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	345050	A. BUILDING _____ B. WING _____	C 09/18/2024

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E 000	Initial Comments The survey team entered the facility on 09/03/24 to conduct a recertification and complaint investigation survey and exited on 09/06/24. The corrective action plan was validated on 09/18/24. Therefore, the exit date was changed to 09/18/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #V2LD11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 09/03/24 to conduct a recertification and complaint investigation survey and exited on 09/06/24. The corrective action plan was validated on 09/18/24. Therefore, the exit date was changed to 09/18/24. The following intakes were investigated NC00220629, NC00220354, NC00220233, and NC00219936. Two (2) of the 10 complaint allegations resulted in a deficiency. Intake NC00220233 resulted in immediate jeopardy. Past Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity J. The tag F600 constituted Substandard Quality of Care. Immediate Jeopardy began on 8/1/24 and was removed on 8/5/24. An extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F 600		

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

Electronically Signed | 10/04/2024

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F 600	Continued From page 1 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, physician, nurse practitioner and staff interviews the facility failed to protect a resident's right to be free from physical abuse. Resident #123 was observed sitting on a black container behind Resident #100 with his left hand around Resident 100's neck and his right arm covered around his left arm. Resident #100 was leaning forward and crying, and her face was blue. Resident #100 continued to cry after the residents were separated. A skin assessment completed after the incident revealed Resident #100 had redness on her cheeks and petechiae (tiny spots of bleeding under the skin) on the front part of her neck. The abuse occurred for 1 of 3 sampled residents reviewed for protection from abuse (Resident #100). The findings included: Resident #123 was admitted to the facility on 8/25/23. His diagnoses included Alzheimer's disease, major depressive disorder, post-traumatic stress disorder (PTSD), dementia	F 600	Past noncompliance: no plan of correction required.	

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with psychotic disturbance, conduct disorder and generalized anxiety disorder.

Review of his significant change Minimum Data Set (MDS) assessment, dated 5/29/24, revealed that he was severely cognitively impaired and required supervision with activities of daily living (ADL). The resident was ambulatory with combative and aggressive behavior toward residents and staff.
Resident #123 received antidepressant, antianxiety and anticonvulsant medications.

Review of physician's orders for Resident #123 for August 2024, revealed that he received psychotropic medications.

Review of the Medication Administration Record (MAR) for August 2024 revealed that the MAR reflected physician's orders and was completed. Resident #123 received scheduled and as needed psychotropic medications.

Review of the care plan for Resident #123, revised on 5/29/24, revealed he had declined in intellectual functioning, expressing emotion, understanding information, characterized by ineffective coping, disorganized thinking, verbal and physical aggression or agitated, combativeness towards staff members and wandering. Resident #123 received psychotropic medications. The interventions including to ensure safety for residents and staff, monitor and document behavior, attempt to redirect resident, allow adequate time to complete tasks, remove resident from public area when behavior is disruptive or unacceptable, observe and report changes in cognitive status, provide the psychiatric consultation as needed, and

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medication treatment per order.

Resident #100 was admitted to the facility on 2/9/23. Her diagnoses included dementia, bipolar disorder and Alzheimer's disease.

Review of her quarterly MDS assessment, dated 7/17/24, revealed that she was severely cognitively impaired and required limited assistance with ADL. Resident #100 received psychotropic medications. She was ambulatory with wandering, refusal and non-cooperative behavior.

Review of the care plan for Resident #100, revised on 7/17/24, revealed she had an ineffective coping, judgment, decision making, deficit in memory and thought process, verbal and physical aggression or agitated, combativeness towards staff members and wandering. The interventions including to ensure safety for residents and staff, monitor and document behavior, attempt to redirect resident, allow adequate time to complete tasks, remove resident from public area when behavior is disruptive or unacceptable, observe and report changes in cognitive status, provide the psychiatric consultation as needed, and medication treatment per order.

Nurse #1's witness statement, dated 8/1/24, indicated on 8/1/24 at 5:15 PM, Resident #123 was sitting on the black container in front of the closet. Resident #100 was standing leaning forward in front of the closet between the container and the closet. Resident #100 was "leaned" over his left knee. Resident #123 had his left arm around Resident #100's neck and his right arm wrapped around his left arm. Resident

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#100's face was blue. "I pulled [Resident #123's] arms apart. [Resident #100] stood up and started walking. I took/directed [Resident #100] up the hall. [Resident #100] was crying. [Resident #100's] face/cheeks petechiae/red. Front of neck red." Another nurse (Nurse #2) stayed with Resident #123. [Nurse #2] directed Resident #123 to his room and was given as needed Ativan IM (intramuscular). Resident #123 was shaking after the interaction but was calm at present.

On 9/4/24 at 3:45 PM Nurse #1 indicated during an interview she was assigned to Residents #123 and #100 on second shift on 8/1/24. At approximately 5:00 PM, she heard a crying noise from an empty resident room. Nurse #1 went to the room with Nurse #2 and observed two residents. Resident #123 was sitting on the small plastic container and Resident #100 standing, leaning forward in front of him. Resident 123's arms were around Resident 100's shoulder and neck and she was crying. Nurse #1 stated both nurses pulled Resident 123's arms away from Resident #100's neck. Nurse #1 redirected Resident #100 to the hallway and left Nurse #2 with Resident #123. Upon assessment, Resident #100 had a small area of redness on the front part of her neck and her cheeks. When Nurse #1 asked Resident #123 what he was doing, the resident stated that he tried to "take his motorcycle to the house." Nurse #1 reported the incident to the administration, completed the incident report, provided the written witness statement, placed Resident #123 on 1:1 monitoring, while Nurse #2 remained with Resident #100 near the nurses' station. Resident #100 stopped crying in about 10-15 minutes. Nurse #1 mentioned prior to the incident, both residents wear at the baseline behavior during the

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shift.

On 9/15/24 at 7:00 PM, during the phone interview, Nurse #1 recalled that on 8/1/24, she observed Resident #123 with his left arm around Resident 100's neck and his right arm covered around his left arm. Resident #100 was breathing, crying, and her face turned blue. Nurse #1 removed Resident 123's arms from Resident #100 and separated both residents. Nurse #1 took Resident #100 to the nurses' station, where she was able to drink water and stopped crying within 10 minutes. Nurse #1 took vital signs, which were within normal limit.

