resident did not receive a Mighty Shake nutritional supplement on her meal tray. An interview was conducted on 5/14/24 at 12:45 PM with Resident #107. Resident #107 stated she did not receive a milk shake on her meal tray. Resident stated she would really like a milk shake. An interview was conducted on 5/15/24 at 11:30 AM with the Registered Dietitian (RD). The RD revealed she completed a clinical review of the resident's nutritional status and did not routinely observe or interview the residents. The RD stated she was aware Resident #107 was not eating well and was losing weight. The RD stated she was not sure why Resident #107 continued to lose weight. The RD further stated she was not aware that Resident #107 had not received her nutritional supplement. An interview was conducted on 5/16/24 at 3:30 PM with the Nurse Practitioner (NP). The NP indicated she expected that residents would receive nutritional supplements as ordered and weekly weights would be completed as ordered. An interview was conducted on 5/17/24 at 9:50 AM with the Dietary Manager. The Dietary Manager stated she expected that supplements would be on the meal trays as ordered. The	F 692	Meal Trays. On 6/10/24, the Staff Facilitator initiated an in-service with the nursing assistants (NA) and nurses regarding Meal Delivery with emphasis on (1) ensuring meal tray is accurate for the meal tray card to include supplements and resident preferences (2) immediately notifying the dietary department when the meal tray is not accurate and (3) obtaining a new meal, supplements or items per resident preference when indicated. The in-service will be completed by 6/24/14. After 6/24/24, any nurse or nursing assistant who has not completed the in-service will complete it upon the next scheduled work shift. All newly hired nurses or NAs will be in-serviced during orientation regarding Meal Delivery. On 6/10/24, the Staff Facilitator initiated an in-service with all nurses regarding Following Physician's Orders with emphasis on obtaining weights per physician orders for residents that required weight monitoring for significant weight changes, notification of the physician for further recommendations, notification of the resident/resident representative of weight changes with documentation in the electronic record. The in-service will be completed by 6/24/14. After 6/24/14, any nurse who has not completed the in-service will complete it upon the next scheduled work shift. All newly hired nurses will be in-service during orientation regarding Following Physician's Orders. The Dietary Manager and/or the assistant	

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F 692	Continued From page 44 Dietary Manager stated she received the order for the nutritional supplement from nursing and then it is put on the meal tray card along with the likes and dislikes and any special items the resident was to receive. The dietary aides were responsible for placing the supplements on the trays. The Dietary Manager stated sometimes she ran out of supplements including Mighty Shakes. The Dietary Manager stated she currently had the Mighty Shake supplement in stock. The Dietary Manager stated it was an oversight that Resident #107 did not receive her Mighty Shakes as ordered and that the extra items were not on her lunch tray on 5/13/24. The Dietary Manager stated she had a lot of new staff, and it was hard to get them to pay attention to the meal tray cards. The Dietary Manager further stated she had a lot of staff turnover, and she was constantly trying to train new staff and trying to make sure they were doing things properly. An interview was conducted on 5/17/24 at 1:50 PM with the Administrator. The Administrator stated she expected the residents to receive nutritional supplements as ordered and weekly weights were to be completed as ordered. The physician was not available for interview on 5/17/24. 2. Resident #19 was admitted to the facility on 11/29/23 with diagnosis which included diabetes and hypertension. Review of Resident #19's electronic health record revealed the following weights were recorded: 11/29/2023- 156.5 pounds (Lbs.) 12/1/2023- 156.5 Lbs.	F 692	administrator will audit 10% of meal trays to include all meals weekly x 4 weeks then monthly x 1 month utilizing the Meal Tray Audit Tool. This audit is to ensure the meal trays were accurate per physician order to include supplements and per resident preference. The Dietary Manager and/or the assistant administrator will address all concerns identified during the audit to include providing a meal tray that reflects an accurate diet to include supplements per physician orders and resident preference and re-training of dietary staff. The Administrator will review the Meal Tray Audit tools weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Assistant Director of Nursing, staff facilitator and/or Quality Assurance Nurse will review 10 % of residents with orders for weight monitoring for significant weight changes weekly x 4 weeks then monthly x 1 month utilizing the Weight Audit Tool. This audit is to ensure weights were obtained per the physician order and the provider was notified of significant weight changes with documentation in the electronic record. The Assistant Director of Nursing, staff facilitator and/or Quality Assurance Nurse will address all areas of concern identified during the audit, including assessment of the resident, notification of the physician of significant weight changes for further recommendations with documentation in the electronic record and re-training of staff. The DON will review the Weight Audit Tool weekly x 4 weeks then monthly	

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F 692	Continued From page 45 12/5/2023- 150.7 Lbs. 12/12/2023- 148.4 Lbs. 12/21/2023- 143.7 Lbs. 12/29/2023- 143.0 Lbs. 1/11/2024- 147.3 Lbs. 1/30/2024- 142.2 Lbs. 2/9/2024- 140.0 Lbs. 3/7/2024- 141.6 Lbs. 3/12/2024- 135.0 Lbs. 4/9/2024- 178.0 4/9/2024- 178.0 documented as incorrect documentation. 4/9/2024- 178.0 Lbs. Review of Resident #19's quarterly Minimum Data Set (MDS) assessment dated 4/11/2024 indicated resident had a weight of 178 pounds. The MDS assessment indicated Resident #19 had no weight loss or weight gain of 5 percent in 30 days or 10 percent in 180 days. A review of Resident #19's electronic health record revealed a 4/11/2024 physician order for daily weights for 2 weeks then weekly due to 43-pound weight gain in 1 month. 4/12/2024- 138.4 Lbs. 4/13/2024- 136.2 Lbs. 4/13/2024- 136.2 Lbs. 4/14/2024- 135.6 Lbs. 4/15/2024- 133.2 Lbs. 4/16/2024- 133.9 Lbs. 4/17/2024- 132.6 Lbs. 4/18/2024- 132.2 Lbs. 4/19/2024- 132.4 Lbs. 4/20/2024 No weight recorded. 4/21/2024 No weight recorded. 4/22/2024- 133.3 Lbs.	F 692	x 1 month to ensure all areas of concern are addressed. The Administrator and/or DON will present the findings of the Meal Tray Audit Tool and the Weight Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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4/23/2024- 133.4 Lbs.
4/24/2024- 131.5 Lbs.
4/25/2024- 134.7 Lbs.
5/2/2024 No weight recorded.
5/6/2024- 132.6 Lbs.
5/13/2024 No weight recorded.
5/14/2024- 129.7 Lbs.

A physician order dated 4/17/2024 indicated regular diet.

A 4/19/2024 physician order indicated Resident #19 was to receive Magic Cup supplement one time a day for additional kilocalories and protein.

Observation of Resident #19's meal tray ticket on 5/13/2024 at 12:45 PM indicated resident received a regular cardiac consistent carbohydrate diet. The meal ticket also indicated Resident #19 was to receive a Magic Cup. Observation indicated a Magic Cup was not on resident's tray.

Observation of Resident #19's meal tray on 5/14/2024 at 12:45 PM revealed no Magic Cup was observed on the meal tray.

Interview with Resident #19 on 5/14/2024 at 12:45 PM revealed she could not eat the lunch meal that was served today as it did not look appetizing to her. Resident #19 stated she thought she had lost weight and that she often had crackers and juice for lunch. Observation indicated Resident #19 had a large cooler in her room of foods that her family had brought in.

A 5/14/24 Nurse Practitioner (NP) progress note indicated resident was evaluated due to unintentional weight loss over the last 6 months

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F 692	Continued From page 47	F 692		

and it appeared to be from the dislike of the taste of the food at the facility. Diet was advanced to regular diet. The progress note did not indicate that Resident #19 was receiving end of life care.

An interview was conducted with the Registered Dietitian on 5/15/2024 at 11:10 AM. The RD stated she was following Resident #19 for significant weight loss. The RD stated Resident #19 had a nutritional supplement ordered and she had not heard of any issues with the resident not receiving it. The RD stated she mainly completed a chart review to evaluate the resident's nutritional status and did not observe the meal trays or interview the resident. The RD stated not receiving the nutritional supplement would contribute to continued weight loss.

Observation of Resident #19's meal tray on 5/16/2024 at 12:45 PM revealed no Magic Cup was observed on the meal tray.

An interview was conducted on 5/16/2024 at 3:30 PM with the Nurse Practitioner (NP). The NP indicated if a resident had an order for a nutritional supplement, she expected the resident to receive the supplement as ordered. The NP further stated resident weights were to be obtained as ordered.

