STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001 SS=C	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to have a comprehensive emergency preparedness(EP) plan for the Extended Care Unit. The EP manual failed to complete all staff training on the emergency preparedness program. The EP manual failed include the policy and procedures to address patient/client population residents and staff who remained in the facility, policy and procedures to track resident and staff who were moved to other facilities and policy and procedures for staff,	E 001	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency	9/27/18

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

Electronically Signed | 09/18/2018

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E 001	Continued From page 1 residents and others who remained in the facility during and emergency. The EP communication plan failed to include contact information of staff, pharmacy, resident, physicians, contact information of the State Licensing and Certification Agency and State Long Term Care Ombudsman. The EP communication plan failed to include procedures of sharing information and medical documentation of it resident with other health care providers that would be providing continuity of care and method of sharing information regarding facility needs and its ability to provide assistance for its occupancy to authorities having jurisdiction during an emergency. The EP communication plan failed to establish a procedure of sharing information and providing documents from its emergency plan to residents, family members or resident representatives. Findings included: 1.A. Review of the EP Manual revealed the facility had not completed or conducted the emergency training and drills for all staff on the Extended Care Unit or exercises with staff to test their EP plan. B. Review of the EP manual provided by the facility revealed no plan or procedure in place to track residents and staff on duty who remained in the facility during emergencies. The manual did not include any tracking system for resident and staff who left facility and were sheltered by other facilities. C. Review of the EP manual provided by the facility revealed the facility did not establish a criteria for its resident or staff who will be	E 001	cited; A comprehensive, all hazards, facility based emergency preparedness plan has been established for the Extended Care Unit. The plan includes the following components: Procedures to address residents, staff and others who stay in the facility during an emergency. Procedures to track residents and staff on duty who remain in facility during an emergency. Procedures to track residents and staff who are moved to other facilities during an emergency. Communication plan with contact information for staff, residents, pharmacy, physicians, state agency, and LTC ombudsman and other facilities. Procedures for sharing health records and information with other providers caring for our residents. Method of sharing occupancy, resident needs and facility ability to provide assistance to authorities having jurisdiction in an emergency. Procedure for sharing information providing documents from emergency plan to residents/representatives and families. Documentation as to how the facility□s emergency plan would be shared with its residents, family member and or resident representatives. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Current residents/representatives and	

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E 001	Continued From page 2 sheltered in the facility in case of emergency. The facility did not include a procedure for sheltering its staff, residents and others who remained in the facility in an event when evacuation could not be executed. D. Review of the EP manual provided by the facility revealed the communication plan did not include the names and contact information of all staff working in the facility, the names and contact information of resident ' s physicians, pharmacy services and contact information of other facilities including but not limited to its sister facilities that would be providing services and care to the resident during and emergency. E. Review of the EP manual provided by the facility revealed the communication plan did not include contact information of the North Caroling Nursing Home Licensure and Certification Agency and contact information of Long Term Care Ombudsman. F. Review of the EP manual provided by the facility revealed the communication plan did not include process and procedure as to how the facility would communicate and share information of its occupancy, residents needs and the facility ' s ability to provide assistance to authorities having jurisdiction or "the Incident Command Center" during an emergency situation. G. Review of the Communication Plan in the EP manual provided by the facility revealed no documentation as to how the facility ' s emergency plan would be shared with its residents, family members and/or resident representatives. During an interview on 8/30/18 at 3:00 PM, the	E 001	families were provided an informational letter explaining how the facility□s emergency plan would be shared with them in an emergency. All new residents will receive the informational letter regarding the emergency preparedness plan as part of the admission packet. Current ECU staff educated on the emergency preparedness program by the administrator or designee on or before 9/27/2018. ECU staff will receive training on the emergency preparedness plan upon hire, and annually. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; Administrator or designee will audit 25% of new employee files monthly x 3 months to ensure new staff members receive training on the emergency preparedness plan. The administrator (or designee) will report findings of the audits to the Quality Assurance Performance Improvement committee monthly x 3 months to determine need for continued auditing and/or education to ensure compliance. " The title of the person responsible for implementing the acceptable plan of correction; Administrator or designee.	

