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	345008	A. BUILDING _____ B. WING _____	C 07/26/2024

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THE CITADEL AT MYERS PARK, LLC	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

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E 000	Initial Comments An onsite recertification and complaint investigation survey was conducted from 7/15/24 through 7/19/24. Additional information was obtained offsite from 7/20/24 through 7/25/24. The survey team returned onsite on 7/26/24. Therefore, the exit date was changed to 7/26/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # OO4611.	E 000		
F 000	INITIAL COMMENTS An onsite recertification and complaint investigation survey was conducted from 7/15/24 through 7/19/24. Additional information was obtained offsite from 7/20/24 through 7/25/24. The credible allegation of immediate jeopardy removal was validated onsite on 7/26//24. Therefore, the exit date was changed to 7/26/24. Event ID# OO4611. Intakes NC219864, NC00218984, NC00217746, and NC00215723 were investigated. Four (4) of the 12 complaint allegations resulted in a deficiency. Immediate jeopardy was identified at: CFR 483.25 at tag F684 at a scope and severity J CFR 483.25 at tag F689 at a scope and severity J Immediate jeopardy began on 05/22/24 and was removed on 07/19//24. The tags F684 and F689 constituted substandard quality of care. An extended survey was conducted.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		8/19/24

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

Electronically Signed | 08/13/2024

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F 657	Continued From page 1 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to revise care plans for 1 of 3 residents (Resident #38) for smoking. The findings included: Resident #38 was originally admitted to the facility on 02/08/19 with diagnoses which included nicotine dependence and hypertension.	F 657	1. Based on record review and staff interviews the facility failed to revise care plans for 1 of 3 residents (Resident #38) for smoking. Resident #38□s care plan was not revised to indicate the resident was an unsafe smoker and required supervision. Resident 38□s care plan was revised on 7/17/2024 to reflect need for supervision while smoking.	

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F 657	Continued From page 2 Review of Resident #38's quarterly Minimum Data Set (MDS) dated 05/03/24 revealed the resident was cognitively intact and required extensive assistance for most activities of daily living (ADL). Review of Resident #38's quarterly smoking assessments dated 06/29/24 revealed the resident was an unsafe smoker and required supervision. Review of Resident #38's care plan revised on 03/07/24 revealed the resident was an unsupervised smoker with a goal he would not suffer injury from unsafe smoking practices through the review date. An interview with the MDS coordinator on 07/18/24 at 1:30 PM revealed when smoking assessments were completed, the results should be communicated to her directly or in the morning meetings that are held daily. The MDS coordinator further revealed Residents #38's care plan should have reflected the resident being a supervised smoker and edited when the smoking assessment was completed on 06/29/24. A joint interview conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 07/18/24 at 11:15 AM revealed Resident #38 was a supervised smoker, and the resident's care plan should have reflected that. An interview conducted with the Administrator on 07/18/24 at 3:00 PM revealed Resident #38's care plan should have been revised to reflect the resident was a supervised smoker. The Administrator further revealed resident care plans	F 657	2. On 7/22/2024, new smoking assessments were completed by the Director of Nursing (DON), Assistant Director of Nursing (DON), and Unit Managers on all resident smokers and an audit was completed to ensure resident care plans appropriately reflected safe smoking status and need for supervision. No other issues were identified. 3. Education to Minimum Data Set Coordinators and DON was completed on 8/7/2024 by the VP of Clinical Services on regulations regarding appropriate and timely care plan revisions. DON completed education with ADON and Unit Managers on requirement to revise care plans appropriately and timely on 8/7/2024. 4. An Ad Hoc Quality Assurance Performance Improvement was held on 8/14/2024 with the Interdisciplinary team to discuss details of this plan. Audits will be completed of all current resident smokers and new admissions weekly x4 weeks then monthly x3 months by the Director of Nursing/Nurse Management to ensure current smoking assessment matches the residents care plan. Results of audits will be discussed at the monthly Quality Assurance Performance Improvement meeting for three (3) months or until substantial compliance is met.	

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F 657	Continued From page 3 reflect the residents care and concerns and were expected to be updated.	F 657		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Medical Director (MD), Nurse Practitioner (NP), Driver #1 and staff, the facility failed to leave Resident #12 in place for a clinical assessment of injury. Resident #12 was in a parked transportation van, unsupervised, with the engine on and the air conditioning on, when she unbuckled her seat belt and fell from her wheelchair. Driver #1 witnessed Resident #12 face down on the floor of the van, and Resident #12 complained to Driver #1 that her head hurt. Driver #1 called the Administrator to notify of the fall. The Administrator instructed Driver #1 to look for any visible signs of injury, and to make Resident #12 comfortable. Driver #1 notified the Administrator she saw a "knot" forming on the Resident's forehead and received instructions to call 911 (Emergency Medical Services - EMS) for paramedics to further evaluate. While on the phone with the Administrator, Driver #1 transferred Resident #12 back into her wheelchair, before paramedics arrived and	F 684	.On 5/22/24 the facility failed to leave Resident #12 in place for a clinical assessment of injury after sustaining a fall in a transport van. Driver #1 made the resident comfortable, observed for injury, and called 911. When paramedics arrived resident #12 was transported to hospital for evaluation and treatment. Resident #12 responsible party and physician was notified of fall with subsequent transfer to hospital. 2. On 7/18/2024, individual interviews were conducted with all residents with a BIMS 13 or above who were transported by the facility transporter by the DON and Assistant Director of Nursing (ADON) to ensure no unreported incidents occurred during facility transportation requiring assessment by a licensed professional. No other residents were affected by this deficient practice. On 8/13/24, the	8/19/24

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secured the Resident with her seatbelt. Driver #1 then called 911. When paramedics arrived, Resident #12 was transported to the hospital where she was diagnosed with a "tiny" acute hemorrhage of the left lateral ventricle posteriorly (bleeding in and around the brain's ventricles), subcutaneous hematoma (collection of blood underneath the skin) of the right forehead and a painful, swollen right eye. This deficient practice occurred for 1 of 2 sampled residents reviewed for quality of care (Resident #12).

Immediate jeopardy began on 5/22/24 when Driver #1 failed to leave Resident #12 in place for a clinical assessment of injury and transferred Resident #12 back into her wheelchair before EMS arrived. Immediate jeopardy was removed on 7/19/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective.

The findings included:

Resident #12 admitted to the facility 3/12/24 with diagnoses that included non-Alzheimer's dementia, mild neurocognitive disorder with behavioral disturbance, end stage renal disease (ESRD), dependence on hemodialysis, glaucoma of the left eye, and bilateral amputation of the lower extremities.