An interview was conducted on 5/16/2024 at 4:30 PM with the Director of Nursing (DON). The DON stated she expected the residents to receive nutritional supplements as ordered and resident weights to be obtained as ordered.

An interview was conducted on 5/17/2024 at 9:50 AM with the Dietary Manager. The Dietary Manager stated she expected that supplements

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F 692	Continued From page 48 would be on the meal trays as ordered. The Dietary Manager stated she received a diet slip from nursing with orders for a nutritional supplement and changes in the diet. The Dietary Manager stated she put the nutritional supplement on the meal tray ticket along with the likes and dislikes and any special items the resident received. The dietary aides were responsible for placing the supplements on the meal trays. The Dietary Manager stated sometimes she ran out of nutritional supplements including the Magic Cups but currently she had them in stock. The Dietary Manager stated it was an oversight that Resident #19 did not receive her Magic Cup as ordered this week. The Dietary Manager stated she had a lot of new staff, and it was hard to get them to pay attention to the meal tray cards. The Dietary Manager further stated she had a lot of staff turnover, and she was constantly trying to train new staff and trying to make sure they were doing things properly. An interview was conducted on 5/17/2024 at 1:50 PM with the Administrator. The Administrator stated she expected the residents to receive nutritional supplements as ordered and resident weights to be obtained as ordered.	F 692		
F 745 SS=E	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services 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 review, and resident, staff and Nurse Practitioner interviews, the facility failed to	F 745	F 745 Provision of Medically Related Social Service	6/24/24

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F 745	Continued From page 49 ensure a resident had an appointment scheduled for a physician ordered mammogram (Resident #22) for 1 of 1 resident sampled for medically related social services. Findings included: Resident #22 was admitted to the facility on 10/7/20. Resident #22's diagnoses included diabetes and history of left breast keloid (thick scar tisssue resulting from excessive growth of fibrous tissue). Resident #22's quarterly Minimum Data Set (MDS) dated 2/23/24 indicated the resident was cognitively intact. Review of the facility grievance log revealed a grievance form dated 12/4/23 completed by the resident received by the Director of Nursing/ Assistant Administrator. The grievance was regarding Resident #22's request for a referral for a mammogram. Resident #22 stated she had requested an appointment for a mammogram, and it had not been scheduled. The outcome of the grievance indicated an appointment for a mammogram was to be made for Resident #22. Findings of the grievance indicated Resident #22 had a history of a partial resection of the left breast keloid with request for a mammogram. The grievance indicated follow up was to be made with the provider regarding the request for a mammogram. Grievance resolution was issued to the resident on 12/6/23. Review of a 12/6/23 letter addressed to Resident #22 indicated resident requested an appointment for a mammogram. After an appropriate investigation supervised by the grievance official it was determined that follow up would be made with the	F 745	On 5/24/24, Resident #22 received a mammogram per request. On 6/10/24, the administrator initiated an audit of grievances for the past 60 days. This audit is to identify any resident concerns related to requesting outside medical appointments to include but not limited to requests for mammograms that had not been completed per resident preference/request. The transporter and unit managers will address all concerns identified during the audit to include scheduling an appointment when indicated, notification of the provider, resident/resident representative of the appointment with documentation in the electronic record and education of staff. The audit will be completed by 6/24/14. On 6/10/24, the Activity Director initiated resident questionnaires with all alert and oriented residents regarding Medical Appointments to identify any resident concerns regarding obtaining outside medical appointments per preference or appointments requested that have not been scheduled. The Social Worker and the Director of Nursing will address all concerns identified during the audit to include scheduling appointments when indicated and education of staff. The questionnaires will be completed by 6/24/14. On 6/10/24 the administrator initiated an in-service with the transportation scheduler, social worker, and all nurses	

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F 745	Continued From page 50 provider about the request for a mammogram. Review of a 2/14/24 physician progress note revealed Resident #22 requested a mammography appointment. The progress note indicated the physician would write an order to schedule a mammogram. Review of Resident #22's physician orders revealed a 2/14/24 physician order to schedule a mammography appointment. Review of Resident #22's electronic health record revealed a 2/26/24 Nurse Practitioner progress note which indicated resident again requested a referral for a mammogram. The order was previously written to schedule the mammogram. An interview was conducted on 5/13/24 at 12:04 PM with Resident #22. Resident #22 stated she requested an appointment for a mammogram, and it had not been scheduled. Resident #22 stated she had a history of a cyst in her breast and had not had a mammogram for several years. A following up interview was conducted on 5/16/24 at 12:26 PM with Resident #22. Resident #22 stated she filed a grievance in December 2023 regarding her request for a mammogram to be scheduled and the appointment had still not been scheduled. Resident #22 further indicated she had breast pain and was concerned about the appointment for the mammogram. Resident #22 stated she was aware that the Nurse Practitioner had written a referral several months ago for the appointment, but it had not been scheduled.	F 745	regarding Requests for Medical Appointments with emphasis on ensuring residents are provided medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being and that requests and/or referrals for services are completed timely per physician order and/or resident preference to include referrals to outside providers when indicated. The in-service also includes the provider, resident and Administrator should be notified if an appointment cannot be scheduled for any reason or the appointment cannot be scheduled within the requested time frame. The in-service will be completed by 6/24/14. After 6/24/24, any transportation scheduler, social worker, or nurse that has not completed the in-service will complete it upon the next scheduled work shift. All newly hired transportation schedulers, social workers, and nurses will be in-serviced during orientation regarding Requests for Medical Appointments. The Assistant Administrator and social worker will review 10% of all new referrals for outside medical appointments and concerns related to medical appointment request per resident preference to include but not limited to request for mammograms weekly x 4 weeks then monthly x 1 month utilizing the Consult Audit Tool. This audit is to ensure residents receive proper treatment and assistive devices to maintain vision and that requests and/or referrals for eye care services were completed timely per	

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F 745	Continued From page 51 An interview was conducted on 5/15/24 at 12:10 PM with the Transportation Specialist. The Transportation Specialist stated she was responsible for scheduling appointments and transportation for the residents and was in the position for the past year. The Transportation Specialist stated she was informed of referrals by the nursing staff, family members and the providers. The Transportation Specialist stated she had not made any appointments lately for Resident #22. She stated she was informed a while back that Resident #22 required an appointment for a mammogram. The Transportation Specialist stated she was still working on trying to get an appointment for the resident for a mammogram. The Transportation Specialist stated she was not sure how Resident #22 needed to be transported and it was difficult to obtain stretcher transportation. An interview was conducted on 5/15/24 at 1:45 PM with the Unit Manager. The Unit Manager stated she was not aware of a referral for Resident #22 to have a mammogram written by the provider in February. The Unit Manager indicated the Transportation Specialist should have been notified of the physician order written in February to schedule a mammogram for Resident #22. An interview was conducted on 5/16/24 at 3:25 PM with the Nurse Practitioner (NP). The NP revealed she would expect to be notified if the facility was not able to schedule an appointment or if there was a delay in obtaining an appointment for a mammogram. The NP indicated a screening mammogram was indicated for Resident #22 and should have been scheduled when the order was written in	F 745	physician order and resident preference to include referrals to outside providers when indicated. The transporter/ scheduler and unit manager will address all concerns identified during the audit to include scheduling appointments when indicated, notification of the provider, resident/resident representative of the appointment with documentation in the electronic record and re-training of staff. The DON will review the Consult Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will present the findings of the Consult Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 745	Continued From page 52 February. The NP stated the NP that evaluated Resident #22 in February no longer worked at the facility. An interview was conducted on 5/17/24 at 12:20 PM with the Administrator. The Administrator stated Resident #22 had filed a grievance in December regarding the appointment for a mammogram and the resolution of the grievance was that administration would follow up. The Administrator stated she expected the appointment would be made when an order was written, and 5 months was too long to wait to obtain an appointment. The Administrator stated she did not know why there was a breakdown in the process to obtain the appointment for the mammogram following the grievance.	F 745		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Pharmacy Consultant, and Nurse Practitioner interviews the facility failed to 1a.) administer the antihypertensive medication Metoprolol prescribed to lower blood pressure, the oral diabetic medication Tradjenta prescribed to lower blood sugar , a phosphate binder Sevelamer (a medication prescribed to lower the amount of phosphorus in the blood when receiving dialysis), and Cymbalta prescribed for neuropathy to a hemodialysis resident after returning from dialysis treatments. This resulted in the resident (Resident #17) not receiving a total of 15 doses of	F 760	F 760 Free of Significant Med Errors On 6/12/24, the unit manager assessed Resident #17 and reviewed the electronic medication administration record (eMAR) to ensure the resident was administered medication per physician orders. The unit manager updated the provider on resident assessment and reviewed the eMAR/missing doses with the provider and adjusted medication times with dialysis days to ensure the resident receives medications per physician	6/24/24

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F 760	Continued From page 53	F 760		

Metoprolol, 15 doses of Tradjenta, 15 doses of Sevelamer, and 8 doses of Cymbalta. 1b.) administer the full course of the oral antifungal Diflucan prescribed for treatment of vaginitis according to the physicians order (Resident #17). This resulted in 2 of the 3 doses of Diflucan not administered. This occurred for 1 of 5 resident reviewed for medication administration (Resident #17).