Nurse #2's witness statement, dated 8/1/24, indicated at 5:15 PM Nurse #2 heard a crying noise and she and another nurse (Nurse #1) went in room 606 (empty resident room). [Resident #100] was bent over near the closet and Resident #123 was sitting on a three tier drawer. [Resident #100] "leaned beside him between the drawer and closet." [Resident #100] had his left arm wrapped around [Resident #100's] neck. We pulled [Resident #123's] arm away from [Resident #100's] neck. [Resident #100's] helmet was on the floor in front of her. Another nurse stayed with [Resident #100]. "I stayed with [Resident #123]. [Resident #123] was visibly shaken." Resident #123 stated, "She stole my money." [Resident #123] walked and sat in a chair and slowly calmed down over ten minutes. "Nurse Aide walked Resident #123 to his room. 1:1 monitoring continues."

During an interview on 9/4/24 at 3:55 PM, Nurse #2 indicated on 8/1/24 at 5:15 PM she heard a crying noise and, together with Nurse #1, entered an empty resident room and found Resident #123

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sitting on a small container, with his left hand around Resident 100's neck and the right hand on her shoulder. Resident #100 was in front of him leaning forward and crying. They separated the residents and assessed both residents. Resident #123 did not have skin issues and stated he tried to get back his motorcycle. Resident #100 had some redness on her cheeks and petechiae (tiny spots of bleeding under the skin) on the front part of her neck. Resident #100 remained near the nurses' station and stopped crying in ten minutes. The resident did not say anything after the incident. Nurse #2 stated when she asked Resident #123 what he was doing, the resident replied he tried to "take his motorcycle to the house."

On 9/16/24 at 9:20 AM, during the phone interview, Nurse #2 indicated that on 8/1/24, she observed Resident #123 was sitting and Resident #100 was staying, bending forward. Resident 123's left arm was around Resident 100's neck, his right arm reached his left arm. Resident #100 was crying, and her face was purplish. Nurses pulled Resident 123's arms away from Resident 100's neck. Nurse #1 took Resident #100 to the nurses' station and Nurse #2 remained with Resident #123. Nurse #2 mentioned that prior to the incident, both residents were at the baseline behavior, walked on the hallway and did not have signs of possible behavior escalation.
Review of the Medication Administration Records (MAR) for August 2024 revealed Resident #123 received as needed Ativan 0.5 ml injection on 8/1/24 at 4:30 PM.

Nurse Aide #1's witness statement, dated 8/1/24, indicated about ten minutes after the incident on 8/1/24 she observed Resident #100 sitting at the

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nurses' station. The resident had a red face. Prior to the incident, Nurse Aide #1 provided incontinence care for Resident #100, and she did not show behavior issues. Approximately thirty minutes prior to the incident, Nurse Aide #1 observed Resident #123 was calm, walked on the hallway and talked about "White House and food" in pleasant happy mood.

During a phone interview on 9/5/24 at 4:00 PM Nurse Aide #1 indicated that on 8/1/24 she was assigned to Residents #123 and #100 on second shift. At 4:30 PM, she provided incontinence care for the Resident #100 and did not observe behavior problems. At approximately 5:00 PM, Nurse Aide #1 observed Resident #123 walking on the hallway, talking loudly, which was his routine behavior. Nurse Aide #1 did not witness the incident between Resident #123 and Resident #100, but right after the incident, she observed Resident #100 near the nurses' station with Nurse #1. Resident #100 did not cry, appeared calm and quiet.

Record review of the skin assessment completed by Nurse #1 on 8/1/24, indicated that Resident #100 had petechiae to the front of the neck and redness on her face.

Record review of the skin assessment, conducted by Nurse #2 on 8/1/24, indicated that Resident #123 had no skin issues.

The Assistant Director of Nursing's (ADON) witness statement dated 8/1/24 indicated that after the incident, when she asked Resident #100 if anyone hurt you, the resident replied "No".

Record review of Psychiatrist's visit dated 8/5/24,

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revealed that Resident #123 was referred for dementia and aggressive physical behavior. He had a history of disturbing behavior and was oriented in person only during the assessment. After consulting with staff and nursing managers, a collaborative decision had been made to increase the dosage of psychotropic medications to reduce agitation and combativeness toward staff and other residents.

Record review of Psychiatrist's visit, dated 8/5/24, revealed that Resident #100 appeared in no acute distress, with delusional ideations and no new psychiatric complaints. She was compliant with current psychotropic treatment and psychotherapy.

On 9/4/24 at 9:15 AM, a phone interview with the Psychiatrist revealed he was aware of the incident between Resident #123 and #100 on 8/1/24. Both residents were diagnosed with psychiatric diseases, received psychotropic medications and psychiatric service. They tolerated it well. The Psychiatrist visited Resident #123 and #100 on 8/5/24. He continued that the staff handled the incident very well, provided 1 on 1 monitoring, redirection, notification and medications. The Psychiatrist stated he adjusted the psychotropic medication regimen for Resident #123, and there were no behavior related issues reported so far. Resident #100 also received close monitoring, was a fall risk and used the helmet for fall precautions. The interview further revealed both residents received appropriate care in the locked unit, which was discussed with the nursing management and resident's family.

Record review of the Investigation Report, dated 8/7/24, indicated that on 8/1/24 at 5:15 PM,

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Resident #123 was observed by the nurses sitting on the three tier drawers in an empty resident room and had his arms on Resident 100's shoulders, around her neck, while she was standing, leaning forward in front of him. Resident # 100 was crying. Upon assessment, she had a reddened area on her cheek and front part of the neck. The report recorded that both residents were separated and the Medical Director, Responsible Party, Law Enforcement and Adult Protective Services (APS), were notified of the incident.

On 9/3/24 at 2:05 PM, during the observation/interview, Resident #100 was sitting in her room and watching TV. She had a helmet on her head. The resident did not recall the incident.

On 9/3/24 at 2:25 AM, during the observation/interview, Resident #123 was in his room. He was calm and did not answer questions. There were no staff members in his room.

