An unannounced Recertification survey was conducted on 12/16/2019 through 12/19/2019. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # GGIV11.

**F 641**

**SS=D**

§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:

The facility failed to accurately code a significant change Minimum Data Set (MDS) for 1 of 6 residents reviewed for MDS coding accuracy (Resident # 35).

Findings included:

Resident # 35 was readmitted to the facility on 08/28/2019 with diagnoses that included immunodeficiency, cutaneous abscess, malignant neoplasm of the brain and skin, depression and malnutrition.

A review of a significant change MDS dated 10/24/2019 for Resident # 35 revealed that Resident # 35 was usually understood and usually understands. Resident # 35 had moderate cognitive impairment with periods of inattention and disorganized thinking. Resident # 35 experienced 12 to 14 days of being tired and depressed and required total assist of at least 2 staff for transfers and at least extensive assist for bed mobility and toileting. Resident # 35 was always incontinent of bowel and bladder, received

**THE PREPARATION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR OF THE CONCLUSIONS STATED ON THE STATEMENT OF DEFICIENCIES. THIS PLAN OF CORRECTION IS PREPARED AND SUBMITTED SOLELY BECAUSE OF REQUIREMENTS UNDER STATE AND FEDERAL LAW.**

1. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED:

Resident #35 had a Minimum Data Set (MDS) modification submitted to correct the coding to hospice question. The date of correction was December 19, 2019.

2. HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE

Lab Director: Electronically Signed 01/15/2020

Electronically Signed 01/15/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 641</td>
<td>Continued From page 1</td>
<td></td>
<td>scheduled pain medication for occasional pain which was rated at a level 4 out of 10. Resident #35 had a poor prognosis and had received 7 days of insulin injection, 7 days of an anticoagulant and an opioid.</td>
<td></td>
<td></td>
<td></td>
<td>RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Residents who are on hospice have had their most recent MDS checked to validate that they are accurately coded. There were no other issues. This audit date was December 19, 2019 and was performed by the Director of Nursing.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>A review of a social worker notes dated 10/14/2019 at 1:44 PM revealed that Resident #35 was admitted to hospice services on 10/12/2019.</td>
<td></td>
<td></td>
<td></td>
<td>3. MEASURES PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: Both MDS coordinators have been reeducated by the Director of Nursing (DON) concerning the expectation that hospice is coded when a resident is placed on hospice care. The date of the education was January 13, 2020. Newly hired nurses completing MDS's will be educated on the expectation that hospice is coded when a resident is placed on hospice care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>A review of the census or billing section of the medical record of Resident #35 revealed that hospice services were initiated on 10/12/2019.</td>
<td></td>
<td></td>
<td></td>
<td>The MDS RN was interviewed on 12/19/2019 at 12:44 PM. The MDS RN (registered nurse) revealed that she had completed a significant change MDS for Resident #35 dated 10/24/2019 and that the MDS was initiated because hospice services started for Resident #35. The MDS RN revealed that she coded all other changes for Resident #35 and that hospice was not coded as an oversight by the MDS RN. The MDS RN revealed that it was her expectation that all MDSs be coded accurately and as per the Resident Assessment Instrument (RAI).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>On 12/19/2019 an interview with the facility business office manager (BOM) was conducted and the BOM confirmed that Resident #35 was initiated on Hospice services 10/12/2019 and remained on hospice services at present. The BOM confirmed that all department managers were aware of the initiation of hospice services on 10/12/2019 via a form titled &quot;status change.&quot;</td>
<td></td>
<td></td>
<td></td>
<td>An interview conducted with the facility administrator on 12/19/2019 at 12:52 PM</td>
</tr>
</tbody>
</table>

**Resident #35** had a poor prognosis and had received 7 days of insulin injection, 7 days of an anticoagulant and an opioid.

A review of a social worker notes dated 10/14/2019 at 1:44 PM revealed that Resident #35 was admitted to hospice services on 10/12/2019.

A review of the census or billing section of the medical record of Resident #35 revealed that hospice services were initiated on 10/12/2019.