A 3/12/24 Transfer, Mobility Evaluation, assessed Resident #1 required the caregiver to perform 100% of the transfer task with the use of a

transportation schedule for last 30 days was reviewed by administrator for all residents with a BIMS□s 12 and below. Most recent skin assessment after van transport was reviewed to ensure no new skin issues were noted.

3. On 7/18/2024, the Vice President of Clinical Services provided education to Director of Nursing (DON) and Nursing Home Administrator (NHA) regarding facility policy of the following: In the event of a transportation related incident, resident is not to be moved until a licensed professional can assess for injuries. On 7/18/2024, DON provided in person one on one education to facility Driver #1 regarding facility policy of the following: In the event of a transportation related incident, resident is not to be moved until a licensed professional can assess for injuries in person.

On 7/18/2024 education was started with all nursing staff, including agency staff by the ADON/Nurse Managers on the following: In the event of a van incident, resident must be assessed by a licensed professional prior to being moved. No staff will be allowed to work, including any new hires and agency staff, without receiving this education. All newly hired nursing staff, including newly hired van drivers, will be educated by ADON/Designee during orientation.

4. An Ad-Hoc QAPI meeting was held with the Interdisciplinary Team on 8/14/24 to discuss this plan. Audits will be conducted

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mechanical lift because she was alert/oriented with intermittent confusion, non-ambulatory due to bilateral amputee status, unable to stand, non-weight bearing and required partial support of a rail or a person to sit at the bedside.

A 3/19/24 admission Minimum Data Set (MDS) assessment indicated Resident #12 expressed herself with clear speech, made herself understood, understood others, moderately impaired cognition with no acute changes in mental status, bilateral lower extremity impairment and used a wheelchair for mobility. The MDS recorded Resident #12 required partial to moderate assistance to move from a sitting to lying position, reported she did not have pain in the last five days of the assessment and received dialysis services.

A 3/25/24 Care Plan indicated Resident #12 required staff assistance with activities of daily living due to poor impulse control, ESRD, with dependence on hemodialysis, glaucoma of the left eye, cognitive communication deficits and bilateral partial traumatic amputation of the lower extremities. Interventions included assessing and anticipating resident needs and assessing resident's understanding of the situation.

An observation and interview of Resident #12 occurred in her room on 7/16/24 at 8:54 AM. Resident #12 did recall having a recent fall or being transported to the hospital. Resident #12 did not recall the date of the fall or any details surrounding the fall of 5/22/24. During the interview, Resident #12 stated, "I am fine."

A 5/22/24 6:30 PM incident report, documented by the Administrator, recorded that on 5/22/24 it

by DON/Designee of all resident falls to ensure a clinical assessment was conducted by a licensed professional prior to moving resident, weekly times 4 weeks, then monthly for 3 months. Results of audits will be discussed at the monthly Quality Assurance Improvement meeting for 3 months or until substantial compliance is achieved.

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was reported by staff that Resident #12 fell and hit her head. The incident report recorded 911 was called and Resident #12 was taken to the hospital for evaluation and treatment. The incident report recorded injuries at the time of the incident as a hematoma to the top of scalp. The incident report described Resident #12 as disoriented to place, situation, time, and oriented to person. The incident report documented predisposing factors were chair position, impulsive behavior, impaired awareness, weakness, confusion, lost balance, and a history of confusion after dialysis treatments. A witness to the fall was recorded as Resident #55.

A 7/18/24 9:25 AM interview with Resident #55, a Resident identified by the facility as alert/oriented to person, place, situation, and time, revealed she was on the facility transportation van when Resident #12 fell. Resident #55 stated Resident #12 was on the transportation van on Wednesday, 5/22/24 at 4:30 PM, parked in front of the dialysis center, when Resident #55 walked onto the facility van after dialysis. Resident #55 stated that Resident #12 was in her wheelchair on the van with her seatbelt fastened and that Resident #12 asked Driver #1 to call a family member. Resident #55 stated that after she got on the van, Driver #1 got off the van to assist Resident #79 from the lobby of the dialysis center onto the van. Resident #55 stated that while the Driver was off the van, Resident #12 also asked Resident #55 for assistance to call a family member. Resident #55 explained that when Resident #55 responded to Resident #12 that she could not assist her because Resident #55 did not know the number, Resident #12 unfastened her seatbelt, reached towards a mobile phone that was nearby, and fell face down on the floor of

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the van. Resident #55 stated after Resident #12 fell, Resident #55 blew the horn on the van, one long blow and one short blow to alert the Driver of an emergency and the Driver immediately returned to the van, without Resident #79. Resident #55 further stated that when Driver #1 returned to the van, Resident #12 was face down on the floor of the van, Driver #1 moved Resident #12 to her wheelchair and called "911".

A 5/22/24 EMS Run Report documented paramedics arrived at the facility transportation van at 4:56 PM in response to Resident #12's fall from a wheelchair. The report documented that on arrival Resident #12 was found sitting in her wheelchair in the facility transportation van. Per the report, Driver #1 reported to paramedics that Resident #12 did not lose consciousness. Paramedics recorded that at 5:00 PM Resident #12 was assessed with a hematoma to the right side of her forehead, with no crepitus (grading, popping, or clicking of a joint) felt. Per the report, Resident #12 complained of right upper arm pain to paramedics, and her pupils were reactive to light. Per the report, Resident #12 was transported by paramedics to the hospital in stable condition for further evaluation.

A 5/23/24 hospital discharge summary recorded Resident #12 admitted to the hospital for evaluation after a fall and discharged back to the facility on 5/23/24 in stable condition. The hospital course described Resident #12 as oriented to self, but unable to determine baseline due to a diagnosis of dementia. The hospital course documented that a CT scan of the head (a computed tomography which is a diagnostic procedure that uses X rays and computers to create detailed cross-sectional images of the

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inside of the body) showed a "tiny" acute hemorrhage of the left lateral ventricle posteriorly and a subcutaneous hematoma of the right forehead. Resident #12 was referred for a neurosurgery consult, a second CT scan was completed with stable results. A tertiary exam (a final means of identifying injury), although limited due to Resident #12's dementia, showed negative results. Her right eye was swollen and painful upon palpation (touch).