On 9/4/24 at 2:15 PM, during an interview, the Medical Director indicated that he was aware of the incident between Residents #123 and #100 in the locked memory unit on 8/1/24. Both residents had diagnoses of Alzheimer's disease and dementia with severely impaired cognition and received psychotropic medications. Both residents were followed by mental health services for a history of behavior, and when this occurred, were referred for psychiatric services. After the incident, Resident #123 received psychiatric consultation in the facility with effective adjustment of the psychotropic medication regimen. The nursing staff gradually replaced the

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1:1 monitoring with 15-minute visual checks. The facility put ongoing monitoring into place for both residents and Resident #100's responsible party agreed with the current plan of care and treatment. The Medical Director stated that the facility had a responsibility to protect all residents in the facility and due to the facility's high-risk population of residents with a mental health/behavior history, that made managing behaviors difficult. The administration and nursing staff met the mental health needs of the residents by making mental health services readily available. On 8/27/24, Resident #123 became verbally, physically aggressive toward staff and was sent to the psychiatric hospital. Upon return from the hospital, the resident remained calm, quiet and did not require 1:1 monitoring.

On 9/5/24 at 4:35 PM, during an interview, the Director of Nursing (DON) indicated staff reported to her on 8/1/24 that Resident #123 had his arms around the Resident #100's neck and shoulders, which resulted in Resident #100's redness on her cheeks and petechia on the neck. Resident #123 did not have injuries. Both residents were diagnosed with psychiatric diseases, received psychotropic medications and psychiatric services. The residents were separated immediately, and Resident #123 was placed on 1:1 monitoring. He received a psychiatric evaluation and medication treatment adjustment. The staff received education on resident-to-resident abuse and the behavior tool audit was conducted for other residents. Both residents returned to the baseline within a few hours after the incident, could not recall the incident, and Resident 100's skin was normal in a few days. DON discussed the incident with Resident #100's responsible party, who

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verbalized understanding and appreciated the interventions.

The DON was notified of immediate jeopardy on 9/16/24 at 10:18 AM.

The facility implemented the following Corrective Action Plan with a completion date of 8/5/24.

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

Resident #123 is alert but not oriented to person and place with a Brief Interview for Mental Status (BIMs) of 1. Diagnoses include Alzheimer's dementia, post-traumatic stress disorder, recurrent major depressive disorder, anxiety, conduct disorder, and adjustment disorder. Resident #100 is alert but not oriented to person and place with a BIMs of 2. Diagnoses include severe dementia and bipolar disorder. Both residents reside in the memory care unit. On 8/1/24 at 5:00 pm, after hearing crying, memory care Nurse #1 and Nurse #2 walked into a room not belonging to the involved residents and observed Resident #123 sitting on a black container in front of the closet, with his left arm around Resident #100 face and neck and his right arm was wrapped around his left arm. Nurse #1 guided Resident #123's arm from Resident #100 neck and separated the two residents. Nurse #2 remained with Resident #123, who was placed on 1:1 monitoring immediately after the incident. Resident #100 was assessed immediately by memory care Nurse #1 and noted to be crying, and her face was blue. Additionally, Nurse #1 observed petechia (pinpoint, round spots that form on the skin, caused by bleeding, which

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makes the spots look red, brown or purple) on Resident #100 face and cheeks. Resident #100 was taken to the nurses' station and placed on 15-minute checks by Nurse #1. Approximately 5 minutes later, Resident #100 had calmed down and was noted to be no longer crying by Nurse #1 and Nursing Assistant (NA) #1. Resident #123 stated that he reached out to get his motorcycle and was trying to make it back from his house. Resident #100 could not verbalize what happened during the incident due to impaired cognition. Nurse #1 administered Ativan 0.5 milligrams (mg) Intramuscular to Resident #123. The Assistant Director of Nursing and Unit Manager notified the physician and resident representatives of the incident. Resident #100 had no long term affects from the incident. Resident #100 remained on every 15-minute checks for 24 hours after the event with no negative findings observed. On 8/2/24, the Social Worker completed a wellness visit with resident #100 with no negative findings. On 8/5/24, Resident #100 was seen by the psych Nurse Practitioner with no new orders.

On 8/16/24, after review of the resident's behaviors in the Interdisciplinary meeting, the interdisciplinary team (Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Social Worker, Activities Director, Minimum Data Set Nurses, and Therapy) made the decision to decrease Resident #123's supervision to 15-minute checks every 1st and 3rd shifts and remain on 1:1 on 2nd shift. On 8/19/24, Resident #123 was seen by psych services with no new orders. On 8/22/24, another review of Resident #123 behavior was completed by the Interdisciplinary team (Administrator, Director of Nursing, Assistant Director of Nursing,

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Unit Managers, Social Worker, Activities Director, Minimum Data Set Nurses, and Therapy). The resident had not had any further behaviors, therefore the interdisciplinary team decided to decrease Resident #123 supervision to every 15-minute checks on all shifts. On 8/27/24, Resident #123 was admitted to a behavior health treatment center per the Nurse Practitioner's orders related to combativeness with staff. The resident representative, who was on site at the facility, was notified and in agreement of Resident #123 being transferred to the behavior health treatment center. The resident's psych medications were adjusted during the stay. On 8/30/24, upon return to the facility, the every 15-minute checks for Resident #123 were removed.

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

On 8/1/24, skin assessments were completed on all residents in the memory care unit for signs and symptoms of abuse by the Unit Manager with no negative findings. No residents in the memory care unit are alert and oriented for interview.

On 8/2/24, 100% of resident's progress notes and behavior alerts in the electronic records were audited by the Assistant Director of Nursing (ADON) to identify any behaviors that occurred in the last 14 days to ensure interventions were in place to prevent escalation of behaviors that may lead to resident to resident altercations/abuse and to ensure the behaviors and interventions were addressed on the resident's care plan. The audit was completed on 8/2/24. No concerns were identified during the audit.

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On 8/2/24, the ADON reviewed incident reports related to resident to resident altercations for the past 30 days to identify patterns and trends. No trends were identified during the audit.

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

On 8/2/24, an in-service was initiated by the Assistant Director of Nursing (ADON) with all facility staff regarding recognizing and de-escalating resident behaviors that may lead to resident to resident altercations. The facility does not utilize agency staff. The in-service emphasized the implementation of early interventions to address behaviors and reporting behaviors to prevent escalation of behaviors that may lead to resident-to-resident altercation/abuse. The in-service was completed with all staff that worked for the period of 8/2/24 through 8/4/24. After 8/4/24, the Assistant Director of Nursing monitored staff completion, and any staff that had not worked and had not completed the in-service would complete the in-service prior to taking an assignment on their next scheduled shift. All newly hired staff will be educated during orientation by the Nurse Managers regarding de-escalating resident behaviors/prevention of resident to resident altercation/abuse. The Administrator discussed this responsibility with the Nurse Managers on 8/2/24.