Findings included.

1a.) Resident #17 was admitted to the facility on 04/04/22 with diagnoses including hypertension, diabetes, end stage renal disease, and neuropathy.

A physician's order dated 03/26/24 for Resident #17 revealed Hemodialysis on Tuesday, Thursday, Saturday at 6:00 AM.

A physician's order dated 04/02/24 for Resident #17 revealed Metoprolol Succinate extended release 50 milligrams (mgs). Give one tablet by mouth daily for hypertension.

Review of Resident #17's Medication Administration Record (MAR) dated April 2024 revealed Metoprolol Succinate extended release 50 milligrams was scheduled for administration daily at 8:00 AM. The MAR had chart code "3" documented on the following dates indicating the medication was not administered due to Resident #17 was out of the facility.

04/02/24 (Tuesday) 8:00 AM: out of the facility.
04/04/24 (Thursday) 8:00 AM: out of the facility.
04/06/24 (Saturday) 8:00 AM: out of the facility.

orders. The Director of Nursing (DON) updated the eMAR.

On 6/13/24, the unit managers initiated an audit of all residents receiving dialysis. This audit is to ensure medication administration times are adjusted to accommodate dialysis days and medications are administered per physician's order. The unit manager and DON will address all concerns identified during the audit to include assessing the resident, verifying with the physician administration times to accommodate dialysis days and education of staff. The audit will be completed by 6/24/24.

On 6/13/24, the unit manager, nurse supervisor, and Quality Assurance nurse initiated an audit of all eMARs to ensure medications were administered per physician order to include residents receiving dialysis and/or residents on antibiotic therapy. The unit managers and/or the Director of Nursing will address all concerns identified during the audit to include assessment of the resident, notification of the provider if medications not administered or not available to administer per physician order for further recommendations with documentation in the electronic record. The audit will be completed by 6/24/24.

On 6/12/24, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) initiated an audit of all medications listed as "not available" to administer from 5/9/24-6/9/24. This audit

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F 760	Continued From page 54 04/09/24 (Tuesday) 8:00 AM: out of the facility. 04/11/24 (Thursday) 8:00 AM: out of the facility. 04/16/24 (Tuesday) 8:00 AM: out of the facility. 04/18/24 (Thursday) 8:00 AM: out of the facility. 04/23/24 (Tuesday) 8:00 AM: out of the facility. 04/25/24 (Thursday) 8:00 AM: out of the facility. Review of Resident #17's Medication Administration Record (MAR) dated May 2024 revealed Metoprolol Succinate extended release 50 milligrams was scheduled for administration daily at 8:00 AM. The MAR had chart code "3" documented on the following dates indicating the medication was not administered due to Resident #17 was out of the facility. 05/02/24 (Thursday) 8:00 AM: out of the facility. 05/07/24 (Tuesday) 8:00 AM: out of the facility. 05/09/24 (Thursday) 8:00 AM: out of the facility. 05/11/24 (Saturday) 8:00 AM: out of the facility. 05/14/24 (Tuesday) 8:00 AM: out of the facility. 05/16/24 (Thursday) 8:00 AM: out of the facility. A physician's order dated 04/04/24 for Resident #17 revealed Tradjenta 5 milligrams. Give one tablet once daily for diabetes. Review of Resident #17's Medication Administration Record (MAR) dated April 2024 revealed Tradjenta 5 mgs give one tablet once daily for diabetes was scheduled for administration daily at 8:00 AM. The MAR had chart code "3" documented on the following dates indicating the medication was not administered due to Resident #17 was out of the facility. 04/04/24 (Thursday) 8:00 AM: out of the facility. 04/06/24 (Saturday) 8:00 AM: out of the facility. 04/09/24 (Tuesday) 8:00 AM: out of the facility.	F 760	is to ensure medications are available and administered per physician order. The DON will address all concerns identified during the audit to include obtaining medications from pharmacy and/or notification of the physician for further recommendations when medication cannot be obtained. The audit will be completed by 6/24/24. On 6/13/24, the Staff Facilitator initiated an in-service with all nurses regarding Following Physician's Orders with emphasis on (1) ordering medications timely to ensure medication available to administer per physician order, (2) obtaining medications from eKit or back up pharmacy when not immediately available (3) notification of the physician when medications to include antibiotics cannot be obtained for further instructions and/or alternative medication (4) adjusting medication times for residents who receive dialysis to ensure medications administered per physician orders, (5) completing the full course of antibiotic therapy unless otherwise ordered by the physician. The in-service will be completed by 6/24/24. After 6/24/24, any nurse who has not worked or received the in-service will complete it upon the next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Following Physician's Orders. The Unit Managers, Assistant Director of Nursing (ADON), and/or Nurse Supervisor will review the Orders Listing Report for	

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F 760	Continued From page 55 04/11/24 (Thursday) 8:00 AM: out of the facility. 04/16/24 (Tuesday) 8:00 AM: out of the facility. 04/18/24 (Thursday) 8:00 AM: out of the facility. 04/23/24 (Tuesday) 8:00 AM: out of the facility. 04/25/24 (Thursday) 8:00 AM: out of the facility. 04/30/24 (Tuesday) 8:00 AM: out of the facility. Review of Resident #17's Medication Administration Record (MAR) dated May 2024 revealed Tradjenta 5 mgs give one tablet once daily for diabetes was scheduled for administration daily at 8:00 AM. The MAR had chart code "3" documented on the following dates indicating the medication was not administered due to Resident #17 was out of the facility. 05/02/24 (Thursday) 8:00 AM: out of the facility. 05/07/24 (Tuesday) 8:00 AM: out of the facility. 05/09/24 (Thursday) 8:00 AM: out of the facility. 05/11/24 (Saturday) 8:00 AM: out of the facility. 05/14/24 (Tuesday) 8:00 AM: out of the facility. 05/16/24 (Thursday) 8:00 AM: out of the facility. A physician's order dated 04/02/24 for Resident #17 revealed Sevelamer 800 milligrams. Give 2 tablets three times a day for Hypophosphatemia. Review of Resident #17's Medication Administration Record (MAR) dated April 2024 revealed Sevelamer 800 mgs. Give 2 tablets three times a day for Hypophosphatemia was scheduled for administration three times a day at 8:00 AM, 12:00 PM, and 4:00 PM. The 8:00 AM dose had chart code "3" documented on the following dates indicating the medication was not administered due to Resident #17 was out of the facility. The 12:00 PM and 4:00 PM doses were signed as administered.	F 760	medications not administered to include antibiotics 5 times a week x 4 weeks then monthly x 1 month. This audit is to ensure medications were available and administered per physician orders, antibiotics were administered for the complete course prescribed and/or the physician notified if medications could not be administered for further recommendations with documentation in the electronic record. The Unit Managers, ADON and/or Nurse Supervisor will address all concerns identified during the audit to include obtaining medications when indicated, notification of the physician when medications cannot be obtained for further instructions with documentation in the electronic record and/or re-training of staff. The Director of Nursing (DON) will review the Orders Listing Report weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Quality Assurance (QA) Nurse and/or Nurse Supervisor will audit all newly admitted/readmitted residents receiving dialysis weekly x 4 weeks then monthly x 1 month utilizing the Dialysis Audit Tool. This audit is to ensure medication administration times are adjusted to accommodate dialysis days and medications are administered per physician’s order. The QA Nurse and/or the Nurse Supervisor will address all concerns identified during the audit to include assessing the resident, verifying with the physician administration times to accommodate dialysis days and	