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E 001	Continued From page 3 Administrator reviewed the emergency preparedness manual and confirmed the emergency plan for the Extended Care Unit was incomplete. The Administrator also acknowledge the identified areas were missing and needed to be separated from the hospital base emergency preparedness program. The Administrator also acknowledged all staff had not completed the EP training.	E 001		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.	F 565		9/27/18

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F 565	Continued From page 4 §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews and staff interviews, the facility failed to resolve grievance that were reported in resident council meetings for 6 of 6 consecutive months. The findings included: During the resident council meeting 10 residents were identified as alert and oriented on 8/10/18 at 2:00 PM. The residents revealed an issue with the resolution of group grievances. The residents in the meeting reported not all grievances were acted upon promptly by the facility and there was no reasonable or satisfiable resolution for the group. The residents reported the on-going group concern included, staff not informing resident of the meal or the day or receive assistance with meal selection and not being offered or received snacks at bedtime. The residents added each month the discussion comes up about not being made aware of what the meal or the day or being offer/receiving snack and nothing seems to get down when the concern was brought to the attention of dietary and administrator. The residents further stated if management was in attendance of the meeting, things should be getting taken care of and they were not. Additional resident concerns included	F 565	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Current resident council grievances are being reviewed and appropriate actions taken by the department identified to address the concern within 3 business days. Actions taken and resolution will be discussed at the following resident council meeting, the next council meeting is scheduled for 9/26/18. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Current residents are at risk for the alleged deficient practice. The Activity Director will document in the monthly resident council minutes the review of concern forms from the previous month	

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F 565	Continued From page 5 the ambassador and the kitchen staff was not consistent with asking them to fill out the meal for the day. We sit and wait to see what is on the plate and had to ask for something else, then we had to wait even longer till it is brought up. If the staff were doing what they were supposed to do from the start there would not be a problem. We can ' t select the meal if we don ' t what ' s on the menu. Review of the menu board in the dining room only list the main meal of the day, there was no identified alternate options. During an interview on 8/29/18 at 3:10 PM, the Activities Director(AD) stated that she documented individual and group grievances and concerns on the concern form and gives them to the department heads She added that some department heads come to the meetings and hear what the residents discuss. The AD stated the on-going concerns for the group had been residents not being able to select their meal of the day and not getting snacks at night. AD reported several residents complained about not being informed and assisted with the meal of the day and waiting for a replacement meal. The dietary staff had been to several meeting and things have not changed for the residents. AD indicated she was uncertain what happens after the group grievance was submitted to the dept heads since they heard the information in the meetings. Review of resident council minutes dated 2/28/18, 3/28/18, 4/25/18, 5/30/18, 6/27/18 and 7/25/18, revealed several monthly food concerns that had not been resolved after review of the concern forms. The concern forms document what was expected to be done but had not been discussed	F 565	for resolution and/or need for further intervention. The Administrator (or designee), Director of Nursing (or designee), and dietary Manager (or designee) will request permission to rotate attendance to the resident council meeting monthly x 3 months and as needed thereafter. Outstanding concerns will be addressed with the group for global issues with actions taken and resolution by the appropriate department director at the following resident council meeting. Individual concerns will be addressed by the appropriate department director within 3 business days and documented on the concern form with actions taken and resolution discussed with the individual voicing the concern. The current staff were in-serviced by the Director of Nursing and/or Administrator regarding the concern/grievance policy and timely resolution of same. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Administrator (or designee) will review the resident council minutes and concerns submitted by the Activity Director monthly. Results of the review will be submitted to the Quality Assurance Performance Improvement committee monthly to determine the need for further monitoring and/or education to ensure compliance.	

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F 565	Continued From page 6 with the residents of the group or resolved the following month. During an interview on 8/30/18 at 8:00 AM, the Administrator stated the expectation was for group grievance to be responded to in a timely manner and appropriate follow-up should be provided to residents individually and collectively as a group by the next monthly meeting. During an interview on 8/30/18 at 12:10 PM, the Dietary Manager(DM) stated the expectation was for the kitchen staff to go to each resident and ask them what their meal choice for the day would be. The main course was posted in the main dining and there was no alternate posted, but hamburgers, hot dogs, sandwiches were available if residents ask. DM added that it was the kitchen staff responsibility to ensure that all resident meal selection sheets were done daily.	F 565	" The title of the person responsible for implementing the acceptable plan of correction; Administrator or designee.	
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to serve food in form ordered by the physician for 1 of 1 sampled resident (Resident # 37). The findings included: Resident #37 was admitted to the facility on	F 805	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.	9/27/18