How will the facility monitor its corrective actions to ensure the deficient practice will not recur?

On 8/1/24, a Performance Improvement Plan was

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developed for prevention of resident to resident altercations/abuse and approved by the Quality Assurance Performance Improvement team (QAPI).
The Unit Managers will review progress notes and behavior alerts 3 times per week x 8 weeks then monthly x 1 month to identify residents with behaviors utilizing the Behavior Audit Tool This audit is to ensure all behaviors are being addressed with an early intervention, physician and resident representative notification, and addressed on the care plan to prevent escalation of behaviors that may lead to resident-to-resident altercations/abuse. The Unit Manager will address all concerns identified during the audit.
The Director of Nursing or Assistant Director of Nursing will review the Behavior Audit Tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were addressed appropriately.

The Administrator or Director of Nursing will present the findings of the Behaviors Audit Tools to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months to review and to determine trends and/or issues that may need further interventions and the need for additional monitoring. On 8/1/24, the prevention of resident to resident altercations/abuse was taken to QA by the Administrator.

The Corrective Action plan was validated onsite on 9/18/24 when staff interviews revealed they had recently received education on Abuse, including "Recognizing and De-escalating Resident Behaviors that Lead to Resident to Resident Altercations". In-service reports and sign-in sheets were used to verify this information. Skin Assessments on all residents in

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F 600	Continued From page 16 the Dementia Unit were completed and reviewed with no new skin issues found. Behavior Audit tools were completed by the Unit Managers and reviewed by the Interdisciplinary Team (IDT), daily. Resident #123's behavioral monitoring was discussed daily from 8/5/24 through 8/27/24. The facility's completion date of 8/5/24 for the Plan of Correction was validated on 9/18/24	F 600		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and family member and staff interviews, the facility failed to provide foot care and arrange podiatry services for 1 of 3 dependent residents reviewed for foot care. Resident #127 was discovered to have long and curled toenails on both feet growing into the next toe which extended 1.5 inches beyond the base of the nail. The findings included: Resident #127 was admitted on 4/27/24 with the	F 687	The facility failed to provide foot care and arrange podiatry services for 1 of 3 dependent residents reviewed for foot care. Resident #127 was seen by the podiatrist on 09/17/2024 and again on 09/23/2024. The podiatrist addressed resident's care needs and toenails were trimmed. The licensed nursing home administrator will ensure that the plan of correction has been implemented and followed. On 09/06/24, a 100% resident audit was	10/11/24

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F 687	Continued From page 17 diagnoses included cognitive impairment and dementia. The admission Minimum Data Set (MDS) dated 4//24 coded Resident #127 as having severe cognitive impairment and she needed assistance with activities of daily living. A care plan focus area dated 8/8/24 revealed Resident #127 was at risk for skin breakdown or development of pressure ulcers related to: Incontinent episodes, Impaired cognition, Inattention, disorganized thinking, pain, and dementia. The goal included the resident would not develop a pressure ulcer. Activities of Daily Living/Personal Care would be completed with staff support as appropriate to maintain or achieve highest practical level of functioning. The interventions included staff would Inspect Resident #127's skin and notify nurse of abnormal changes per facility protocol. Lubricate skin with moisturizing lotion. If a heavier moisturizer was needed, use a skin cream. Allow for flexibility in care routine to accommodate resident's mood. The podiatry order dated 4/29/24 revealed a request for a podiatry consult next in-house visit to address thick, overgrown toenails. Review of the podiatry schedule from April 2024 and July 2024; revealed no consultation report or notation was made in Resident #127's chart that she had been seen by the podiatrist or had been scheduled to be seen. Review of Resident #127's skin assessments done by nursing on the following dates 4/29/24, 4/30/24, 5/10/24, 5/19/24, 5/27/24, 6/4/24,	F 687	completed by the Director of Nursing and the Unit Mangers for all in-house residents to assess all resident's feet for the need for podiatry services. Physician orders for podiatry services were obtained as needed by licensed nurses and consult orders were written by the Medical Director and the Nurse Practitioner based on findings determined during this audit. Beginning on 10/2/24, the facility licensed nurses will ensure all new admissions receive a skin assessment upon admission, to include resident's feet and toenails. The facility licensed nurses will complete a weekly skin assessment for all residents that will include condition of feet and toenails. The Director of Nursing, Assistant Director of Nursing and Unit Managers will address all concerns identified during the assessments to include notification of Medical Director, Nurse Practitioner for possible consults for podiatry services. On 10/01/24, the Director of Nursing initiated an in-service for all facility licensed nurses on conducting skin assessments to include the condition of resident's feet and toenails. After 10/01/24, any facility licensed nurses who have not received the in-service will be in-serviced prior to beginning their next scheduled work shift. All newly hired facility licensed nurses will be in-serviced during orientation regarding skin assessments, to include the condition of the resident's feet and toenails and to report the findings to the Medical Director or Nurse Practitioner. On 10/04/24, The Director of Nursing	