On 12/19/2019 an interview with the facility business office manager (BOM) was conducted and the BOM confirmed that Resident #35 was initiated on Hospice services 10/12/2019 and remained on hospice services at present. The BOM confirmed that all department managers were aware of the initiation of hospice services on 10/12/2019 via a form titled "status change."

The MDS RN was interviewed on 12/19/2019 at 12:44 PM. The MDS RN (registered nurse) revealed that she had completed a significant change MDS for Resident #35 dated 10/24/2019 and that the MDS was initiated because hospice services started for Resident #35. The MDS RN revealed that she coded all other changes for Resident #35 and that hospice was not coded as an oversight by the MDS RN. The MDS RN revealed that it was her expectation that all MDSs be coded accurately and as per the Resident Assessment Instrument (RAI).

An interview conducted with the facility administrator on 12/19/2019 at 12:52 PM
revealed the administrator expected that all MDS assessments be coded correctly as per the RAI manual and that a significant change MDS be completed for any resident initiated on hospice services and that the MDS reflect that the resident received hospice service.

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 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 record review, observation and staff interviews, the facility failed to obtain an order for oxygen for 1 of 1 resident reviewed for respiratory care (Resident #63).

Findings included:

Resident #63 was admitted to the facility on 8/29/2017 with diagnoses to include hypertension, diabetes and contracture of joint.

A nursing note dated 10/15/2019 at 11:00 PM noted that Resident #63 had a low oxygen saturation level of 85 % (normal 88-99%) and the nurse applied oxygen at 2 liters per minute by a nasal cannula.

CORRECTED ACTION FOR AFFECTED RESIDENT:

Resident #63’s order for oxygen at 2 liters/minute continuous was clarified with the provider (Medical Director) and then transcribed into the orders for the medical record December 18, 2019.

IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY SAME DEFICIENT PRACTICE:

Residents receiving orders during change of condition have been identified for the
A review of the physician orders for Resident #63 from October 2019 to December 2019 revealed no order was in place for the administration of oxygen.

The most recent quarterly Minimum Data Set assessment dated 11/19/2019 assessed Resident #63 to be severely cognitively impaired and she did not use oxygen.

Resident #63's treatment administration record and medication administration record for December 2019 was reviewed and no documentation was present regarding the administration of oxygen.

Resident #63 was observed on 12/16/2019 at 12:08 PM in bed. She had a nasal cannula on an oxygen concentrator that was set at 2 liters.

An observation was conducted on 12/17/2019 at 9:17 AM of Resident #63 and she was in bed with oxygen administered at 2 liters per minute by nasal cannula.

Resident #63's alert and oriented roommate was interviewed on 12/17/2019 at 9:17 AM and she reported Resident #63 had been using oxygen "for a long time."

Nursing assistant (NA) #3 was interviewed on 12/17/2019 at 9:17 AM and she reported that Resident #63 wore the oxygen "all the time."

NA #2 was interviewed on 12/18/2019 at 9:54 AM and she reported Resident #63 wore the oxygen all the time. NA #2 was unable to find orders or directions for the oxygen use in the nursing
### SUMMARY STATEMENT OF DEFICIENCIES

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>F 695</td>
<td>Continued From page 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>assistant Kardex (a program that lists treatments and interventions for nursing assistants to provide care to the residents.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The nurse who wrote the note on 10/15/2019 was not available for interview.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse #1 was interviewed on 12/18/2019 at 10:16 AM and she reported that Resident #63 should have an order for the oxygen, but she was unable to locate the order for the oxygen.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>An interview was conducted with Nurse #2 and the Staff Development Coordinator (SDC) on 12/18/2019 at 10:20 AM and neither were able to find orders for Resident #63 to use oxygen. The SDC reported that oxygen orders should be entered into the electronic order system to populate the medication administration record.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse #2 was interviewed again at 10/18/2019 at 1:50 PM and she reported she was not certain why the order for oxygen had not been entered into the electronic order system.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Director of Nurses (DON) was interviewed on 12/18/2019 at 2:19 PM and she reported that on 10/15/2019 when the resident had a low oxygen level, the nurse applied the oxygen and contacted the physician assistant. The DON reported the order had not been transcribed into the electronic documentation system. The DON reported she felt the transcription of the order had been overlooked and that she expected all orders to be entered into the system.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The facility physician was interviewed on 12/19/2019 at 11:53 AM and he reported Resident #63 was not harmed by receiving oxygen.</td>
<td></td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>F 695</td>
<td>The DON, who is responsible for this plan of correction, will report the results of monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.</td>
<td></td>
</tr>
</tbody>
</table>
## Summary Statement of Deficiencies

### F 695

- Continued From page 5 oxygen since October.