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F 805	Continued From page 7 7/28/17. The diagnoses included Parkinson Disease, dysphagia, atrial fibrillation, ventricular fibrillation and hypertension. The annual Minimum Data Set(MDS) dated 7/30/18, indicated Resident #37 cognition was intact and she had no swallowing disorder. The assessment further indicated that Resident #37 required supervision for eating was on a chopped regular diet. Review of the Speech evaluation dated 11/28/17 indicated Resident #37 had history of dysphagia due to resident report of difficulty managing harder consistency. The diet was downgraded to mechanical soft chopped solids. Effective January 2018 the diet was upgraded to regular with chopped foods. Review of the diet order dated 12/8/17, revealed a regular diet, regular texture, regular consistency -with CUT UP FOODS - BITE SIZE PIECES, prune juice at breakfast diet coke lunch & dinner vanilla glucerna twice a day with breakfast and dinner. Review of the care plan dated 7/30/18, identified the problem as Resident #37 requested a regular diet. The goal included Resident #37 would tolerate the prescribed diet and have no significant and not have a significant weight loss (5% in one month/10% in 6 months). Although she is not actively dieting, she would be happy with a gradual weight loss (2-4 per month). Fluid related weight changes likely as she has a history of fluid retention requiring diuretics. The intervention included diet per physician orders. (diet liberalized 12/8/17). Monitor / record / report signs and symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing	F 805	" The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Resident #37 is receiving food in form ordered by the physician and is currently on speech therapy caseload. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Current resident□s diet orders have been reviewed by the interdisciplinary team. Speech therapy screens and/or evaluations initiated as indicated. Diet orders have been updated for accuracy as indicated. Current dietary and nursing staff were in-serviced by the Director of Nursing and/or Dietary Director and/or Resident Care Quality Coordinator regarding serving food in form ordered by the physician. Newly admitted residents/patients dietary orders will be reviewed for food form accuracy during clinical morning meeting after admission. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The interdisciplinary management team, to include weekend supervisor, will audit 25% of lunch meal deliveries and meal forms to ensure physician order is followed. This audit will be completed daily x 4 weeks, and then 10% weekly x 8	

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F 805	Continued From page 8 to eat or appears concerned during meals. Provide mealtime assistance and cut up foods into bite size pieces as needed. Speech therapy consult, if appropriate or ordered. During an observation on 8/28/18 at 12:50PM, Resident #37 was eating pizza and salad. The salad had the basic fixings of tomatoes, cucumbers, shredded carrots, lettuce and broccoli. The broccoli spears were not cut up, they were whole stalks. She started choking on a large uncut piece of broccoli. Resident #37 could not speak for herself or get the staff attention that was in the dining room. Another resident had to yell to get staff attention to assist with Resident #37 coughing of the food. The Dietary manager(DM) assisted with helping the resident to dislodge the broccoli until nursing who was present took over. After the DM gave the resident several pats on the back some of the food was dislodged, but the resident continued to have some difficulty coughing up the remaining food particles. The nurse later approached resident as she was trying to clear the remaining part of the food. Resident #37 ' s face was very red and she was out of breath, when nursing instructed the aide to take resident to her room. No further assessment was done at this time. There were two other aides and activities staff present, who were assisting and feeding other residents. During an interview on 8/28/18 at 1:00 PM, Resident #37 stated she was very scared and felt like she would choke to death. "My food should have been chopped up smaller. "I am not eating another salad." Resident #37 indicated this had never happened to her before. During an interview on 8/29/18 at 1:40 PM, the	F 805	weeks. The Director of Nursing (or designee) will report findings of the audits to the Quality Assurance Performance Improvement committee monthly x 3 months to determine need for continued auditing and/or education to ensure compliance. " The title of the person responsible for implementing the acceptable plan of correction; Director of Nursing or designee.	

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F 805	Continued From page 9	F 805		

Registered Dietician review the record and indicated there was no concerns with resident ' s diet or weight loss. Resident #37 was able to communicate her meal preference and food needs. Currently unaware of any food issues from resident. She stated she was unaware of the choking incident with Resident #37. The expectation would be to assess the resident meal preferences, consistency of diet and make a referral for possible diet changes. The resident ' s food should be cut up in bite sizes as documented in the record.

During an interview on 8/30/18 at 10:10 AM, Nurse#3 stated she did not write a report or report the incident to DON because the resident was able to cough up whatever she had been eating. Nurse #3 added since she did not have to do the hemilic maneuver the resident would be fine. Nurse #3 further stated that the DON spoke with her today and told her the expectation was to assess the resident for further problems, report to the director of nursing, document the incident in the nursing note, contact the physician and do a referral to speech department.

During an interview on 8/30/18 10:52 AM, the Director of Nursing (DON) stated the expectation was for the nursing to assess the resident make sure she was ok, document in the nursing notes, report incident the director of nursing, and make necessary referrals.

During an interview on 8/30/18 at 12:10 PM, the Dietary Manager(DM) stated on the date of the resident's choking incident he did not report it to the director of nursing since there was a nurse in the dining room and "I assumed she would write up a report and handling things from that point.