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F 687	Continued From page 18 6/13,24, 6/21/24, 6/25/24, 6/28/24, 7/1/24, 7/8/24, 7/16/24, 7/30/24, 8/2/24, 8/7/24, 8/14/24, 8/21/24, 8/28/24and 9/4/24, revealed there was no information documented on the assessment about the condition of Resident #127's toenails or feet. An observation was conducted on 9/03/24 at 11:10 AM, Resident #127 was sitting in room (wheelchair) and the toenails on left foot(big toe) 1 1/2 inches from the nail bed(black, toenail scrapping the floor. The right foot(big toe and 3rd and pink toe, long thick, black nail bed, scraping the floor. Resident unable to discuss the condition of her feet. The toenails on both feet were observed to have visible thick layers of what appeared to be dirt and thick layers of skin between the toes, and thick, calcified, dry patches on the bottoms of her feet. The toenails were observed to be curled over each toe on both feet and were about 1.5 inches in length from the base of the nail, very thick, with jagged edges, and the toenails had grown long enough to be in contact with the adjacent toes. The bottoms and back of her feet were observed to have thick, scaly, dry skin, and hard brown patches. An interview was conducted on 9/3/24 at 3:13 PM, with the family member who stated she requested a podiatry consult and the time of admission in April and was told the podiatrist visited the facility every three months and Resident #127 would be added to the list. She further stated a follow-up request for a podiatry consult was made in July and she had not received a response as of this date. She stated she was appalled that staff were not cleaning the toenails and had not made the referral.	F 687	initiated an in-service on nail care that can be provided by a certified nursing assistant when needed and the need to notify nursing when the nail care cannot be completed by the CNA. After 10/04/24, any certified nursing assistants that have not received the education will be in-serviced prior to beginning their next scheduled shift. All newly hired certified nursing assistants will be in-serviced during orientation regarding nail care and reporting of care concerns with feet and nails to include the nursing staff. Beginning 10/2/24, The Director of Nursing, Assistant Director of Nursing and Unit Managers will monitor 15 skin assessments weekly for 4 weeks during Cardinal IDT to ensure that skin assessments include the visualization of toenails and feet for care needs. All audits will be taken to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. IDT team will determine at that time the need for continued monitoring. Date of alleged compliance: 10/11/24	

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An interview was conducted on 9/5/24 at 10:30 AM, with Nurse Aide #4 stated she had worked with Resident # on a regular basis and the toenails had been in the current condition for several months.
Nurse Aide #4 stated the condition of the toenails had been reported to nursing, but she was uncertain when the podiatry appointment had been scheduled. She was not specific how many times it had been reported to the charge nurse.

A follow-up observation was conducted on 9/5/24 at 10:37 AM, Resident #127 was seated in the small front dining room. Resident #127 had one sock off and there was no change of condition of Resident #127's foot care.

An observation was conducted on 9/5/24 at 10:38 AM, with Nurse #3 who removed the sock for Resident #127 and confirmed the condition of the toenails on the left foot. The big toenail was curling under the toe, pinky toe extended beyond the nail bed, right foot, big toe, 3rd and 4th toenail curled underneath the foot. The skin on both feet and between toes were dry, scaly with calcification. Nurse # 3 stated per the physician order dated 4/29/24 a referral should have already been completed. She stated the resident came to the current unit at the end of July and should have been placed on the podiatry list for July. Nurse #3 reported she spoke with the social work department the 1st week of August.

An interview was conducted on 9/5/24 at 11:26 AM, with Nurse#3 and Nurse #9 who stated Resident #127 came to the unit the end of July. Both Nurses stated the resident's toenails were in this condition when Resident #127 transferred to the secured unit and several calls were made to

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the social workers because the resident would need an outside service to cut the toenails due to the thickness and overgrown toenails. The resident would also benefit from a calming medication prior to treatment due to physical aggressive behaviors. Both nurses felt the toenails were not something that could be done by in-house podiatry and a request was sent to the Social Workers on 8/7/24. The Nurse# 9 stated the resident should have been seen when the order was initially submitted.

An interview was conducted on 9/6/24 at 9:38-10:42 AM, with Unit Manager #1 and Social Work Director in conjunction with a record review revealed the physician order for a podiatry consult was ordered 4/29/24 and had not been completed. The Unit Manager confirmed when Resident #127 was admitted she was on another unit and the resident's toenails were in poor condition. The Unit Manager reported she tried to cut the toenails herself from time to time. The Unit Manager #1 reviewed the weekly skin assessment form, and it did not document the condition of the resident's feet or toenails. She explained that unless there was an impairment documented, the form does not advance to document any other condition. The Unit Manager #1 stated if a skin impairment was checked then the full body diagram would come up and nursing would then document what they observed. The Unit Manager #1 confirmed a complete assessment of head-to-toe findings would include the condition of a resident's feet and/or need for podiatry services. The Social Worker Director stated she was not aware of the order written on 4/29/24. She stated Resident #127 was not scheduled for the July visit because the list was full, and she did not recall when she was notified

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F 687	Continued From page 21 the resident should to be seen. An interview was conducted on 9/6/24 at 12:10 PM with Nurse Aide #6 who stated Resident #127's toenails were thick and overgrown since admission. He reported to nursing several times that the resident needed to be seen by podiatry because the aides were unable to cut the toenails during care and nothing was done. An interview was conducted on 9/6/24 at 12:12 PM, with the Director of Nursing who stated the podiatrist was scheduled every 3 months and it was expected that any residents who needed podiatry service be added to the schedule. She said the Nurse Aides were responsible for reporting to nursing when resident's toenails were extremely long or sharp, and/or needed podiatry trim/cut the nails. The Director of Nursing further stated the Nurses were responsible for completing the weekly full body assessments which would include the condition of resident's toenails. The nurses would document if they had cut/trim toenails and/or the resident was referred for podiatry services. The Nurses would let the Social Workers know which residents needed to be referred to the podiatrist. The Director of Nursing added the Nurses were authorized to cut/trim toenails for residents who did not need podiatry services.	F 687		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		10/11/24

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F 695	Continued From page 22 care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to post cautionary signage outside the resident's room to indicate supplemental oxygen (O2) was in use for 7 of 7 residents reviewed for respiratory care (Resident #109; Resident #79; Resident #114; Resident #70; Resident #51; Resident #343; and Resident #32). The findings included: The facility's policy on Oxygen Therapy (Reviewed Date 4/15/24) indicated its objective was, "To administer oxygen in conditions in which insufficient oxygen is carried by the blood to the tissues." The procedures specified in this policy included #2 (of 7) which read, "Place sign "Oxygen is use" [typed in capital letters] outside the room of the resident." 1-a. Resident #109 was admitted on 05/23/24 with a diagnosis of chronic obstructive pulmonary disease. Review of Resident #109's physician order for September 2024 revealed an order for continuous oxygen to maintain oxygen levels greater than 90%. Review of the quarterly Minimum Data Set (MDS) dated 07/03/24 indicated Resident #109 had severe cognitive impairment and coded for the use of oxygen.	F 695	The facility failed to post oxygen in use signage outside the resident's room to indicate supplement oxygen was in use for 7 of 7 residents reviewed for respiratory care. The licensed nursing home administrator will ensure that the plan of correction has been implemented and followed. The Director of Nursing and the Unit Manager placed oxygen in use signage on the door entering the room for residents #109, #79, #114, #70, #51, #343, #32 identified on 09/05/2024. On 09/05/24, The Director of Nursing and the Unit Managers completed a 100% audit of all facility residents who were on oxygen to ensure oxygen in use signage was placed outside the resident's room where oxygen therapy was currently in use by a resident or present in the room for resident use. On 10/1/24, the Director of Nursing initiated an in-service with all licensed nurses and nursing assistants on the use of precaution signs for residents in use of oxygen therapy that included the use of appropriate signage outside of the resident's room. After 10/01/24, any licensed nurses or nursing assistants who has not received the in-service will be in-serviced prior to next scheduled work shift. All newly hired licensed nurses or nursing assistants, agency will be	