A 7/18/24 9:44 AM interview with Driver #1 revealed she was the transportation driver for about a year and a nurse aide for the facility. Driver #1 stated that on Wednesday, 5/22/24 she was the only staff member on the van and around 3:50 PM she picked up Resident #12 from dialysis, placed her on the transportation van and secured her in the wheelchair with restraints and a seatbelt. Driver #1 stated that after she secured Resident #12 on the transportation van, she then drove to a second dialysis center and arrived around 4:30 PM to pick up three additional residents from dialysis. Driver #1 stated that when she pulled up to the dialysis center, she parked in front of the dialysis center, left the transportation van running and the air conditioning on while Resident #55 got on the transportation van, sat down and fastened her seatbelt. Driver #1 stated she advised the residents to remain in their seats secured with their seatbelts while she went inside the dialysis center to get Resident #79. Driver #1 said she left the van to go get Resident #79 and as soon as she walked inside of the dialysis center, Driver #1 heard the horn blow one long blow and one short blow, so she left Resident #79 in the lobby of the dialysis center and immediately returned to the transportation van because she knew it was an

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emergency. Driver #1 stated when she returned to the transportation van, she saw Resident #12 lying face down on the floor of the van. Resident #55 told Driver #1 that Resident #12 unfastened her seat belt to get up to call her sister and fell. Driver #1 stated she got Resident #12 up off the floor and put Resident #12 back in her wheelchair. When asked why Driver #1 put Resident #12 back into her wheelchair, Driver #1 stated "because the floor of the van was hot, and I did not want to leave her there." Driver #1 said Resident #12 said her head was hurting and when Driver #1 got Resident #12 up she could see a knot forming over her right eye. Driver #1 stated that when she saw Resident #12 on the floor of the van, she called the Administrator and while Driver #1 was on the phone with the Administrator, Driver #1 picked Resident #12 up at the same time, told the Administrator that she was putting Resident #12 back in her wheelchair and about the "knot" on her forehead. Driver #1 said the Administrator told her to call 911. Driver #1 said she called 911 and when the paramedics arrived, Resident #12 was seated in her wheelchair with her seatbelt fastened and Resident #12 told the paramedics "I am fine." Driver #1 stated the paramedics assessed Resident #12 seated in her wheelchair. Driver #1 stated that she was trained as a NA that if an accident occurred during transportation, to call 911 immediately and not to move the resident but that in the case of Resident #12 she did not want to leave the Resident on the hot floor of the transportation van.

A 7/18/24 9:33 AM interview with Unit Manager (UM) #1 revealed she was notified during the morning clinical meeting on 5/23/24 that Resident #12 was in the hospital for evaluation of a

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hematoma. UM #1 further stated that she did not know what transportation drivers were trained to do, but that NAs were trained not to move the resident after a fall until the nurse could assess the resident.

The Director of Nursing (DON) was interviewed on 7/18/24 at 11:57 AM. The DON stated that nursing staff were trained that if a resident sustained an injury from a fall the nurse should assess the resident in the position observed from the fall before the resident was moved. The DON stated, "That's what we train and expect." The DON further stated that if there was major injury from a fall on the transportation van, the resident should remain in place until EMS arrived, but in the case of Resident #12, the DON supported the Driver's decision to get Resident #12 off the floor to prevent any further injury.

The Administrator was interviewed on 7/18/24 at 11:34 AM and stated that she completed the incident report regarding a 5/22/24 fall Resident #12 had on the transportation van. The Administrator stated that on 5/22/24 at approximately 4:40 PM, she received a call from Driver #1 who notified the Administrator that the Driver was inside the dialysis center when the Driver heard the horn on the van and came back out to the transportation van. The Administrator said that when the Driver got back on the van, she saw Resident #12 on the floor of the van. The Administrator stated that the Driver said Resident #55 told the Driver that Resident #12 unbuckled her seatbelt, moved around, and landed on the floor of the transportation van. The Administrator stated she asked Driver #1 if Resident #12 was alert, breathing, and to look for signs of injury. The Administrator said Driver #1 told the

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Administrator that Resident #12 had a "knot" on her forehead, but that the Driver did not see any further injuries. The Administrator stated she told the Driver not to move the van, make Resident #12 comfortable, call 911, tell them where the van was parked so they could locate the van and evaluate Resident #12. The Administrator stated that she could not say that she was made aware that Driver #1 moved Resident #12 off the floor of the van back to her wheelchair before EMS arrived. The Administrator stated if she had known that Driver #1 needed to move Resident #12 off the floor of the van, the Administrator would have asked more questions to determine if it was necessary to move the Resident.

A 7/18/24 12:16 PM phone interview with the NP revealed she was notified of the fall that occurred on the transportation van for Resident #12. The NP stated that typically a resident should remain in place for EMS to evaluate, but that the NP could understand why Driver #1 moved Resident #12 off the floor of the van since Driver #1 thought the floor of the van was hot. The NP stated she thought that it was okay to move Resident #12 if the transfer was safe to prevent a worse injury described by the NP as "possibly a burn."

A phone interview with the MD occurred on 7/18/24 at 8:31 PM. The MD stated he was notified on the day of the fall when Resident #12 fell on the transportation van, but that he could not recall the specific date. The MD said he was certain staff told him that she sustained a hematoma and was sent to the hospital but that he did not recall the details of the incident. The MD also stated that if a resident sustained a neck injury or some other significant injury, he would

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agree to leave the resident in place until paramedics arrived, but given the circumstances that Driver #1 felt like the floor of the van was hot, he could agree with moving her off the floor of the van and he had no concern with moving Resident #12 under those circumstances.

The Administrator was notified of immediate jeopardy on 7/18/24 at 3:55 PM.

The facility provided the following credible allegation of immediate jeopardy removal.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

On 5/22/2024, Resident #12, a resident with a diagnosis of dementia, unbuckled her seat belt, leaned forward and fell from her wheelchair while on the facility's transportation van. Driver #1, who is a certified nursing assistant, witnessed Resident #12 face down on the floor of the van. Resident #12 complained to Driver #1 that her head hurt. Driver #1 observed Resident #12 with a knot forming on her forehead above her left eye. Driver #1 stated she called the administrator, who is also a registered nurse and notified the administrator of the fall and knot forming to the Resident's forehead. It was reported to the Administrator that no other obvious injuries were identified by Driver #1. The administrator instructed Driver #1 to assist with making resident #12 comfortable. Driver #1 then assisted Resident #12 from the hot floor of the van back to her wheelchair while on the phone with the administrator and received instructions to call 911. Driver #1 called 911 and remained with the resident until emergency services arrived.

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Resident #12 was transported to the hospital and diagnosed with a tiny acute hemorrhage of the left lateral ventricle posteriorly. Resident #12's responsible party and physician were notified of fall with subsequent transfer to the hospital.

All residents who are transported by the facility van have the potential to be affected.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 5/22/2024, the Administrator re-educated Driver #1 on facility van transportation policies and completed a Transportation Skills Assessment of the Transportation Aide/ CNA with no concerns noted.

On 5/23/2024, an Ad Hoc meeting was held with the following in attendance: the Administrator, the Director of Nursing, the Nurse Managers, the Rehab director, the MDS nurse, the Activity Director, and the Wound Care Nurse. The Medical Director, who was notified of the incident on 5/22/2024, was not in attendance, but was updated by the Administrator of the meeting's agenda and findings. Other resident incidents were reviewed during this meeting. There were no incidents identified in which a resident was moved before being assessed by licensed professionals.