The Administrator was interviewed on 12/19/2019 at 12:36 PM and he reported the facility had initiated a daily clinical meeting to review all residents and check for new orders and to make certain all orders were entered into the system correctly. The Administrator reported the order to apply oxygen to Resident #63 occurred before this morning meeting was started and that was why the order was missed. The Administrator reported that he expected all orders to be entered into the electronic documentation system when the orders were received.

### F 812

Food Procurement, Store/Prepare/Serve-Sanitary

<table>
<thead>
<tr>
<th>CFR(s): 483.60(i)(1)(2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>§483.60(i) Food safety requirements. The facility must -</td>
</tr>
<tr>
<td>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/16/20</td>
</tr>
</tbody>
</table>
Based on observations, staff interviews and record reviews, the facility failed to follow their policies and procedures for storing refrigerated food off the floor and storing dry food in sealed containers, that were not labeled and dated once the items were opened in 1 of 1 walk-in refrigerator, 1 of 1 walk-in cooler and 1 of 1 dry storage room in the kitchen, and 2 of 2 nourishment refrigerators. The nourishment refrigerators were located at the main nursing station and on the 600 hall. Furthermore, food brought in from outside the facility did not have the resident's name or date, nor were the items discarded within seven days.

Findings included:

Record review of the facility's policies related to Food Storage revealed the following:

Policy dated 2/19/19 titled Storage of Refrigerated Food, read in part that refrigerated items must be stored at least 6 inches off the floor and labeled with the date opened.

The policy for Storage of Dry Food, dated 2/20/19 read in part: all food must be sealed in tight-fitting containers, labeled and dated.

The policy titled, Food Brought in from Outside the Facility, dated 2/25/19, read in part: all opened food will be stored with the name of the food item, resident name, dated and discarded within seven days to ensure food safety.

1. During the initial tour of the kitchen on 12/16/19 from 9:54-10:30am with the Dietary Manager, an inspection was completed of the walk-in refrigerator, walk-in freezer and the dry storage room. The following was observed: The following items had previously been opened and were not labeled with an open date or an expiration date.

CORRECTIVE ACTION FOR AFFECTED RESIDENTS:

Any and all food that was found to be open and/or unlabeled was disposed of immediately.

OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:

The rest of the food in the dry storage pantry, nourishment rooms and the refrigerated and frozen storage areas in the kitchen were examined by the Certified Dietary Manager to determine if any items were open and unlabeled or expired. Any items identified without proper label, date or were expired were discarded.

MEASURES PUT INTO PLACE AND/OR SYSTEMATIC CHANGES TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR:

All Dietary employees were reeducated by the Certified Dietary Manager on December 18 and 19, 2019 regarding the following policies:

* Storage of Dry Food
* Storage of Refrigerated Foods

The CDM was re-educated by the Regional Registered Dietician on January 7, 2020.

First shift Housekeeping will inspect nourishment room refrigerators and freezers daily to ensure food safety.
Continued From page 7

a. Walk in refrigerator-1 large bottle of nectar thickened water, 1 large bottle of nectar thickened orange juice, 1 container of whipped cream and 1 bottle of lemon juice.

b. Walk-in cooler-Two unsealed boxes of frozen breaded chicken were open without a date. The tape on both boxes was torn on all four sides.

c. Dry Storage Area-The following items were expired based on the labeled date-croutons in a clear plastic bag with a sealed zip top, opened 6/15/19. The items that did not have a label for the required opened date included 1 bottle each of grape jelly and Heinz 57 sauce, and 2 bottles of green and red food coloring.