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F 695	Continued From page 23 During an observation on 09/03/24 at 1:38 PM of Resident #109's room, there was no signage for oxygen use found anywhere near Resident #109's room entrance. Resident #109 was observed wearing oxygen via nasal cannula at 2 liters per minute (LPM). During an observation on 09/04/24 at 10:00 AM there was no signage for oxygen use found anywhere near entrance of Resident #109's room. During an observation on 09/05/24 at 3:45 PM there was no signage for oxygen use found anywhere near entrance of Resident #109's room. 1-b. Resident #79 was admitted on 01/05/23 with diagnoses of chronic obstructive pulmonary disease and atrial fibrillation. Review of Resident #79's physician order for September 2024 revealed an order for continuous oxygen to maintain oxygen levels greater than 90%. Review of the annual MDS dated 07/11/24 indicated Resident #79 had severe cognitive impairment and coded for the use of oxygen. During an observation on 09/03/24 at 12:38 PM of Resident #79's room, there was no signage for oxygen use found anywhere near Resident #109's room entrance. Resident #109 was observed wearing oxygen via nasal cannula at 2 liters per minute (LPM). During an observation on 09/04/24 at 10:10 AM	F 695	in-serviced during orientation regarding the use of oxygen therapy and required signage outside of the resident's door. On 10/4/24, the Unit Managers will begin auditing 10 residents receiving oxygen therapy for appropriate signage outside of the resident rooms weekly for 4 weeks. The Director of Nursing, Assistant Director of Nursing and Unit Managers will address all concerns identified during the audit to include additional education of licensed nurses or nursing assistants. All audits will be taken to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. IDT team will determine at that time the need for continued monitoring. Date of alleged compliance: 10/11/24	

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there was no signage for oxygen use found anywhere near entrance of Resident #79's room.

During an observation on 09/05/24 at 3:50 PM there was no signage for oxygen use found anywhere near entrance of Resident #79's room.

1-c. Resident #114 was admitted on 01/05/23 with diagnoses of chronic obstructive pulmonary disease and respiratory failure.

Review of Resident #114's physician order for September 2024 revealed an order for continuous oxygen to maintain oxygen levels greater than 90%.

Review of the quarterly MDS dated 08/01/24 indicated Resident #114 had cognitively intact and coded for the use of oxygen.

During an observation on 09/03/24 at 12:21 PM of Resident #114's room, there was no signage for oxygen use found anywhere near Resident #114's room entrance. Resident #114 was observed wearing oxygen via nasal cannula at 2 liters per minute (LPM).

During an observation on 09/04/24 at 10:15 AM there was no signage for oxygen use found anywhere near entrance of Resident #114's room.

During an observation on 09/05/24 at 3:50 PM there was no signage for oxygen use found anywhere near entrance of Resident #114's room.

1-d. Resident #70 was admitted on 05/27/24 with a diagnosis of respiratory failure.

Review of Resident #70's physician order for

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September 2024 revealed an order for continuous oxygen to maintain oxygen levels greater than 90%.

Review of the quarterly Minimum Data Set (MDS) dated 08/12/24 indicated Resident #70 had cognitively intact and coded for the use of oxygen.

During an observation on 09/03/24 at 1:04 PM of Resident #70's room, there was no signage for oxygen use found anywhere near Resident #70's room entrance. Resident #70 was observed wearing oxygen via nasal cannula at 2 liters per minute (LPM).

During an observation on 09/04/24 at 10:22 AM there was no signage for oxygen use found anywhere near entrance of Resident #70's room.

During an observation on 09/05/24 at 3:55 PM there was no signage for oxygen use found anywhere near entrance of Resident #70's room.

1-e. Resident #51 was readmitted to the facility on 8/8/24 with diagnoses that included acute congestive heart failure, acute and chronic respiratory failure with hypercapnia (a condition of abnormally elevated carbon dioxide levels in the blood.), chronic obstructive pulmonary disease with (acute) exacerbation and acute and chronic respiratory failure with hypoxia.

Review of the recent significant change MDS Assessment dated 8/12/24 indicated the resident was admitted to the facility on 5/20/22 and was assessed as cognitively intact. Assessment indicated the resident received respiratory therapy with supplemental oxygen and was

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hospice care.

Review of Resident #51's physician's orders dated 8/12/24 indicated oxygen flow to be provided at 3 liters per minute (LPM) via nasal cannula and to keep oxygen saturation level greater than 90 percent (%) every hour. Oxygen saturation to be checked each shift.

Resident #51 was care planned (dated 8/25/24) for potential for ineffective breathing pattern due to respiratory failure, congestive heart failure and chronic obstructive pulmonary disease. Interventions included providing oxygen via nasal cannula as prescribed.

During an observation and interview on 9/3/24 at 1:00 PM, Resident #51 was observed in bed with supplemental oxygen provided via nasal cannula by an oxygen concentrator placed next to the bed. Resident #51 indicated he received continuous oxygen. Observation revealed there was no oxygen signage posted on the resident's door or anywhere near the entry to Resident #51's room indicating oxygen was in use.

On 9/4/24 at 10:30 AM, Resident #51 was observed lying in his bed and watching TV. The resident was receiving supplemental oxygen provided via nasal cannula by the oxygen concentrator placed next to the bed. No signage was observed placed on the resident's room doorway or inside the room indicating oxygen was in use.

Observation on 9/5/24 at 11:23 AM and at 12:39 PM revealed Resident #51 was lying in bed. Resident #51 was receiving supplemental oxygen via nasal cannula. The oxygen concentrator was

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observed to be running beside his bed. No cautionary signage was placed on the resident's door or near the entrance to the room indicating oxygen was in use.