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F 805	Continued From page 10 He further stated he was responsible for cross checking the resident ' s diet card with the meal. He confirmed the tray had come from the kitchen, but he did not know how the broccoli ended up on the tray because the standard salad was only lettuce, tomatoes, chopped carrots or cucumbers. The salad fixings were normally packaged salads. The only time broccoli would be in a salad if it was a broccoli salad. The DM stated he did not know how the brocolli got in the resident's salad.	F 805		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and staff interviews, the facility failed to offer and deliver bedtime snacks for 8 of 10 residents	F 809	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider	9/27/18

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F 809	Continued From page 11 during the group interview and 2 of 2 individual residents who requested to receive a bedtime snack. (Resident #2, #6, #7, #10, #13, #14 #15, #25, # 33 and #37). Findings included: During the resident council group interview 08/29/18 02:00PM, the residents stated that they were not being offered or receiving snacks at night. Residents reported staff had told them there were not enough snacks available when asked and staff would tell them there was no more. 1. During an interview on 8/29/18 at 2:00 PM, Resident #2 was identified as alert and oriented. Resident#2 stated he was not receiving snacks at night and had to ask several staff why there was enough to go around. Resident reported staff would just walk away and say there was no must wait till morning. 2. During an interview on 8/29/18 at 2:00 PM, Resident #6 was identified as alert and oriented. Resident #6 stated snacks were not being provided for residents and were not enough available. Resident#6 stated it had been reported to nursing and dietary about the snacks, but nothing happened. 3. During an interview on 8/29/18 at 2:00 PM, Resident #7 was identified as alert and oriented. Resident #7 stated she had to ask staff several times for snacks and have been told there was nothing left, or they have run out. "I don ' t feel like we should have to ask for snacks every night. Why don ' t they have enough for residents like they suppose too.	F 809	with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. " The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; Residents #2, #6, #7, #10, #13, #14, #15, #25, #33, and #37 are being offered HS snacks. " The procedure for implementing the acceptable plan of correction for the specific deficiency cited; Current residents are at risk for the alleged deficient practice. Current nursing staff were in-serviced by the Director of Nursing and/or Resident Care Quality Coordinator related to offering HS snacks to residents on a nightly basis and documenting the acceptance or refusal in POC. Dietary staff were in-serviced by the Dietary Manager related to delivery of variety of snacks to the nurse□s station. " The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing (or designee) will audit compliance with documentation of HS snack acceptance or refusal of 25% of residents daily x 2 weeks, then 3x week for 2 weeks, then weekly x 2 months. The Dietary Manager (or designee) will	

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	345004	A. BUILDING _____ B. WING _____	08/30/2018

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F 809	Continued From page 12 4. During an interview on 8/29/18 at 2:00 PM, Resident #10 was identified as alert and oriented. Resident #10 reported staff don ' t consistently offer snacks or report there was none left. "They don ' t go and get anything for you, so you have keep extra snacks from when you do get them until some becomes available. We pay enough money every month to have snack available. 5. During an interview on 8/29/18 at 2:00 PM, Resident #13 was identified as alert and oriented. Resident #13 stated residents had to ask for snacks because staff either don ' t bring anything around or say there was nothing left. When you talk to the DM he said there was plenty, but when you ask staff there is nothing left or not enough. "We as residents should not have to constantly ask for snacks only to be told there was none left. Many of us hide or hold extra snacks in the room because there may not be enough the next day." 6. During an interview on 8/29/18 at 2:00 PM, Resident #14 was identified as alert and oriented. Resident #14 stated she gets peanut butter and jelly all the time and has not been offered anything different. If it was not for her family she would not get a snack. 7. During an interview on 8/29/18 at 2:00 PM, Resident #25 was identified as alert and oriented. Resident #25 stated they do not bother to come by my room, I have to walker around and look for staff to get a snack. The staff say it not enough or not available. We don ' t get a variety of anything. We are not offered fruits, sandwiches and crackers. 8. During an interview on 8/29/18 at 2:00 PM,	F 809	audit compliance of delivery of snacks to the nurse□s station daily x 2 weeks, then 3x week for 2 weeks, then weekly x 2 months. The Director of Nursing (or designee) and Dietary Manager (or designee) will report the results of the audits to the Quality Assurance Performance Improvement committee monthly x 3 months to determine the need for further monitoring and/or education to ensure compliance. " The title of the person responsible for implementing the acceptable plan of correction; Director of Nursing or designee.	