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F 760	Continued From page 56 04/02/24 (Tuesday) 8:00 AM: out of the facility. 04/04/24 (Thursday) 8:00 AM: out of the facility. 04/06/24 (Saturday) 8:00 AM: out of the facility. 04/09/24 (Tuesday) 8:00 AM: out of the facility. 04/11/24 (Thursday) 8:00 AM: out of the facility. 04/16/24 (Tuesday) 8:00 AM: out of the facility. 04/18/24 (Thursday) 8:00 AM: out of the facility. 04/23/24 (Tuesday) 8:00 AM: out of the facility. 04/25/24 (Thursday) 8:00 AM: out of the facility. Review of Resident #17's Medication Administration Record (MAR) dated May 2024 revealed Sevelamer 800 mgs. Give 2 tablets three times a day for Hypophosphatemia was scheduled for administration three times a day at 8:00 AM, 12:00 PM, and 4:00 PM. The 8:00 AM dose had chart code "3" documented on the following dates indicating the medication was not administered due to Resident #17 was out of the facility. The 12:00 PM and 4:00 PM doses were signed as administered. 05/02/24 (Thursday) 8:00 AM: out of the facility. 05/07/24 (Tuesday) 8:00 AM: out of the facility. 05/09/24 (Thursday) 8:00 AM: out of the facility. 05/11/24 (Saturday) 8:00 AM: out of the facility. 05/14/24 (Tuesday) 8:00 AM: out of the facility. 05/16/24 (Thursday) 8:00 AM: out of the facility. A physician's order dated 04/25/24 for Resident #17 revealed Cymbalta 60 milligrams (mgs) oral capsules delayed release. Give 30 mgs by mouth in the morning for neuropathy. Review of Resident #17's Medication Administration Record (MAR) dated April 2024 revealed Cymbalta 60 mgs oral capsules delayed release. Give 30 mgs by mouth in the morning for	F 760	re-training of staff. The DON will review the Dialysis Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern are addressed. The Director of Nursing will forward the Orders Listing Report, and Dialysis Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 760	Continued From page 57	F 760		

neuropathy was scheduled for administration at 9:00 AM daily. The MAR had chart code "3" documented on the following dates indicating the medication was not administered due to Resident #17 was out of the facility.

04/25/24 (Thursday) 9:00 AM: out of the facility.
04/30/24 (Tuesday) 9:00 AM: out of the facility.

Review of Resident #17's Medication Administration Record (MAR) dated May 2024 revealed Cymbalta 60 mgs oral capsules delayed release. Give 30 mgs by mouth in the morning for neuropathy was scheduled for administration at 9:00 AM daily. The MAR had chart code "3" documented on the following dates indicating the medication was not administered due to Resident #17 was out of the facility.

05/02/24 (Thursday) 9:00 AM: out of the facility.
05/07/24 (Tuesday) 9:00 AM: out of the facility.
05/09/24 (Thursday) 9:00 AM: out of the facility.
05/11/24 (Saturday) 9:00 AM: out of the facility.
05/14/24 (Tuesday) 9:00 AM: out of the facility.
05/16/24 (Thursday) 9:00 AM: out of the facility.

The Minimum Data Set (MDS) quarterly assessment dated 04/19/24 revealed Resident #17 had moderately impaired cognition. She had no rejection of care and received hemodialysis.

A progress note documented by the Nurse Practitioner dated 05/15/24 revealed in part; Resident #17 was alert and oriented to person, place, and time. She was sitting in her wheelchair at the nurses station in no distress. She was appropriate and not drowsy. Her blood pressure was 116/76 (systolic/diastolic), pulse

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rate was 88 beats per minute. Her blood sugar was 144 mg/dl (milligrams per deciliter). The cardiovascular exam indicated Resident #17 was at her baseline. Neuropathic pain of stumps (bilateral below knee amputation) to thighs and right hand were minimal. She had no tremors.

During an interview on 05/17/24 at 1:00 PM Medication Aide #1 stated on the days Resident #17 was at dialysis she documented code "3" indicating Resident #17 was out of the facility at the time the medications were due. She stated once she documented that the resident was out of the facility the medication would not show up again on the MAR. She stated the medications were not given once Resident #17 returned from dialysis because it did not show on the MAR as needing to be administered.

During an interview on 05/17/24 at 2:00 PM the Director of Nursing stated Nurse #4 and Nurse #5 who documented Resident #17 was out of the facility for the dates the medication was not administered in April and May 2024 were not available for interview. She stated Nurse #4 was away on vacation and she made attempts today to contact Nurse #5 and there was no response. She stated the Medical Director was unavailable for interview due to a family emergency. She stated the medication times should have been adjusted to administer to Resident #17 after she returned from dialysis and that was not done.

During a phone interview on 05/17/24 at 3:30 PM the Nurse Practitioner stated she routinely evaluated Resident #17 and last examined her on 05/15/24. She indicated she was not aware that Resident #17 was not receiving her morning medications on dialysis days. She stated the

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Metoprolol was prescribed to Resident #17 to control high blood pressure and her blood pressure reading on 05/15/24 was 116/76 (systolic/diastolic). She indicated her blood pressures have been okay. She stated the Tradjenta was prescribed to Resident #17 for additional protection for diabetes and she also received sliding scale insulin. She stated her blood sugars were stable. She indicated the Cymbalta was prescribed for neuropathy and there had been no reports of increased pain or adverse symptoms. She stated Sevelamer was prescribed to Resident #17 due to being on dialysis and was a phosphate binder. She indicated her phosphorus levels were within normal limits and no abnormal phosphorus levels had been reported from dialysis staff. She stated Resident #17 was alert, oriented, and typically in her wheelchair throughout the day. She stated there had been no reports to her regarding a change of condition and the medication times should have been adjusted to account for dialysis. She indicated Resident #17 had not exhibited any significant outcome from not receiving the Metoprolol, Tradjenta, Cymbalta, or Sevelamer daily.

1b.) A physician's order dated 04/30/24 for Resident #17 revealed Diflucan 150 milligrams. Give one tablet by mouth in the morning every other day for vaginitis.

Review of the Medication Administration Record (MAR) dated May 2024 for Resident #17 revealed Diflucan 150 milligrams. Give one tablet by mouth in the morning every other day for vaginitis was scheduled to be administered at 9:00 AM

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beginning 05/01/24. The medication had chart code "10" documented on the following dates indicating the medication was not available. The MAR read as follows:

05/01/24 9:00 AM "10" medication not available.
05/03/24 9:00 AM "10" medication not available.
05/05/24 9:00 AM the medication was signed as administered.

A progress note documented by the Nurse Practitioner dated 05/15/24 revealed in part; Resident #17 was evaluated for urinary tract infection. She was alert and oriented to person, place, and time. She was sitting in her wheelchair at the nurses station in no distress. She was positive for urinary tract infection and would start Gentamycin 80 mgs IM (intramuscular) daily for 7 days.

During a phone interview on 05/17/24 at 9:30 AM the Consultant Pharmacist stated the order for Diflucan was received at the Pharmacy on 04/30/24 at 7:00 PM. The Pharmacy dispensed 3 tablets on 05/01/24. She stated Diflucan was also kept in the e-kit (kit located in the facility containing extra doses of medications for backup use) in the facility. Her record showed 6 doses of Diflucan were available on 05/01/24 in the e-kit at the facility. She reported they should have had the full course of the medication available for administration on 05/01/24. She indicated she was not aware of any adverse effects from Resident #17 not receiving the full course of treatment.

During an interview on 05/17/24 at 2:00 PM the

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F 760	Continued From page 61 Director of Nursing stated Nurse #4 and Nurse #5 who documented the medication was not available on 05/01/24 and 05/03/24 were not available for interview. She reported that Nurse #4 was away on vacation, and she had made attempts today to contact Nurse #5 and there was no response. During a phone interview on 05/17/24 at 3:30 PM the Nurse Practitioner stated she was not aware that Resident #17 did not get the 3 doses of Diflucan. She stated it was prescribed for vaginitis and one dose (150 mgs) of Diflucan could be sufficient. She stated she prescribed 3 doses to effectively clear her symptoms. She stated she evaluated Resident #17 on 05/15/24 for symptoms of urinary tract infection (UTI) and prescribed Gentamycin IM (intramuscular) for UTI treatment. She indicated although Resident #17 was positive for urinary tract infection it was not necessarily a direct result from not getting the full course of Diflucan for vaginitis. During an interview on 05/17/24 at 4:00 PM the Director of Nursing (DON) stated "10" on the MAR indicated the medication was not available. She stated the Nurse should have checked the e-kit while waiting for the medication to come from the Pharmacy. She indicated once the medication was available the MAR was not adjusted to account for the missed doses. She stated education had already been started on medication administration last night when she was made aware of the concern with Diflucan. She stated the full course of the Diflucan should have been administered according to the physicians order.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals	F 761		6/24/24

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F 761	Continued From page 62 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews the facility failed to secure a medication cart that was left unattended and unlocked with the keys in the lock while the cart was in the hallway near resident rooms. This was observed for 1 of 4 medication carts reviewed for medication storage. (400 Hall medication cart) Findings included.	F 761	F 761 Label/Store Drugs and Biologicals On 5/13/24, the Director of Nursing (DON) verbally educated Nurse #3 regarding Medication Storage with emphasis on ensuring the medication cart is locked when not directly supervised by the assigned nurse. The medication cart was immediately secured by the hall nurse.	