During an interview on 9/5/24 at 1:21 PM, Nurse #5 stated she was assigned to Resident #51 and worked the first shift (7 AM - 3 PM). Nurse #5 indicated the resident had diagnoses of chronic obstructive pulmonary disease and was on continuous oxygen via nasal cannula at 3 Liters/minute. She stated the resident's oxygen saturation was checked every hour to ensure it did not drop. Nurse #5 further stated Resident #51 was non-compliant with his medication and oxygen therapy. The resident was alert and oriented and aware of the need for continuous oxygen. Nurse #5 indicated she was unsure why there was no cautionary signage for supplemental oxygen placed upon entry to each resident's room to indicate oxygen was in use. Nurse #5 further indicated that the Unit Manager was responsible for placing the signage on the door.

During an interview on 9/5/24 at 3:24 PM, Nurse #7 indicated she was assigned to the resident and worked the second shift (3 PM - 11 PM). Nurse #7 further stated Resident #51 was on continuous oxygen running at 3 Liters/ minute. She indicated the resident at times was non-compliant oxygen therapy and would remove the tubing from his nose. The resident's oxygen saturation was checked hourly to ensure it was above 90%. Nurse #7 indicated she had not noticed the signage not on the door. She stated the assigned nurse, or the Unit Manager were responsible to place the "oxygen in use" signage on the door when any resident was admitted with oxygen or received an order for oxygen therapy.

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The Nurse indicated she would notify the Assistant Director of Nursing (ADON) or Unit Manager about not having a signage on the resident's door.

1-f. Resident #343 was readmitted to the facility on 8/16/24 with diagnoses that included dementia with agitation, pneumonia, acute respiratory failure with hypoxia and congestive heart failure.

Review of the recent significant change MDS Assessment dated 7/5/24 indicated the resident was admitted to the facility on 5/17/24 and was assessed as severely cognitively impaired. Assessment indicated the resident did not received respiratory therapy with supplemental oxygen.

Review of Resident #343's physician's orders dated 8/16/24 indicated oxygen flow to be provided at 2 liters per minute (LPM) via nasal cannula. Oxygen saturation level to be kept greater than 90 percent (%) every hour due to congestive heart failure.

Review of the recent significant change MDS Assessment dated 8/28/24 indicated the assessment was in progress.

Resident #343 was care planned (reviewed date 8/28/24) for potential for ineffective breathing pattern related to heart failure. Interventions included providing oxygen therapy 2 Liters/ minute via nasal cannula as ordered by the physician.

During an observation and interview on 9/3/24 at 12:50 PM, Resident #343 was observed sleeping in his bed with supplemental oxygen provided via

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nasal cannula by an oxygen concentrator placed next to the bed. Observation revealed there was no oxygen signage posted on the resident's door or anywhere near the entry to the room indicating oxygen was in use.

On 9/4/24 at 10:30 AM, Resident #343 was observed sleeping in his bed. The resident was receiving supplemental oxygen provided via nasal cannula by the oxygen concentrator placed next to the bed. No signage was observed placed on the resident's room doorway or near the entrance of the room indicating oxygen was in use.

Observation on 9/5/24 at 11:23 AM revealed Resident #343 was lying in bed. The resident was receiving supplemental oxygen via nasal cannula. The oxygen concentrator was observed to be running beside his bed. No cautionary signage was placed on the resident's door or near the entrance to the room indicating oxygen was in use.

During an interview on 9/5/24 at 1:21 PM, Nurse #5 stated she was assigned to Resident #343 and worked the first shift (7 AM - 3 PM). Nurse #5 indicated the resident had diagnoses of Pneumonia and was on continuous oxygen via nasal cannula at 2 Liters/minute. Nurse #5 further stated Resident #343 was non-compliant, would pull out his oxygen tubing and was closely monitored. Nurse #5 indicated she was unsure why there was no cautionary signage for supplemental oxygen placed upon entry to each resident's room to indicate oxygen was in use. Nurse #5 further indicated that the Unit Manager was responsible for placing the signage on the door.

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1-g. Resident #32 was admitted to the facility on 10/11/23 with reentry from a hospital on 11/8/23. Her cumulative diagnoses included chronic obstructive pulmonary disease (COPD) with dependence on supplemental oxygen.

The resident's current physician's orders included an order (dated 2/20/24) for supplemental oxygen to be provided at 4 liters per minute (LPM) via nasal cannula to keep her oxygen saturation level greater than 90 percent (%).

Resident #32's most recent Minimum Data Set (MDS) was a significant change in status assessment dated 6/5/24. The MDS assessment reported the resident had severely impaired cognitive status. Her MDS assessment indicated the resident received respiratory therapy with supplemental oxygen.

Resident #32's comprehensive care plan (last reviewed/revised on 8/8/24) included an area of focus related to her potential for / or actual ineffective breathing pattern due to her diagnoses (Date Initiated 10/12/23; Revised on 6/18/24). The interventions for this area of care included the provision of oxygen therapy at 4 LPM via nasal cannula as ordered (Date Initiated: 10/12/23; Revised on: 11/9/23).

An observation was conducted on 9/3/24 at 12:25 PM as Resident #32 was asleep in her bed with supplemental oxygen provided via nasal cannula by an oxygen concentrator placed next to her bed. There was no signage placed on the resident's door or anywhere near the entry to Resident #32's room to indicate oxygen was in use.

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On 9/4/24 at 3:52 PM, Resident #32 was again observed to be lying in her bed. The oxygen concentrator placed next to her bed was powered on, but the nasal cannula was observed to be lying on the resident's pillow above her head as she laid on the bed. No signage was placed on the resident's door or upon entry to the room to designate oxygen was in use.

Another observation was conducted on 9/5/24 at 8:50 AM as Resident #32 was sitting on the side of her bed eating her breakfast. The resident had her nasal cannula in place and the oxygen concentrator was observed to be running. There was no cautionary signage placed on the resident's door or near the entrance to her room to indicate the supplemental oxygen was in use.