An interview was conducted on 12/16/19 at 10:30am with the Dietary Manager (DM) whom stated these items listed above should all have been labeled. The Dietary Manager stated the boxes of chicken had not been used and the tape was torn when placed under shelf. She stated the croutons were good for 1 month from the opened date and the condiments should have been labeled with an open date.

2. On 12/18/19 at 3:38pm a follow-up interview with the Dietary Manager was conducted regarding the non-labeled food items. The DM stated items should have been properly labeled. She stated these items had now been discarded.

3. On 12/18/19 at 3:55pm a follow-up observation with the DM was conducted for the kitchen and dietary storage areas and checked for labeling and expired food.

open items are dated, labeled and discarded timely. This is documented on quality audit tools daily and will be done daily for 2 weeks then weekly for 8 weeks. Housekeeping staff were re-educated on food storage, cleanliness of nourishment room refrigerators and freezers by facility Administrator on December 31, 2019. Ongoing monitoring of nourishment rooms will be done by the facility RD and the corporate RD quarterly.

PERFORMANCE MONITORING:

The CDM, or designee on weekends, will monitor/inspect the storage of both dry and refrigerated foods daily to ensure that items open were dated as they were opened and all items are labeled and discarded by expiration date. This will be documented daily for 7 days then 5 days/week for 3 weeks, then weekly for 8 weeks. On going monitoring will be completed by facility RD monthly and corporate Regional RD quarterly.

The CDM will report the results of all monitoring and corrective action to the QAPI committee monthly for review for the time frame of the monitoring period or as it is amended by the committee.
a. The dry storage room had 1 bottle of grape jelly not labeled. A large bag of grits was open in a zip sealed plastic bag that was not closed at the top and without a label.

b. Observation of the walk-in refrigerator revealed a large net bag of multiple heads of cabbage (greater than 10) on the floor of and an opened bottle of nectar thickened water with no label on the shelf.

4. On 12/18/19 at 4:10pm, an observation of the 2 nourishment rooms near the main nursing station and the 600 hallway was made with the DM present.

a. Nourishment Room 1 near the main nursing desk was inspected. Review of the items in the freezer in Nourishment Room 1 revealed a frozen dinner of chicken fettuccine with a date written in black marker of 11-3-18. The frozen dinner had a used by date of 8/2019. Other items not labeled or dated included: reusable water bottle with a pull up lid with water inside, purple grapes in a gray plastic bag, an opened large bottle of nectar thickened water, an opened carton of Resource 2.0 and 21 assorted pudding, yogurt and fruit cups.

b. The 600 Hall Nourishment Refrigerator/Freezer items that observed to not be labeled or labeled incorrectly were: a gray plastic bag in the freezer with a small fast food cup of chocolate ice cream and a sealed vanilla caramel ice cream bar. This bag was marked with a room number that could not be determined, and there was no name or date. An opened frozen bottle of red fruit drink, an opened disposable water bottle, a chicken pot pie with no
<table>
<thead>
<tr>
<th>F 812</th>
<th>Continued From page 9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>name, date or room, 4 small cups of Breyers ice cream with no expiration date visible, no name, date or room, 4 vanilla pudding cups with the name but no date or room, 1 large box of frosted flakes with a 10/4/19 expiration date, numerous yogurts without the resident's names or dates, several had an expired manufacture date.</td>
</tr>
</tbody>
</table>

An interview was conducted with the DM during the observation at 4:10PM on 12/18/19. The DM stated the nourishment rooms were not the dietary department's responsibility.

On 12/18/19 at 4:46 PM observations of both nourishment rooms with the Director of Nursing (DON) revealed that the above named items were still in the refrigerator. The DON discarded all the expired and unlabeled food items.

At 12/18/19 5:00 PM an interview with the DON stated both nourishment rooms should be checked nightly by nursing staff and any food in any refrigerator or freezer without the name, date, room should be discarded.

An interview was conducted 12/18/19 at 5:19 PM with the Administrator and he was informed of findings in the kitchen, and the two nourishment refrigerators/freezers. The Administrator stated the process would be that the kitchen staff are to label an item when it is opened with the date, and that the nourishment rooms are checked on third shift. Staff are accountable to go through employee and resident refrigerators/freezers and ensure all items are dated and labeled and discard any items that are not.