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F 761	Continued From page 63 During an observation on 05/13/24 at 03:10 PM the medication cart on the 400 hallway was observed unattended and unlocked with the cart keys left in the lock. The nurse was not in site of the cart. A visitor was standing 3 feet away from the medication cart. The nurse was observed coming out of a resident's room from down the hallway approximately 2-3 minutes later. During an interview on 05/13/24 at 3:15 PM Nurse #3 stated she got distracted when she was called away by a resident. She acknowledged she walked away from the medication cart and left the keys in the lock and the cart unlocked. She stated it was done in error. During an interview on 05/17/24 at 11:43 AM the Director of Nursing stated Nurse #3 reported to her after the error. She stated Nurse #3 was called into a resident's room in a hurry and left the cart unlocked. She indicated education would be provided.	F 761	On 6/11/24, the administrator completed an audit of all medication carts. The audit is to ensure all medication carts were locked when not directly supervised by assigned nurse. No additional concerns were noted. On 5/13/24 by the administrator with all nurses and medication aides regarding Medication Storage with emphasis on removing keys and securing medication cart when not directly supervised by the assigned nurse/medication aide. In-service will be completed by 6/24/24. After 6/24/24, any nurse or medication aide who has not worked or received the in-service will complete it upon the next scheduled work shift. All newly hired nurses or medication aides will be in-service during orientation regarding Medication Storage. All newly hired nurses and medication aides will be in-serviced during orientation regarding Medication Storage. The unit managers and Quality Assurance (QA) Nurse will audit all medication carts twice weekly x 4 weeks, then monthly x 1 month utilizing the Medication Audit Tool. This audit is to ensure all medication carts were locked and keys removed when not under direct supervision of the nurse. The nurse and/or medication aides will be immediately re-trained by the Unit Manager, QA nurse, and RN supervisor for any identified areas of concern. The DON will review the Medication Audit Tool for completion and to ensure all areas of concerns are addressed 2 times a week x	

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F 761	Continued From page 64	F 761	4 weeks, then monthly x 1 month. The Director of Nursing will forward the Medication Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, the facility failed to ensure food was palatable and served at an appetizing temperature for 4 of 8 residents reviewed for food palatability and temperature (Residents #22, #116, and #107) and 5 of 5 Resident Council members in attendance at a Resident Council meeting (Residents #23, #119, #14, #75 and #41). Findings included: 1. Resident #22 was admitted to the facility on	F 804	F 804 Nutritive Value/Appear, Palatable/Prefer Temp On 6/13/24, the administrator observed meal delivery for Resident #22, Resident #107, and Resident #116. During the observation, the meal trays were accurate for resident preference and the resident verbalized the meal was served at the appropriate temperature and was pleasing to taste. On 6/13/24, the Staff Facilitator initiated a	6/24/24

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F 804	Continued From page 65 10/7/20 with diagnosis which included diabetes. Resident #22's quarterly Minimum Data Set (MDS) dated 2/23/24 indicated the resident was cognitively intact. An interview was conducted with Resident #22 on 5/13/24 at 12:00 PM. Resident #22 revealed the food was cold and not appetizing or cooked well. Resident #22 stated she wished she could make a choice about what she received to eat. Meal observation of Resident #22's lunch tray on 5/13/24 at 12:30 PM revealed resident received 2 chicken tenders, a scoop of potato salad and a scoop of macaroni and cheese. Resident refused the meal and stated the macaroni and cheese was dry and the chicken tenders were hard. Resident #22 requested 2 grilled cheese sandwiches. Resident received 1 grilled cheese sandwich. An interview was conducted on 5/14/24 at 9:12 AM with Resident #22. Resident #22 indicated the food was frequently not hot when it was served, and it was not palatable. Resident #22 stated she had received cold food and food that did not look or taste good for a while. An interview was conducted on 5/17/24 at 9:50 AM with the Dietary Manager. The Dietary Manager stated she was not aware that Resident #22 had any food complaints. The Dietary Manager indicated Resident #22 preferred grilled cheese for lunch and dinner recently and the kitchen provided them per resident's preference. An interview was conducted on 5/17/24 at 12:20 PM with the Administrator. The Administrator	F 804	food preference survey and educated Resident #116 and Resident #107 regarding meal alternatives to include how to request an alternative meal. Any new preferences will be updated. On 6/15/24, the Staff Facilitator completed a food preference survey and educated Resident #22 regarding meal alternatives to include how to request an alternative meal. Any new preferences will be updated. On 6/13/24, the administrator and Director of Nursing (DON) initiated an audit of meal preparation to ensure food was prepared in a manner to be well seasoned and palatable to taste per recipe. The administrator addressed all concerns identified during the audit to include education of the cook when indicated. The audit will be completed by 6/24/24. On 6/13/24, the Admissions Director, Social Worker, Activities, Staff Facilitator, and Activity Director initiated resident questionnaires regarding Meal Delivery with all alert and oriented residents. Questionnaires included (1) are foods served at an appetizing temperature (hot foods served hot/cold foods served cold, if not, do staff offer another tray or to heat food when indicated? (2) Is food seasoned to your liking, if not do staff provide salt/pepper/sugar when requested? (3) are your food preferences/dislikes honored? If not, please explain and (4) Is food cooked fully, tender and easy to consume? If not,	

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F 804	Continued From page 66 stated she was not aware of Resident #22 having any concerns about cold food. 2. Review of Resident #116's 3/19/24 quarterly Minimum Data Set (MDS) assessment revealed resident was cognitively intact. . Interview on 5/13/24 at 1:47 PM with Resident #116 indicated the food often does not look or taste good. Resident #116 stated she frequently drinks a nutritional supplement provided by her family instead of eating due to the meals being cold and not palatable. Resident #116 stated her meals were always cold, not reheated and she often could not eat it because of this. Meal observation on 5/14/24 at 12:45 PM indicated Resident #116 had her lunch meal tray in front of her which consisted of chicken and dumplings, carrots and mashed potatoes and gravy. Resident #116 indicated she had tried a few bites of her meal but could not eat it. Resident #116 stated the meal did not look appetizing and did not taste good. Resident was observed drinking a nutritional supplement that she received on her meal tray. Resident #116 indicated she was drinking her supplement instead because she could not eat the meal that was served. Resident #116 stated she could ask for an alternate, but it was usually a peanut butter and jelly sandwich, and she could not eat that since she had diabetes. An interview was conducted with the Registered Dietitian (RD) on 5/15/24 at 11:15 AM. The RD stated she was in the position at the facility for 5 months. The RD stated she was not aware of any issues with the food that was served. The RD stated she was not involved with the menu or	F 804	please explain. The Administrator, Social Worker, and Dietary Manager will address all concerns identified during the audit to include updating food preferences, offering additional meal tray/seasoning when indicated and education of staff. The questionnaires will be completed by 6/24/14. On 6/13/24, the social worker, admissions director, and/or activity director initiated resident food preference surveys with all alert and oriented residents. This audit is to ensure identify resident food preferences and to ensure the meal tray card reflects food preferences. The administrator will address all concerns identified during the audit to include updating food preferences when indicated. The surveys will be completed by 6/24/14. On 6/13/24, the staff facilitator (SF) initiated an in-service with the nursing assistants (NA) and nurses regarding Meal Delivery with emphasis on (1) ensuring meal tray is accurate for the meal tray card to include supplements and resident preferences (2) immediately notifying the dietary department when the meal tray is not accurate to include resident preferences, tray is not served at an appetizing temperature to be reheated or resident requests an alternative meal and (3) offering resident additional seasoning to include but not limited to salt/pepper/sugar/butter to ensure meal is palatable. The in-service will be completed by	