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Resident #37 was identified as alert and oriented. Resident #37 reported snacks were not consistently being passed out at night and staff don ' t really try come around to see if you want anything. "Sometimes you will hear in the hall residents asking and staff saying there was no more, but the staff don ' t really try to make an effort to try and get it for them. "Why are we asking for things we should be getting anyway."

During an observation on 8/29/18 at 7:45 PM to 9:00 PM, several residents were up watching television and walking/rolling around in the facility. Several residents could be heard in the hall from their rooms asking staff for snacks or something to drink. Staff were not offering or passing out snacks to residents. Observation of the nourishment room, revealed the snack drawer only had a handful of sugar free cookies 2nd drawer had graham crackers. The refrigerator had large amounts of supplemental fluids, juices, 3 turkey sandwiches no names, ice cream, pudding and jello.

During an interview on 8/29/18 at 8:10PM, NA #4 and NA#5 stated the expectation was to offer all residents snacks and document whether they accept or not. Both aides stated there was no specific place to document whether they offered, accepted or refused the snack. NA#4 stated there was not a variety of things to offer residents or there was not enough. We can only offer what is the snack drawer or the refrigerator. NA#5 reported resident would ask for things like fruits, sandwiches, different types of crackers or cakes. Both aides reported whatever was available was what was offered, some nights there wasn ' t much to offer and no one to call to get anything else.

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F 809	Continued From page 14 During an interview on 8/29/18 at 8:45 PM, Nurse #1 stated the expectation was for all resident to be offered a snack whether they accept or refused. She indicated she would asked the aides which resident accepted or refused. Nurse #1 added there was no place to document the information. If they were receiving snacks from nurse it would be documented in the record. During an interview on 8/29/18 at 8:50 PM, Nurse #2 stated the expectation was for all residents to be offered a snack. Nurse #2 further stated she would asked the aide who received a snack, or she would base it on her observation of the resident with a snack, she added there was no documentation of whether a resident was offered, accepted or refused a snack. During an observation on 8/30/18 7:45 AM, the Administrator looked in the nourishment room refrigerator and snack drawers and confirmed the content of the snack drawers and refrigerator. The content was the same snacks that was available from the previous night. Administrator stated the expectation was for all resident to be offered snacks whether they accept or not. He confirmed there was no system in place to monitor or document the process. During an interview on 8/30/18 at 12:10 PM, the Dietary Manager(DM) stated the expectation was the kitchen staff should check the nourishment room several times a day and before the end of shift to make sure there was sufficient snacks available. The stock person should be making sure there was a variety of snacks available.	F 809		

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2 a. Resident # 15 was readmitted on 6/9/18 with a diagnosis of Diabetes Mellitus(DM) Type 2, End Stage Renal Disease (ESRD) and dependence of Renal Dialysis, Heart Failure, and acquired absence of right and left above knee.

Review of the Minimum Data Set (MDS) coded as significant change, dated 6/15/18 revealed Resident # 15 was admitted to the facility on 12/19/16. The resident was assessed as moderately cognitively impaired and could communicate needs to the staff. The resident needed set up for meals and in need of extensive assistance for transfers. The care plan indicated the resident was scheduled for dialysis on Monday, Wednesday, and Friday.

During an interview with Resident #15 on 8/28/18 at 9:47 AM, resident stated he does not receive any bedtime snack and was not offered snacks by staff.
During an interview on 8/30/18 at 4:22 PM, Nurse Aide (NA) # 1 stated he was unsure what snacks to provide Resident # 33. NA #1 further stated the resident does not ask for any snacks at bedtime. NA#1 indicated the resident was diabetic and there was no labeled snack for the resident.

2 b. Resident # 33 was readmitted on 6/9/18 with a diagnosis of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Anxiety disorder and chronic pain.

Review of the quarterly Minimum Data Set (MDS) dated 7/24/18 revealed Resident# 33 was admitted to the facility on 3/25/15. The resident was assessed as moderately cognitively impaired and could communicate needs to the staff. The resident needed set up for meals.

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F 809	Continued From page 16 During an interview on 8/27/18 at 3:29 PM, Resident # 33 stated snacks were not offered at night. During an interview on 8/29/18 at 4:41 PM, NA #2 stated snacks were provided to residents who requested them. NA#2 was unsure if any resident got an assigned snack. During an interview on 8/29/18 at 5:15 PM, NA #3 stated snacks were offered to residents only if requested. During an interview on 8/30/18 at 12:46 PM, the Director of Nursing (DON) stated it was her expectation that staff offer snacks to all residents per regulations. She stated she was in preliminary discussion with dietary to provided labeled snacks to resident with diabetes and no decision has been reached yet.	F 809		