On 7/18/2024, the Vice President of Clinical Services provided education to Director of Nursing (DON) and Nursing Home Administrator (NHA) regarding facility policy of the following: In the event of a transportation related incident,

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resident is not to be moved until a licensed professional can assess for injuries. No changes to policy were necessary at this time.

On 7/18/2024, DON provided in person one on one education to facility Driver #1 regarding facility policy of the following: In the event of a transportation related incident, resident is not to be moved until a licensed professional can assess for injuries in person. Driver #1 is an employee of the facility; no other drivers are employed at this time. Driver #1 is directly supervised by the facility Administrator, who received in person education regarding facility policy by Vice President of Clinical Services.

On 7/18/2024, individual interviews were conducted with all residents with a BIMS 13 or above who were transported by the facility transporter by the DON and Assistant Director of Nursing (ADON) to ensure no unreported incidents occurred during facility transportation requiring assessment by a licensed professional. No other residents were affected by this deficient practice.

On 7/18/2024 education was started with all staff, including agency staff by the ADON/Nurse Managers on the following: If the transport driver notifies the facility regarding a transportation related incident, inform them to contact emergency services and not move resident until a licensed professional can assess them. The facility Administrator and Director of Nursing's contact information is posted at all three nurse's stations. No staff will be allowed to work, including any new hires and agency staff, without receiving this education. This information will also be added to the new hire orientation. The

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Administrator will notify the Assistant Director of Nursing and/or Nurse Manager of this responsibility.

Any newly hired facility van drivers will be educated during orientation by the DON/Administrator regarding facility policy: In the event of a transportation related incident, resident is not to be moved until a licensed professional can assess for injuries.

On 7/18/2024 an in person Ad hoc Quality Assurance Performance Improvement (QAPI) meeting was held. The Administrator, the Director of Nursing, the Nurse Manages, the Rehab director, the MDS nurse, and the Wound Care Nurse attended this meeting to review the incident and credible allegation for the removal of the immediate jeopardy.

Effective 7/18/2024, the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

IJ removal date 7/19/2024.

The Credible Allegation of IJ removal plan was validated onsite on 7/26/24 with an effective date of 7/19/24. The facility provided documentation of re-education, verification of facility approved contract and facility-employed transportation drivers, documentation of transportation driver's safety skills assessment, and QAA plan. Interviews with alert and oriented residents who used facility transportation resulted in no concerns expressed related to emergency response during transportation. Staff hired or contracted for transportation were interviewed

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F 684	Continued From page 16 and communicated knowledge of emergency response protocols and safety re-education during transportation incidents per the facility policy. Nursing staff were interviewed and communicated knowledge of how to advise a driver who calls the facility to communicate a transportation related incident, per facility policy and re-education. An observation of staff boarding residents for transportation demonstrated contract staff and facility employed staff following safety protocols for residents with health issues per facility policy. The IJ removal date of 7/19/24 was validated.	F 684		
F 685 SS=E	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with the Nurse Practitioner (NP), and staff, the facility failed to follow up on a hospital recommendation for an ophthalmology (eye) consultation for 1 of 1 sampled resident reviewed for services to maintain vision (Resident #12).	F 685	1. Based on observation, record review and staff interviews, the facility failed to follow up on a hospital recommendation for an ophthalmology consultation for 1 resident reviewed for services to maintain vision (Resident #12). On 7/24/24, resident #12 had scheduled	8/19/24

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F 685	Continued From page 17 The findings included: Resident #12 was admitted to the facility 3/12/24 with diagnoses that included neurovascular glaucoma of the left eye, and ocular hypertension of the left eye. A 3/19/24 admission Minimum Data Set assessment indicated Resident #12's cognition was moderately impaired, and her vision was adequate. A 5/22/24 6:30 PM incident report documented that on 5/22/24 staff reported that Resident #12 fell and hit her head. The incident report recorded 911 (emergency medical services) was called and Resident #12 was taken to the hospital for evaluation. The incident report recorded injuries at the time of the incident as a hematoma to the top of her scalp. A 5/23/24 11:51 AM hospital discharge summary recorded Resident #12 admitted to the hospital on 5/22/24 for evaluation after a fall. The hospital course documented her right eye was swollen and painful upon palpation (touch). The hospital discharge summary recorded a recommendation for an outpatient ophthalmology consultation. Resident #12 discharged back to the facility on 5/23/24 in stable condition. A 5/23/24 9:13 PM nurse progress note, written by Nurse #1 recorded Resident #12 returned to the facility at 4:45pm, denied pain, and was noted with a swollen right eye from a fall. A 5/23/24 9:01 PM nurse progress note, written by the Nurse Supervisor #1 recorded Resident #12 returned to the facility from the hospital, with	F 685	ophthalmology appointment, which was rescheduled by Ophthalmology office for 8/22/2024. 2. On initial audit was completed by 8/18/24 by Director of Nursing (DON) and Regional Clinical Educator on all newly admitted and re-admitted resident discharge summaries for prior 90 days, as well as order listing reports for current consults and referrals to ensure recommended appointments were followed up on timely. No other issues were identified. 3. Education began on 8/7/2024 by the DON/Designee to all licensed nurses on the requirement to ensure residents receive proper and timely follow up of all recommended consults and referrals. All nurses not educated by 8/18/2024 will be educated prior to their next scheduled shift. All newly hired licensed nurses will be educated upon orientation by Assistant Director of Nursing/Designee. 4. An Ad Hoc Quality Assurance Performance Improvement was held on 8/14/2024 with the Interdisciplinary team to discuss details of this plan. Audits will be completed weekly x4 weeks then monthly x3 months by DON/designee of all newly admitted and re-admitted resident discharge summaries for recommendations for consults and referrals to ensure appropriate follow up. Results of audits will be discussed at the monthly Quality Assurance Performance Improvement meeting for three (3)	

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no signs of acute distress. The Nurse Supervisor #1 documented that Resident #12 was noted with swelling to the right eye, no complaints of pain, pupils were reactive to light, and there were no new areas of concern.

A 6/11/24 NP progress note recorded Resident #12 had a recent unwitnessed fall with an evaluation in the hospital and that Resident #12 was in need an ophthalmology evaluation for right eye pain.

A Care Plan revised 6/13/24 indicated Resident #12 required assistance with activities of daily living due to glaucoma of her left eye. Interventions included referral for ophthalmology consultation for right eye edema and pain.

An observation and interview of Resident #12 occurred in her room on 7/16/24 at 8:54 AM. Resident #12 was observed in her bed and noted with mild swelling/puffiness around her eyes and cheeks. Resident #12 denied pain or discomfort to her face and stated, "I am fine."