An interview was conducted on 9/5/24 at 3:35 PM with the Nurse #6. Nurse #6 was identified as the hall nurse assigned to care for Resident #32. When asked how staff and/or visitors would be alerted to supplemental oxygen being in use for a resident in his/her room, she stated any changes on use of oxygen would be shared in report and would also be on the resident's Medication Administration Record. Nurse #6 stated as long as she had been working at the facility (the past 9 months), there had not been any cautionary signage for supplemental oxygen placed upon entry to each resident's room to indicate oxygen was in use. When asked who she thought may be responsible for placing signage of oxygen use on a residents' door, the nurse reported she thought it may be the Unit Manager.

During an interview on 9/5/24 at 3:40 PM, the Unit Manager for the 200 and 400 halls indicated she had been working at the facility for the past 4

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F 695	Continued From page 32 years and has not been placing any "oxygen in use" signage on the residents' doors. The Unit Manager stated the facility had not been using the signage on the door for any residents using supplemental oxygen for a long time. The Unit Manager reported she thought the Assistant Director of Nursing (ADON), or the admitting nurse was responsible for placing this signage on the door when a resident used supplemental oxygen. An interview was conducted on 9/5/24 at 4:01 PM with the facility's Director of Nursing (DON). During the interview, the DON reported sometime after the facility's last annual recertification, the facility was informed they were no longer required to be using the "Oxygen in Use" signage at the entrance to each resident's room where supplemental oxygen was being used. The DON reported these signs were taken down and had not been used since that time.	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		10/11/24

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F 812	Continued From page 33 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to label and date food stored for use in a nourishment room refrigerator and freezers and failed to date opened nutritional supplements in 2 of 2 nourishment refrigerators reviewed for food storage (100 hallway and 500 hallway nourishment room). These practices had the potential to affect food served to residents. Findings included: a. On 9/3/24 at 9:55 AM, an observation of the nourishment room freezer (100 hallway nourishment room), revealed two opened 2.5-pounds (lbs.) bag of frozen smoothie mix. These bags were not labeled or dated. During an interview on 9/3/24 at 9:55 AM, the Dietary Manager stated she was unsure whom the bags belonged to. The Dietary Manager indicated all food placed in the nourishment refrigerator or freezer should be labeled and dated. The Dietary Manager on 9/3/24 at 12:25 PM, stated the frozen smoothie mix bags were placed in the freezer by the activity staff. The activity department was going to do an activity of making smoothies with the residents. During an interview on 9/4/24 at 3:50 PM, the Director of Nursing (DON) stated the bags of	F 812	The facility failed to label and date food stored for use in a nourishment room refrigerator and freezers and failed to date opened nutritional supplements in 2 of 2 nourishment refrigerators reviewed for food storage (100 hallway and 500 hallway nourishment room). The licensed nursing home administrator will ensure that the plan of correction has been implemented and followed. No specific residents were identified as having been affected. On 10/1/24, all facility residents have the potential to be affected. On 10/1/24, the Housekeeping Supervisor checked all nourishment room refrigerators/freezers to ensure that food items were appropriately labeled and dated. All concerns were identified were addressed immediately. On 10/1/24, the Director of Nursing initiated an in-service with all dietary, nurses and nursing assistants on the process to properly label the open date or use by date on food products placed in the nourishment room refrigerators. All in-services will be completed by 10/10/24. After 10/10/24, any dietary, licensed nurses and nursing assistants who has not received the in-service will be in-serviced prior to their next scheduled work shift. All newly hired dietary, licensed	

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F 812	Continued From page 34 frozen smoothie mix were placed in the freezer by the activity department. This was to be used for an activity with the residents. The DON stated all food should be labeled and dated prior to placing them in the nourishment refrigerator or freezer. b. On 9/3/24 at 10:00 AM, an observation of the nourishment room refrigerator (500 hallway nourishment room) revealed 2 insulated lunch bags and a brown paper lunch bag containing store bought pizza dinner box with no label. The refrigerator also contained an opened 16 fluid ounce soda bottle and opened 12 fluid ounce energy drink with no label. The refrigerator also contained two 32 fluid ounce nutritional supplements, that were opened. There was no label indicating the open date or use by date on them. Review of the manufacturer's recommendations for nutritional supplement Med Pass 2.0 read, in part "MED PASS products can safely remain on a medication cart as long as it is kept at refrigerated temperature range (34 - 40 degrees F). Cover, label and refrigerate opened containers of MED PASS products and discard after 4 days as long as the product has been kept at proper refrigerated temperature range. If product is not kept refrigerated, discard after 4 hours." Observation of the nourishment room freezer (500 hallway nourishment room) on 9/3/24 at 10:05 AM revealed an opened 1-liter soda bottle with blue colored frozen liquid and 3 boxes of frozen dinner boxes with no name or label on it. During an interview on 9/3/24 at 10:05 AM, the Dietary Manager stated she was unsure who had	F 812	nurses, or nursing assistants will be in-serviced during orientation regarding the process to properly label the open date or use by date on all food products placed in the nourishment room refrigerators. On 10/1/24, the Unit Manager will audit their assigned units nourishment room refrigerators 2 to 3 times per week for 4 weeks. The Director of Nursing, Assistant Director of Nursing, Assistant Director of Nursing and Unit Managers will address all concerns identified during the audit to include additional education of dietary, licensed nurses or nursing assistants. All audits will be taken to Quality Assurance Performance Improvement monthly x1 month and discussed with the Interdisciplinary team (IDT) members. IDT team will determine at that time the need for continued monitoring. Date of alleged compliance: 10/11/24	

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placed the insulated lunch boxes in the refrigerator. The Dietary Manager stated the nurses were responsible to label any food brought in by resident's family prior to be placed in the refrigerator. The nursing staff were also responsible to label opened nutritional supplement placed in the nourishment refrigerator.

During an interview on 9/4/24 at 3:50 PM, the Director of Nursing (DON) stated the 2 insulated lunch boxes were food brought in by resident's family members. The DON indicated that the nursing staff should label and date all foods brought in by resident's family members prior to placing them in the nourishment refrigerator. The DON further stated all nurses should label nutrition supplement when opened during medication administration with an open date. The nutritional supplements should be placed in the refrigerator after use and discarded within 24 hours of opening.

The DON was interviewed again on 9/6/24 at 4:28 PM. During interview with DON, she stated that the nourishment refrigerators were cleaned daily at 6:00 AM and food brought in by resident's family the previous day was discarded that morning. The food that was brought in by the family was stored in the nourishment refrigerators for less than 24 hours.