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F 804	Continued From page 67 the diet. The RD stated her main role was to provide a clinical review of the resident's record and this did not involve interview of the resident or observation of the meals. The RD stated Resident #116 had significant weight loss. The RD stated she was not aware Resident #116 was not eating the meals due to concerns with the food temperature and palatability. The RD did not indicate that she would follow up with the Dietary Manager. 3. Resident #107 was admitted on 10/5/22. Review of Resident #107's electronic health record revealed a Nurse Practitioner progress note which indicated resident was evaluated on 3/5/24 due to staff concerns that resident's appetite was poor and resident was not eating the meals. The progress note indicated Resident #107 informed the Nurse Practitioner that the food was no good. The progress note further stated the resident had a poor appetite with a down trend in weights. The progress note did not indicate that resident was receiving end of life care. Interview with Resident #107 on 5/13/24 at 11:07 AM revealed the food was not good. Resident #107 stated she kept snacks in her room that her family supplied. Resident #107 stated the food frequently was not hot or palatable. Resident #107 indicated the staff were aware she did not like the food, and they added the extra items that sometimes she received and sometimes she did not. Observation of the lunch meal on 5/13/24 at 12:30 PM revealed Resident #107's meal tray ticket indicated resident was to receive a regular	F 804	6/24/14. After 6/24/14, any nurse or nursing assistant who has not completed the in-service will complete it upon the next scheduled work shift. All newly hired nurses or NAs will be in-service during orientation regarding Meal Delivery. On 6/13/24, the administrator and staff facilitator (SF) initiated an in-service with the dietary staff regarding Preparing Meal Trays with emphasis on ensuring the meal tray is accurate with the meal tray card per physician's order to include and per resident preference. The in-service also includes the dietary staff must complete test trays for temperature monitoring prior to sending trays out to the units to ensure trays are served at preferable temperatures. The in-service will be completed by 6/24/14. After 6/24/14, any dietary staff who has not completed the in-service will complete it upon the next scheduled work shift. All newly hired dietary staff will be in-serviced during orientation regarding Preparing Meal Trays. The activity director, admissions coordinator, dietary manager, and/or the social worker will complete 5 resident questionnaires weekly x 4 weeks, then monthly x 1 month regarding Meal Delivery with all alert and oriented residents. These questionnaires are to identify any concerns related to meal delivery and to ensure food was palatable, served at an appetizing temperature and per resident preference. The Social Worker and Dietary Manager will address all concerns identified during the audit to include updating food preferences,	

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F 804	Continued From page 68 enriched meal program diet with double vegetables, 2 bowls of soup, a peanut butter and jelly sandwich, and a sugar free milk shake supplement. Observation of Resident #107's meal tray revealed resident received a Styrofoam container which contained 2 chicken tenders, a scoop of potato salad, and a scoop of macaroni and cheese. Resident was observed not eating the meal that was provided. Resident had a container with food that her family had provided that she was eating. Interview with Resident #107 indicated the chicken was cold and hard and the macaroni and cheese was cold and dry. Observation of Resident #107's lunch meal tray on 5/14/24 at 12:40 PM revealed resident received two bowls of soup, a peanut butter and jelly sandwich and a foam container which contained chicken and dumplings, carrots and mashed potatoes and gravy. An interview was conducted with Resident #107 on 5/14/24 at 12:40 PM. Resident #107 stated the meal she received was not hot and not palatable. Resident #107 stated the chicken and dumplings looked sloppy and messy with the chicken ground up and it was cold. An interview was conducted with Resident #107 on 5/15/24 at 12:45 PM. Resident #107 stated she ate a peanut butter and jelly sandwich for lunch. Resident #107 stated she did not think she should eat peanut butter and jelly sandwiches every day because she was diabetic, but the meals were not good, and she often just could not eat it. 4. Review of the Resident Council meeting minutes from December 2023 through May 2024	F 804	offering additional meal tray/seasoning when indicated and re-training of staff. The Administrator will review the resident questionnaires weekly x 4 weeks, then monthly x 1 month, to ensure all concerns are addressed. The administrator and/or the dietary manager will complete meal temperature audits 3 times a week to include all meals x 4 weeks then monthly x 1 month utilizing the Meal Temperature Audit Tool. This audit is to ensure meals are served at an appetizing temperature per regulations. The administrator and/or the dietary manager will address all concerns identified during the audit to include providing additional meal tray when indicated and re-training of staff. The Administrator will review the Meal Temperature Audit Tool 3 times a week x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator will forward the Meal Temperature Audit Tool and the Meal Delivery Questionnaires to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 804	Continued From page 69	F 804		

revealed the following food concerns:

- 1/3/24 Concern was voiced regarding food thrown on trays and not hot enough. The grievance follow up indicated dietary staff were educated by the manager on food presentation and food temperatures were to be checked prior to leaving the kitchen. The grievance follow up indicated staff were to work on delivering the food quicker to ensure appropriate temperatures on arrival for the residents.

- 3/6/24 Concern was voiced regarding vegetables being served mushy. The grievance follow up indicated the Dietary Manager explained that vegetables were sometimes mushy due to cooking a large quantity.

- 5/1/24 Concern was voiced that food was not hot when served in Styrofoam trays and meals were repeated frequently. The grievance follow up indicated foam containers were used due to a recent dishwasher fire and they would resume normal meal service once the new dishwasher is installed.

During the survey a Resident Council meeting was held on 5/14/24 at 2:30 PM and was attended by the Resident Council President (Resident #23) and a sample of other cognitively intact residents (Resident #119, #14, #75 and #41). The sample of residents in the Resident Council meeting stated the food had been discussed in the Resident Council meetings for months and they continued to receive cold food. The sampled residents stated they received meals that were not palatable and food that did not look or taste good. The residents stated the food was a big concern in the facility.

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F 804	Continued From page 70	F 804		

An interview was conducted on 5/16/24 at 4:35 PM with the Director of Nursing (DON). The DON stated the facility needed to work on a system for residents to receive an alternate meal and to ensure the residents received a hot, palatable meal. The DON indicated food service and meal delivery was an area that needed to be investigated more closely.

An interview was conducted on 5/17/24 at 9:50 AM with the Dietary Manager. The Dietary Manager stated she was not aware that the residents had any food complaints. The Dietary Manager stated she was not informed of any grievances filed regarding the food. The Dietary Manager stated that she had new staff, and it was hard to get them trained and to pay attention to how the meals were served. The Dietary Manager indicated she had a high turnover of staff and was constantly training staff. The Dietary Manager further stated she had some insulated meal carts, but not enough to deliver all the meals. The Dietary Manager indicated she obtained likes and dislikes from the residents on admission but did not make routine rounds to update these or receive feedback regarding the food. The Dietary Manager stated she was told by the Administrator to improve the food and the food temperatures, but she did not think there was anything she could do.

An interview was conducted on 5/17/24 at 12:20 PM with the Administrator. The Administrator stated she expected that the food would be palatable and served at an appropriate temperature per resident preferences. The Administrator further stated she expected that staff would offer alternate meals if a resident did

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F 804	Continued From page 71 not like what was served and would take the meal to the kitchen to be reheated if it was cold.	F 804		
F 806 SS=E	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, the facility failed to provide alternative meals for 6 out of 8 residents reviewed for nutrition (Resident # 7, Resident #21, Resident #22, Resident #116, Resident #107, and Resident #19). Findings included: 1a. Resident #7 was admitted to the facility on 04/20/23. Review of a quarterly Minimum Data Set Assessment dated 03/15/24 for Resident #7 documented he had intact cognition. In an interview with Resident #21 on 05/16/24 at 12:08 PM he stated when he gets his food it's cold, dried out and hard. He stated he was not aware he could ask for an alternate meal if he did not like what was served to him.	F 806	F 806 Resident Allergies, Preferences, Substitutes On 6/13/24, the Staff Facilitator initiated a food preference survey and educated Resident #7, Resident #21, Resident #116, and Resident #107 regarding meal alternatives to include how to request an alternative meal. Any new preferences will be updated. On 6/15/24, the Staff Facilitator completed a food preference survey and educated Resident #22 and Resident #19 regarding meal alternatives to include how to request an alternative meal. Any new preferences will be updated. On 6/13/24, the administrator observed meal delivery for Resident #7, Resident # 21, Resident #22, Resident #19, Resident #107 and Resident #119. During the	6/24/24