A review on 7/18/24 of the medical record for Resident #12 and the appointment schedule revealed no appointment for an eye consultation was recorded.

Nurse #1 was interviewed on 7/18/24 at 12:31 PM with the Administrator, Director of Nursing (DON) and the Assistant Director of Nursing (ADON) present. Nurse #1 stated that when a resident returned to the facility from the hospital, the assigned nurse was responsible to assess the resident and document a progress note. Nurse #1 stated she was the assigned 3 PM - 11 PM nurse for Resident #12 on 5/23/24 when the Resident

months or until substantial compliance is met.

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returned from the hospital, Nurse #1 assessed Resident #12 and wrote a progress note, but Nurse #1 did not review the hospital discharge summary, process any physician orders or make any referrals. Nurse #1 stated that the Nurse Supervisor #1 was also in the facility that day and she would have reviewed the hospital discharge summary and processed any new physician orders. Nurse #1 stated that Resident #12 was currently at baseline with no complaints of eye pain.

A 7/18/24 1:10 PM phone interview with Nurse Supervisor #1 revealed she was the 3 PM - 11 PM shift Supervisor on 5/23/24 when Resident #12 returned to the facility from the hospital after evaluation from a fall, but that she no longer worked at the facility. Nurse Supervisor #1 stated that she assessed Resident #12 when the Resident returned to the facility, she did not think Resident #12 returned with any physician orders, but that she did not remember. Nurse Supervisor #1 stated that if Resident #12 did return to the facility with new orders, the Nurse Supervisor would have reviewed the hospital discharge summary and processed any physician orders. Nurse Supervisor #1 stated that she also knew the DON could pull the hospital discharge summary to see if there were any physician orders. The Nurse Supervisor #1 stated that she did not make any referrals for Resident #12 because she did not think the Resident returned with any new orders, but that it was her typical practice to review the hospital discharge summary when a resident returned to the facility from the hospital and process any new physician orders. She stated if there were any new orders to process, "I would do that."

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A 7/18/24 9:33 AM interview with Unit Manager (UM) #1 revealed that when a resident returned to the facility from the hospital, the nurse or nurse manager should review the discharge summary for any new physician orders, discuss any new orders with the MD and implement the orders per the MD review. UM #1 stated that it was the responsibility of the UM to also complete a review of the hospital discharge summary to ensure all physician orders or recommendations were implemented. During a follow up phone interview on 7/25/24 at 10:18 AM, UM #1 stated that she faxed documents to an eye doctor to request an eye consultation for Resident #12 towards the end of May 2024, but could not recall the specific date. UM #1 stated that she did not keep the fax confirmation from this referral, but that the fax confirmation was a document that was usually kept. UM #1 stated that when a request for a consultation was made, the doctor's office typically called the facility to make an appointment. The UM #1 stated that the facility did not receive a return call to make an eye doctor appointment for Resident #12 and that she did not follow up on the request for the referral. UM #1 stated that if the doctor's office did not call back, the facility should follow up to make sure the request for a referral was received and to see if an appointment could be made. The UM #1 stated Resident #12 did not have any current complaints of eye pain.

The DON was interviewed on 7/18/24 at 11:57 AM with the Administrator and the ADON present. The DON stated when a resident returned to the facility from the hospital, the nurse or nurse manager should review the hospital discharge summary for any medication changes, discuss these changes with the MD or NP and review the

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order with the MD or NP for approval. A follow up phone interview on 7/25/24 at 10:14 AM the DON stated that UM #1 faxed a referral request to an eye doctor the end of May 2024 but that the facility did not receive a return call, so the DON called the eye doctor on 7/19/24 to make an appointment for Resident #12. The DON stated that the facility did not follow up on the eye doctor appointment until 7/19/24, but that there should have been follow up sooner to get an eye doctor appointment for Resident #12. The DON stated that the mild swelling/puffiness for Resident #12 was her baseline, and she did not have any current complaints of pain.

The Administrator was interviewed on 7/18/24 at 11:24. The Administrator stated she expected the eye doctor referral to be made for Resident #12 and for staff to follow up if the eye doctor did not call to make an appointment.

During a 7/18/24 12:16 PM phone interview with the NP and the Administrator, DON, and ADON present, the NP stated that she reviewed the 5/23/24 hospital discharge summary when she assessed Resident #12 on 6/11/24 after a fall. The NP stated that she noted in her progress note that Resident #12 needed an ophthalmology evaluation per hospital recommendations due to right eye pain from the fall. The NP stated that she expected the facility to make the referral with an eye doctor and follow up to ensure the appointment was made.

The MD was interviewed on 7/26/24 at 11:52 AM. He reviewed the hospital discharge summary during the interview and stated that he agreed that Resident #12 should have an ophthalmology consult due to her complaints of eye pain after

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F 685	Continued From page 22 the fall on 5/22/24. He stated that an ophthalmology consult appointment could take several months to get, unfortunately, but that he would expect better follow up by the facility to ensure the appointment was obtained.	F 685		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with residents, Medical Director (MD), Nurse Practitioner (NP), Driver #1 and staff, the facility failed to supervise Resident #12, a Resident diagnosed with dementia and bilateral amputations, to prevent a fall. Driver #1 left Resident #12, unsupervised while secured in her wheelchair on the facility's parked transportation van with the engine and air conditioning left on and other residents on the van. While unsupervised by Driver #1, Resident #12 unbuckled the seatbelt to her wheelchair, leaned forward and fell face down to the floor of the van. Driver #1 immediately returned to the transportation van when she heard the horn sound and found Resident #12 face down on the floor of the van. Resident #12 complained to Driver #1 that her head hurt. Driver #1 called the Administrator and received instructions to look for signs of injury. Driver #1 told the Administrator	F 689	1. The facility failed to supervise Resident #12, a Resident diagnosed with dementia and bilateral amputations, to prevent a fall. Driver #1 left Resident #12, unsupervised while secured in her wheelchair on the facility's parked transportation van. Driver #1 made the resident comfortable, observed for injury, and called 911. When paramedics arrived resident #12 was transported to hospital for evaluation and treatment. Resident #12 responsible party and physician was notified of fall with subsequent transfer to hospital. 2. On 7/18/2024, individual interviews were conducted with all residents with a BIMS 13 or above who were transported by the facility transporter by the DON and	8/19/24

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F 689	Continued From page 23 she saw a knot on the Resident's head and received instructions to call 911. Driver #1 called 911 and when paramedics arrived, Resident #12 was transported to the hospital where she was diagnosed with a "tiny" acute hemorrhage of the left lateral ventricle posteriorly (bleeding in and around the brain's ventricles), subcutaneous hematoma (collection of blood underneath the skin) of the right forehead and a painful, swollen right eye. Additionally, the facility failed to supervise Resident #38, assessed as a resident who required supervision when smoking cigarettes, when Resident #38 maintained smoking materials and smoked a cigarette in her room while unsupervised. This deficient practice occurred for 2 of 13 residents reviewed for supervision to prevent accidents at a scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) (Residents #12 and #38). Immediate jeopardy began on 5/22/24 when Resident #12 was left unsupervised in the facility's transportation van, fell and sustained injuries. Immediate jeopardy was removed on 7/19/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. The findings included: 1. Resident #12 admitted to the facility 3/12/24 with diagnoses that included non-Alzheimer's	F 689	Assistant Director of Nursing (ADON) to ensure no unreported incidents occurred during facility transportation. No other residents were affected by this deficient practice. On 8/13/24, the transportation schedule for last 30 days was reviewed by administrator for all residents with a BIMS□s 12 and below. Most recent skin assessment after van transport was reviewed to ensure no new skin issues were noted. 3. On 7/18/24, the Director of Nursing provided one on one education to the transportation aide/CNA regarding the need for supervision for residents who are identified as requiring supervision during transportation. The transportation aide/CNA will be accompanied by an additional staff member, a CNA or a personal care assistant (PCA) for the supervision of any residents who are identified as requiring supervision as determined by a review to the resident's cognitive status, past or current behaviors and their latest functional ability assessment. This staff member will remain on the van with the residents while the driver is boarding, during the drive and while off-loading the residents. There is one transportation aide/CNA who is supervised by the Administrator of the facility. Any newly hired transportation aid will be educated by ADON/Designee upon orientation. 4. An Ad-Hoc QAPI meeting was held with the Interdisciplinary Team on 8/14/24	

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bilateral amputation of the lower extremities. Interventions included to cue, reorient, supervise as needed, to assess, anticipate resident needs, assess resident's understanding of the situation and follow facility fall protocol.

A 4/12/24 physician order for Resident #12 recorded (named kidney center) every Monday, Wednesday, and Friday at 12:15 PM for hemodialysis.

A 5/15/24 11:00 AM incident report documented Resident #12 fell from her wheelchair in the dining room and the fall was witnessed by another resident. The incident report documented Resident #12 was assessed without visible signs of injury. The NP was notified, and an order was obtained to send Resident #12 to dialysis as ordered with instructions for continued monitoring.

A 5/15/24 NP progress note recorded Resident #12 was assessed after a fall from her wheelchair. The NP progress note recorded there was no change in mental status, vital signs were assessed at baseline and Resident #12 was transferred to dialysis. The NP ordered neuro checks prior to dialysis, monitor vital signs and notify dialysis to monitor closely during treatment.

A 5/22/24 (Wednesday) 12:45 PM nurse progress note recorded Resident #12 left the facility for dialysis.

A 5/22/24 6:30 PM incident report, documented by the Administrator, recorded that on 5/22/24 it was reported by staff that Resident #12 fell and hit her head. The incident report recorded 911 was called and Resident #12 was taken to the

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hospital for evaluation and treatment. The incident report recorded injuries at the time of the incident as a hematoma to the top of her scalp. The incident report described Resident #12 as disoriented to place, situation, time, and oriented to person. The incident report documented predisposing factors were chair position, impulsive behavior, impaired awareness, weakness, confusion, lost balance, and a history of confusion after dialysis treatments. A witness to the fall was recorded as Resident #55.

A 5/22/24 witness statement documented by Driver #1 recorded the following "On Wednesday, 5/22/24, at (named dialysis center) parking lot, while going in to get Resident #79 out of the building, around 4:30 PM, Resident #12 took off her seatbelt and fell on the floor. Resident #55 stated that Resident #12 was trying to get up and call her sister. I immediately called my Administrator and helped Resident #12 back in her chair. I was told to call 911 and that's what I did. 911 came soon and checked out Resident #12 and took her to (named) hospital."

A 5/22/24 EMS Run Report documented paramedics arrived at the facility transportation van at 4:56 PM in response to Resident #12's fall from a wheelchair. Per the report, Driver #1 reported to paramedics that Resident #12 took her seatbelt off and fell face first onto the floor of the van. Paramedics recorded that at 5:00 PM Resident #12 was assessed with a hematoma to the right side of her forehead, with no crepitus (grading, popping, or clicking of a joint) felt. Per the report, Resident #12 complained of right upper arm pain to paramedics, her pupils were reactive to light and her lungs were clear and equal. Per the report, the injuries and complaint

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of pain were sustained when Resident #12 fell 3 feet from a seated position onto the floor of the van. Per the report, Resident #12 was transported by paramedics to the hospital in stable condition for further evaluation.

A 5/23/24 hospital discharge summary recorded Resident #12 admitted to the hospital on 5/22/24 for evaluation after a fall and discharged back to the facility on 5/23/24 in stable condition. The hospital course described Resident #12 as oriented to self, but unable to determine baseline due to a diagnosis of dementia. The hospital course documented that a CT scan of the head (a computed tomography which is a diagnostic procedure that uses X rays and computers to create detailed cross-sectional images of the inside of the body) showed a "tiny" acute hemorrhage of the left lateral ventricle posteriorly and a subcutaneous hematoma of the right forehead. Resident #12 was referred for a neurosurgery consult, a second CT scan was completed with stable results. A tertiary exam (a final means of identifying injury), although limited due to Resident #12's dementia, showed negative results. Her right eye was swollen and painful upon palpation (touch).

An observation of and interview with Resident #12 occurred in her room on 7/16/24 at 8:54 AM. Resident #12 was observed in her bed and stated she did recall having a recent fall and transported to the hospital. Resident #12 did not recall the date of the fall or any details surrounding the fall of 5/22/24. During the interview, Resident #12 stated, "I am fine."