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F 806	Continued From page 72 1b. Resident #21 was admitted to the facility on 10/12/23. Review of a quarterly MDS assessment dated 03/05/24 documented Resident #21 had intact cognition. An observation of the lunch meal served to Resident #21 included fried shrimp. In an interview with Resident #21 on 05/13/24 at 2:00 PM she stated she did not eat anything that came out of the ocean, and she was not going to eat the lunch that was served. She stated she had not told dietary about the seafood dislike, but they did know she did not eat eggs or sausage and sometimes she was served both. She reported that she had a dinner that her roommate's family had brought in for her and that was what she planned on eating. She stated she was not offered an alternative. She noted that in the past a staff member came around and reviewed the menu for the week and asked her to choose which meal she preferred. She stated that lasted about 2 weeks and after that no one had been around to offer her an alternate meal choice. She noted she ate food brought in a lot because half the time the food she was served she either didn't like or it was cold when it was served to her. Two examples of documentation for resident meal choices were reviewed. For the week of 04/15/24 documentation showed that residents were asked which meal or alternate was preferred each day beginning on Wednesday, 04/17/24. Residents were not interviewed regarding the menu on 04/15/24 or 04/16/24 of	F 806	observation the meal tray was accurate for resident preference and served at an appetizing temperature. The residents were provided with an alternative meal when requested. On 6/13/24, the Social Worker, activity director, admissions coordinator, and dietary manager initiated resident questionnaires regarding Alternative Meals with all alert and oriented residents. Questionnaires included (1) Do staff offer you an alternative meal when requested? (2) Are you aware of what meals are available as an alternative meal? (3) Are you given a choice of food alternative? And (4) What three items would you like to see on the alternative meal menu? The Administrator, Social Worker, and Dietary Manager will address all concerns identified during the questionnaires to include education of residents and of staff. The questionnaires will be completed by 6/24/14. On 6/13/24, a resident council meeting was held with the dietician, Administrator and Director of Nursing and alert and oriented residents regarding Alternate Meal Process to include (1) meal preferences (2) select meal process (3) how to request alternate meal options and (4) 3 resident preference options for meal alternative. Any alert and oriented resident who did not attend resident council meeting will be educated 1:1 by the social worker. Education will be completed by 6/24/14. The dietary manager will update the alternative meal options when	

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that week. The week of 5/13/24 documentation showed that residents were asked which meal or alternate was preferred each day beginning on Thursday, 05/16/24. Residents were not interviewed regarding the menu on 05/13/24, 05/14/24, or 05/15/24 the week of 05/13/24.

In an interview with the Administrator on 05/17/24 at 11:23 AM she stated she did expect the residents to have a choice for meal preferences. She explained she did not know why residents were not interviewed this week on 05/13/24, 05/14/24 or 05/15/24 regarding meal choices and were not interviewed on 04/15/14 and 04/16/14 for the week of 04/15/24. She stated the evening receptionist was given a menu for the week. She then was to interview each resident who was able to be interviewed to obtain meal preferences. She stated this process started in April 2024. Prior to that menus were put on each unit and the aides would go around daily and ask each resident what they preferred. She explained that process failed because the aides didn't have time to do that and complete their other duties.

In an interview with Receptionist #3 on 05/17/24 at 11:21 AM she stated she had only gone around with the menus and interviewed residents for meal preferences one time and that was this Wednesday. She explained because she wasn't given the menu until Wednesday, she could only interview for preferences beginning with Thursday's menu (05/16/24).

In an interview with Receptionist #1 on 05/17/24 at 12:56 PM she stated she had in the past went around and asked residents what meal they wanted for a week at a time. It used to be that a list of residents was made and if any resident indicated per resident council preferences.

On 6/13/24, the staff facilitator (SF) initiated an in-service with the nursing assistants (NA) and nurses regarding Meal Delivery with emphasis on (1) ensuring meal tray is accurate for the meal tray card to include resident preferences (2) immediately notifying the dietary department when the meal tray is not accurate to include resident preferences, tray is not served at an appetizing temperature to be reheated or resident requests an alternative meal and (3) offering resident additional seasoning to include but not limited to salt/pepper/sugar/butter to ensure meal is palatable. The in-service will be completed by 6/24/14. After 6/24/14, any nurse or nursing assistant who has not completed the in-service will complete it upon the next scheduled work shift. All newly hired nurses or NAs will be in-service during orientation regarding Meal Delivery.
On 6/17/24, the administrator completed an in-service with the Dietary Manager regarding Select Meal Process with emphasis on completing an interview with all alert and oriented residents regarding meal preference/alternative meal and ensuring resident preference for meal is honored.

The Social Worker and/or the assistant administrator will complete 5 resident questionnaires weekly x 4 weeks, then monthly x 1 month with alert and oriented

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F 806	Continued From page 74 wanted something different that day it would be documented and given to the kitchen. She stated that currently it was done weekly. She explained the last time she did this she only asked 9 residents what they preferred to eat each day because it took too long to interview and circle the choices on the menu. She said she was supposed to ask all alert and oriented residents what their preferences were, but she could not get to everyone. She explained after the residents were interviewed the menus would then be given to the kitchen so that meal preferences could be honored each day. She explained the last time she did go around with the weekly menus she could only do Wednesday through Sunday because the menu for the week wasn't given to her until Tuesday evening. In an interview with Receptionist #2 on 5/17/24 at 2:48 PM she stated the process currently in place was to obtain menu preferences for a week at a time. She thought this process had been in place for 2 or 3 months. Prior to that she would go to the halls and ask the nurses which residents were alert and oriented and those were the residents she would interview and review the menu with them. She would circle the resident's choices and return the menus to the kitchen. Usually on Mondays and sometimes Tuesdays no choice were given because the receptionist would not get the menu in time to go around, plus whichever day they went around to inquire about choices would start the following day, not that day. She stated she had been employed since Nov 2023 and had completed choice menus "plenty of times." She noted that recently the main receptionist thought it took too much time away from the receptionist answering the phone and had talked to the Dietary Manager about	F 806	residents regarding Alternative Meals. This questionnaire is to ensure residents are offered a select meal option and is provided an alternative meal selection when requested. The Social Worker and Dietary Manager will address all concerns identified during the questionnaires to include providing an appropriate meal tray when indicated and retraining staff. The Administrator will review the resident questionnaires to ensure that all concerns are addressed. The dietary manager will review the Select Menu Interviews weekly x 4 weeks then monthly x 1 month to ensure that residents are offered meal options/alternative meals options per preference. The assistant administrator will address all concerns identified during the audit to include re-training of Dietary Manager. The Administrator will review the Select Menu Interviews weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator will forward the Alternative Meal Questionnaires and the Select Menu Interviews to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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	345119	A. BUILDING _____ B. WING _____	C 05/17/2024

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having someone else go around and interview the residents.

In an interview with the Dietary Manager on 05/17/24 at 10:31 AM she stated she had worked at the facility for 2 years. She explained the process was for the receptionists to go around and interview residents for meal preferences. When the kitchen received the menus each meal ticket would be adjusted for residents who wanted something other than the main meal. She stated this process had been in place for about a month. She noted the main menus were posted on halls 300, 500, and 700. She explained alternate menu choices are not posted. She noted that any resident who did not get a choice was because the residents were not in their rooms when staff went around to ask. She reported that she was responsible for providing the receptionist with the menu each week. She did not know why for the week of 5/13/24 that residents were not asked what they wanted to eat on 05/13/24, 05/14/24, and 05/15/24 or for the week of 4/15/24 for 04/15/24 and 04/16/24 because the menu was out. She stated she wasn't sure why the process was not working but that it was a "work in progress." She stated alternates were available from the "everyday menu" that included the following choices: cheeseburger, chef salad, cold cut sandwich, grilled cheese, or the chef's daily choice. All entrees except the chef's salad came with chips and the vegetable of the day.

c. Resident #22 was admitted to the facility on 10/7/20.

Resident #22's quarterly Minimum Data Set (MDS) dated 2/23/24 indicated the resident was cognitively intact.

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An interview was conducted with Resident #22 on 5/13/24 at 12:00 PM. Resident #22 stated she wished she could make a choice about what she received to eat.

An interview was conducted on 5/14/24 at 9:12 AM with Resident #22. The resident indicated the only thing she was offered as an alternate was a grilled cheese sandwich.

A meal observation conducted on 5/16/24 at 12:26 PM revealed Resident #22 was in bed with the head of the bed elevated feeding herself a pasta take out meal. Resident stated she ordered take out as she did not like the lunch and did not want a grilled cheese sandwich again. Resident #22 stated the staff used to take the orders for the meals and offer the meal or an alternate prior to the meal but they had not been doing that for a long time.

An interview was conducted on 5/17/24 at 9:50 AM with the Dietary Manager. The Dietary Manager stated she was not aware of Resident #22 having any food complaints. The Dietary Manager stated she had items available for alternate meals. The Dietary Manager indicated the facility was asking the residents about alternate meals, but it had not been done recently.

An interview was conducted on 5/17/24 at 12:20 PM with the Administrator. The Administrator further stated she expected food preferences to be honored, residents to be served meals according to their preferences and alternate meals to be provided.

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d. Resident #116 was admitted to the facility on 1/22/24 with diagnosis which included in part chronic obstructive pulmonary disease and diabetes.