A 7/18/24 at 9:25 AM interview with Resident #55, a Resident identified by the facility as

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alert/oriented to person, place, situation, and time, revealed on Wednesday, 5/15/24 around 11:00 AM Resident #55 and Resident #12 were in the 1st floor dining room, Resident #12 was in her wheelchair, released the brakes on her wheelchair and slid out of her wheelchair onto the floor. Resident #55 said nurses came right away, checked her out, determined she was not injured and that she was fine. Resident #55 said she and Resident #12 went to dialysis that day and Resident #12 appeared fine on the ride to/from dialysis. Resident #55 further stated that she was also on the facility transportation van the next Wednesday, 5/22/24, when Resident #12 fell. Resident #55 stated Resident #12 was on the transportation van on Wednesday, 5/22/24 at 4:30 PM, parked in front of the dialysis center, when Resident #55 walked onto the facility van after dialysis. Resident #55 stated that Resident #12 was in her wheelchair on the van with her seatbelt fastened and that Resident #12 asked Driver #1 to call a family member. Resident #55 stated that after she got on the van, and fastened her seat belt, and Driver #1 got off the van to assist Resident #79 from the lobby of the dialysis center onto the van. Resident #55 stated that while the Driver was off the van, Resident #12 also asked Resident #55 for assistance to call a family member. Resident #55 explained that when Resident #55 responded to Resident #12 that she could not assist Resident #12 because she did not know the number, Resident #12 unfastened her seatbelt, reached towards a mobile phone that was nearby, and fell face down on the floor of the van. Resident #55 stated after Resident #12 fell, Resident #55 blew the horn on the van, one long blow and one short blow to alert the Driver of an emergency and the Driver immediately returned to the van, without Resident

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#79. Resident #55 further stated that when Driver #1 returned to the van, Resident #12 was face down on the floor of the van. Resident #55 stated that the Driver always left the other Residents for "a minute or two" on the van while she left to get Resident #79 from the lobby of the dialysis center and help him onto the van.

A 7/18/24 9:44 AM interview with Driver #1, with the Unit Manager (UM) #1 present, revealed she was the transportation driver for about a year and a nurse aide for the facility. Driver #1 stated she received driver safety training when she became the Driver for the facility and received re-education in May 2024 after the fall incident with Resident #12 occurred on the transportation van. Driver #1 stated that on Wednesday, 5/22/24 at around 3:50 PM she picked up Resident #12, a Resident described with dementia and intermittent confusion, from dialysis, placed her on the transportation van and secured her in the wheelchair with restraints and a seatbelt. Driver #1 stated that after she secured Resident #12 on the transportation van, she then drove to a second dialysis center and arrived around 4:30 PM to pick up additional Residents (Residents described as alert, oriented, and without confusion) from the dialysis center. Driver #1 stated that when she pulled up to the dialysis center, she parked in front of the dialysis center, left the transportation van running and the air conditioning on while Resident #55 got on the transportation van, sat down and fastened her seatbelt. Driver #1 stated she advised the Residents to remain in their seats secured with their seatbelts while she went inside the dialysis center to get Resident #79. Driver #1 said it typically took about one to two minutes to get Resident #79 from the lobby of the dialysis center

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and bring him to the transportation van as he waited for the Driver in the lobby of the dialysis center. Driver #1 said that it was her routine to park in front of the dialysis center, secure the other Residents on the transportation van and have them wait on the van while she left the van, and went to the lobby of the dialysis center to get Resident #79. The Driver further stated, but this time as soon as she walked inside of the dialysis center, Driver #1 heard the horn blow one long blow and one short blow, so she left Resident #79 in the lobby of the dialysis center and immediately returned to the transportation van because she knew it was an emergency. Driver #1 stated when she returned to the transportation van, she saw Resident #12 lying face down on the floor of the van. Resident #55 told Driver #1 that Resident #12 unfastened her seat belt to get up to call a family member and fell. Driver #1 said Resident #12 said her head was hurting and Driver #1 could see a knot forming over the Resident's right eye. Driver #1 stated that when she saw Resident #12 on the floor of the van, she called the Administrator and told the Administrator about the fall and the "knot" on the Resident's forehead. Driver #1 said the Administrator told her to call 911. Driver #1 said she called 911 and when the paramedics arrived, Resident #12 told the paramedics "I am fine." Driver #1 stated the paramedics assessed Resident #12 and transported the Resident to the hospital. Driver #1 stated that she always transported Residents to/from dialysis alone because it was a quick drop off and pick up. Driver #1 stated Resident #12 had periods of confusion, but she had never taken her seatbelt off before on the transportation van when the Driver instructed her to stay buckled in her seat. Driver #1 also stated that she probably heard about her fall on 5/15/24 in the

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dining room, but that was months ago, and she did not recall.

A 7/18/24 9:33 AM interview with UM #1 revealed she was notified during the morning clinical meeting on 5/23/24 that Resident #12 was in the hospital for evaluation of a hematoma. The UM #1 said she was notified that Resident #12 sustained a hematoma over her right eye after a fall when she unbuckled her seatbelt on the transportation van, leaned forward and fell onto the floor of the transportation van. The UM #1 described that it was not unusual for Resident #12 to have intermittent confusion and lean forward in her wheelchair, especially when she was tired and that she was often more tired and confused on the days she went to dialysis.

The Director of Nursing (DON) was interviewed on 7/18/24 at 11:57 AM. The DON stated she expected Residents with confusion to be supervised during transport.

The Administrator was interviewed on 7/18/24 at 11:34 AM and stated that she completed the incident report regarding a 5/22/24 fall Resident #12 had on the transportation van. The Administrator stated that on 5/22/24 at approximately 4:40 PM, she received a call from Driver #1 who notified the Administrator that the Driver was inside the dialysis center when the Driver heard the horn on the van and came back out to the transportation van. The Administrator said that when the Driver got back on the van, she saw Resident #12 on the floor of the van. The Administrator stated that the Driver said Resident #55 told the Driver that Resident #12 unbuckled her seatbelt, moved around, and landed on the floor of the transportation van. The Administrator

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stated she asked Driver #1 if Resident #12 was alert, breathing, and to look for signs of injury. The Administrator said Driver #1 told the Administrator that Resident #12 had a "knot" on her forehead, but that the Driver did not see any further injuries. The Administrator stated she told the Driver not to move the van, make Resident #12 comfortable, and to call 911. The Administrator stated that it was not the facility's practice to send an additional staff member to supervise residents when there was more than one resident on the facility transportation van to drop off or pick up residents from dialysis because the drop off and pick up was so quick. The Administrator also stated that per the facility policy, a resident with a diagnosis of dementia who displayed confusion, would satisfy the facility policy for a resident with other health issues who required supervision. The Administrator further stated that Driver #1 received driver safety training when she became the Driver for the facility and received re-education in May 2024 after a fall incident occurred on the transportation van. The Administrator provided documentation of driver safety re-education for Driver #1, but stated she could not locate documentation of initial driver safety training when Driver #1 began in this role about a year ago.

A 7/18/24 12:16 PM phone interview with the NP revealed she was notified of the fall that occurred on the transportation van for Resident #12. The NP described Resident #12 as a "confused" Resident with a diagnosis of dementia and a history of falls and for these reasons she would expect Resident #12 to always be supervised during transportation on the facility transportation van.

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A phone interview with the MD occurred on 7/18/24 at 8:31 PM. The MD stated he was notified on the day of the fall when Resident #12 fell on the transportation van. The MD stated that he did not agree with, nor was it a good idea to leave Resident #12 unsupervised on the transportation van due to her intermittent confusion and dementia.