Review of Resident #116's electronic health record revealed a physician order dated 1/22/24 for a consistent carbohydrate diet.

Review of Resident #116's 3/19/24 quarterly Minimum Data Set (MDS) assessment revealed resident was cognitively intact.

Interview on 5/13/24 at 1:47 PM with Resident #116 indicated the food often did not look or taste good and she was not aware of an alternate meal other than a peanut butter and jelly sandwich. Resident #116 stated she frequently drank a nutritional supplement provided by her family instead of eating.

Meal observation on 5/14/24 at 12:45 PM revealed Resident #116 was sitting on the side of her bed with her lunch tray in front of her. Resident #116 had not eaten any of the lunch. Resident was observed drinking her nutritional supplement.

Interview on 5/14/24 at 12:45 PM with Resident #116 revealed she was drinking a nutritional supplement instead of eating the meal. Resident #116 stated she did not like the meal and was not aware of a list of alternate meals. Resident #116 stated she knew that she could get a peanut butter and jelly sandwich, but she could not eat that since she was a diabetic.

e. Resident #107 was admitted on 10/5/22 with diagnosis which included stroke and diabetes.

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Interview with Resident #107 on 5/13/24 at 11:07 AM revealed the food was not good and she mostly ate snacks supplied by her family. Resident #107 was not aware of alternate options at meals.

Meal observation on 5/13/24 at 12:30 PM revealed Resident #107's was in bed with the head of the bed elevated with her meal tray in front of her. Resident #107 had not eaten from the meal tray but instead was eating from a container of food that her family had provided.

An interview was conducted with Resident #107 on 5/14/24 at 12:40 PM. Resident #107 stated the meal she received was not hot and not palatable and she was not offered an alternate.

An interview was conducted with Resident #107 on 5/15/24 at 12:45 PM. Resident #107 stated she ate a peanut butter and jelly sandwich for lunch. Resident #107 stated she was told you get what you get for your meals. Resident #107 stated she did not like to eat peanut butter and jelly sandwiches every day because she was diabetic. Resident #107 stated the food was not good, she often just could not eat it and was not offered an alternate meal.

f. Resident #19 was admitted to the facility on 11/29/23 with diagnosis which included diabetes and hypertension.

Review of Resident #19's 4/11/24 quarterly Minimum Data Set (MDS) assessment indicated resident was cognitively intact.

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F 806	Continued From page 79 Interview with Resident #19 on 5/14/24 at 12:45 PM revealed she could not eat the lunch meal that was served as it was not appetizing. Resident #19 stated sometimes staff stated they did not have an alternate meal available. An interview was conducted on 5/17/24 at 9:35 AM with Nurse #1. Nurse #1 stated the facility used to give copies of the menu and asked the residents if they wanted the meal or an alternate, but it had not been done for a while. An interview was conducted on 5/17/24 at 1:50 PM with the Administrator. The Administrator stated she expected the residents to receive alternate meals. The Administrator stated she did not know what the breakdown was with the alternate meals.	F 806		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		6/24/24

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F 880	Continued From page 80 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 81 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff, resident, and the Nurse Practitioner interviews the facility failed to implement the Enhanced Barrier Precautions (EBP) policy regarding donning Personal Protective Equipment (PPE) to include donning gloves and gown during high contact resident care activities. Two Nurse Aides were observed providing care to a resident with an indwelling central venous catheter used for dialysis and who received wound care to the right lower extremity and were not wearing a gown during care. This occurred for 1 of 5 resident (Resident #82) observed for Infection Control. Findings included. The facility's Enhanced Barrier Precautions policy updated on 04/01/24 read: Enhanced Barrier Precautions were used in conjunction with Standard Precautions to reduce the risk of multidrug resistant organism (MDRO) transmission during high contact resident care activities. This included the use of both gloves and gown. Enhanced Barrier Precautions are to be in place for the duration of the residents stay or until resolution of a wound or discontinuation of an indwelling medical device. During an observation on 05/14/24 at 9:45 AM a	F 880	F 880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) On 5/15/24, the Director of Nursing (DON) in serviced nursing assistant (NA) #3 and NA #4 and regarding Enhanced Barrier Precautions (EBP) to include the use of personal protective equipment (PPE) while providing care, linen change, and services in rooms identified as requiring Enhanced Barrier Precautions. On 6/13/24, the nurse supervisors initiated 15 random resident care observations with all staff to include all shifts. This audit is to ensure staff were utilizing appropriate use of PPE when in rooms designated as requiring isolation precautions to include but not limited to EBP. The nurse supervisors and/or the DON will address all concerns identified during the audit to include education of staff. The observations will be completed by 6/24/14. On 5/15/24, the infection preventionist/ Quality Assurance (QA) Nurse initiated an in-service with all nurses, medication aides, nursing assistants, housekeeping	

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F 880	Continued From page 82 sign was posted by Resident #82's room door that read in part: Enhanced Barrier Precautions. Providers and staff must wear gloves and a gown for the following high-contact resident care activities: dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs, device care or use of a central line, urinary catheters, feeding tubes, and wound care. During an observation on 05/14/24 at 9:45 AM Nurse Aide #3 was observed in Resident #82's room changing the bed linens. Resident #82 was sitting at the bedside in her wheelchair. Nurse Aide #3 had on gloves when changing the bed linens but no gown. A cart with PPE (personal protective equipment) supplies was in the residents room. Nurse Aide #3 stated she had a gown on when she transferred Resident #82 to the wheelchair then took it off before changing the bed linens. She stated she knew Resident #3 was on Enhanced Barrier Precautions and acknowledged that she should wear a gown and gloves when providing direct care including changing bed linens. She indicated she had received training on Enhanced Barrier Precautions. She stated it was done in error. During an interview on 05/14/24 at 9:45 AM Resident #82 was alert and oriented to person, place, and time. She stated she was on "precautions" because of her dialysis port, and she had a wound on her leg. She stated she had also been on Contact Precautions for a while due to C. diff. (clostridium difficile - a bacteria that causes infection of the colon). During an interview on 05/14/24 at 10:00 AM the Nurse Practitioner stated Resident #82 was no	F 880	staff and therapy staff regarding Enhanced Barrier Precautions with emphasis on donning/doffing PPE while providing direct patient care, treatments, and/or changing linens for residents identified as requiring EBP. In-service will be completed by 6/24/14. After 6/24/14, any staff who has not worked or received the in-service will complete it upon the next scheduled work shift. All newly hired nurses, medication aides, nursing assistants, housekeeping staff and therapy staff will be in-service during orientation regarding Enhanced Barrier Precautions with emphasis on donning/doffing PPE while providing direct patient care, treatments, and/or changing linens for residents identified as requiring EBP. All newly hired nurses, medication aides, nursing assistants, housekeeping staff and therapy staff will be in-serviced during orientation by the staff facilitator and/or infection preventionist/QA Nurse regarding Enhanced Barrier Precautions. The Infection Preventionist/QA Nurse and/or Staff Facilitator will complete 10 Resident Care Audits weekly x 4 weeks then monthly x 1 month. This audit is to ensure staff utilize appropriate PPE when in rooms designated as requiring isolation precautions to include but not limited to EBP. The Infection Preventionist will address all concerns identified during the audit to include re-training of staff. The Director of Nursing (DON) will review the Resident Care Audits weekly x 4 weeks then monthly for 1 month to ensure all identified areas of concern have been	

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F 880	Continued From page 83 longer on Contact Precautions for C. difficile as of 05/13/24 and was now on Enhanced Barrier Precautions due to having a dialysis access device and receiving wound care. During an observation on 05/15/24 at 2:10 PM Nurse Aide #4 was observed in Resident #82's room providing incontinence care. She was observed wearing gloves but no gown. She stated she had the gown on at first then discarded it then started with incontinence care without replacing her gown. She stated she had received training on Enhanced Barrier Precautions. She stated it was a mistake and she should have put a gown on before providing incontinence care. During an interview on 05/17/24 at 09:30 AM the Infection Control Nurse indicated Resident #82 was on Enhanced Barrier Precautions due to having a dialysis access device and wound care. She stated Resident #82 came off of Contact Precautions for C. difficile on 05/13/24 and was now on Enhanced Barrier Precautions. She indicated the nurse aides had been trained on Enhanced Barrier Precautions and should have worn a gown along with gloves when providing direct care. During an interview on 05/17/24 at 5:00 PM the Director of Nursing (DON) stated staff should wear the appropriate PPE when providing direct care to residents on Enhanced Barrier Precautions. She stated education would be provided.	F 880	addressed. The Director of Nursing will forward the results of the Resident Care Audits to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	