The Administrator was notified of immediate jeopardy on 7/18/24 at 3:55 PM.

The facility provided the following credible allegation of immediate jeopardy removal.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

On 5/22/24, the facility transportation aide, who is also a certified nursing assistant (CNA), transported four residents from dialysis to the facility. During transport, a resident with a diagnosis of dementia, was left unsupervised while secured in her wheelchair on the facility's transportation van. The van was parked, left running while the AC unit was on. While unsupervised by the transportation aide/CNA, the resident unbuckled the seatbelt to her wheelchair, leaned forward and fell.

All residents who are transported by the facility van have the potential to be harmed by this alleged deficiency.

The resident who had the fall was sent to the emergency room for evaluation and treatment. The remaining residents on the van returned to the facility. The Administrator who was on site at

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the time of the incident and who is also a registered nurse, assessed the remaining 3 residents. No injuries and no distress were noted, and those residents continued with their established routines for the evening. The facility van was not used for the remainder of the day.

The transportation aide/CNA gave her statement to the facility administrator concerning the incident. It was determined that she was the only staff member on the van with multiple residents being transported from their appointments that day. This staff member was unable to both supervise the residents on the van and board the remaining residents, causing the incident. This driver has only transported a maximum number of 4 residents to dialysis alone and on days that nurse manager has determined that an escort is needed for outside appointments, staff have accompanied the van driver, or the family of the resident meets the driver at the appointment. For resident outing activities that use the facility van, the activity assistant accompanies the driver for supervision of the residents.

The transportation schedule was reviewed with the Nurse Managers, and it was determined that one resident who had an appointment the next day did not require supervision. No other residents required transportation. The resident's cognitive ability, history of behaviors, and their most recent functional ability assessment which identifies such tasks as the resident's mobility status, transfer from car, bed, chair status, bending and picking up an object and ambulation capabilities, was used to make that determination.

On 5/22/2024, the Administrator re-educated

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Driver #1 on facility van transportation policies and completed a Transportation Skills Assessment of the Transportation Aide/ CNA with no concerns noted.

On 5/23/2024, an Ad Hoc meeting was held with the following in attendance: the Administrator, the Director of Nursing, the Nurse Managers, the Rehab director, the MDS nurse, the Activity Director, and the Wound Care Nurse. The Medical Director, who was notified of the incident on 5/22/2024, was not in attendance, but was updated by the Administrator of the meeting's agenda and findings. It was also determined that the van driver could not supervise all four residents to dialysis. The number of residents the transportation aide/CNA would now transport for appointments will be two residents, allowing the driver to keep the residents in eyesight during boarding and offloading. Additionally, any resident with a predetermined need for additional supervision due to cognitive impairment, history of behaviors, or functional limitations will be escorted by facility staff/designated individuals during transportation.

On 5/23/2024, the Administrator initiated audits of the boarding and off-loading residents onto the van to ensure that the residents were secured appropriately in their chairs. This audit was weekly for a total of four weeks with no concerns noted.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 7/18/24, the Director of Nursing provided one

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on one education to the transportation aide/CNA regarding the need for supervision for residents who are identified as requiring supervision during transportation. The transportation aide/CNA will be accompanied by an additional staff member, a CNA or a personal care assistant (PCA) for the supervision of more than 1 resident who require supervision as determined by a review to the resident's cognitive status, past or current behaviors and their latest functional ability assessment. This staff member will remain on the van with the residents while the driver is boarding, during the drive and while off-loading the residents. There is one transportation aide/CNA who is supervised by the Administrator of the facility.

On 7/18/24, the Director of Nursing assessed all residents with a BIMS of 9 or below, past or active behaviors, and the resident's most recent functional ability assessment to determine the need for supervision during transportation. All residents identified as needing supervision will be supervised by facility staff/designated individuals during transportation. A CNA or a personal care assistant (PCA) will be scheduled to serve as an additional staff member for the supervision of the residents. This information will be posted on the transportation schedule that is posted at each nursing station daily. Also on this posting, the Administrator and Director of Nursing information will be available.

On 7/18/2024, care plans were updated as appropriate by the Director of Nursing/Assistant Director of Nursing and the Administrator, for any resident requiring this supervision.

On 7/18/2024 the Administrator held an in person

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Ad Hoc Meeting with the Interdisciplinary Team (IDT), which included the Director of Nursing, the Assistant Director of Nursing, two Nurse Managers, the Wound Care Nurse, the Rehab Director, the MDS nurse, to discuss incident and the credible allegation for the immediate jeopardy removal plan.

On 7/18/2024, the Assistant Director of Nursing, and the Nurse Managers began training all facility staff including agency staff on the facility process for residents who are transported by the facility van that have the need for supervision. Staff will use the resident's most recent BIMs and the most recent functionality assessment which shows how a resident. This education included that when transporting more than one resident, there will be an additional staff member provided, how this information is determined, and where this information is posted for staff information. No staff will be allowed to work, including any new hires and agency staff, without receiving this education. This education will also be added to the new hire orientation for the facility. The Administrator notified the Assistant Director of Nursing and the Nurse Managers of this responsibility.

Effective 7/18/2024, the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 7/19/2024

The Credible Allegation of immediate jeopardy removal plan was validated onsite on 7/26/24 with an effective date of 7/19/24. The facility provided documentation of re-education, verification of

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facility approved contract and facility-employed transportation drivers, documentation of transportation driver's safety skills assessment, and QAA plan. Interviews with alert and oriented residents who used facility transportation resulted in no concerns expressed related to emergency response during transportation. Staff hired or contracted for transportation were interviewed and communicated knowledge of emergency response protocols and safety re-education during transportation incidents per the facility policy. Nursing staff were interviewed and communicated knowledge of how to advise a driver who calls the facility to communicate a transportation related incident, per facility policy and re-education. An observation of staff boarding residents for transportation demonstrated contract staff and facility employed staff following safety protocols for residents with health issues per facility policy. The IJ removal date of 7/19/24 was validated.
2. Review of the facility smoking policy revised 01/22/24 titled, "Resident Smoking" revealed under Policy Explanation and Compliance Guidelines that smoking materials of residents requiring supervision with smoking will be maintained by nursing staff.

Resident #38 was originally admitted to the facility on 02/08/19 with diagnoses which included nicotine dependence, traumatic subarachnoid hemorrhage without loss of consciousness, fracture of occiput (skull fracture), psychosis, altered mental status, acute cystitis without hematuria, hyperlipidemia, and hypertension.

Review of Resident #38's quarterly Minimum Data Set (MDS) dated 05/03/24 revealed the resident was cognitively intact and required

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extensive assistance for most activities of daily living (ADL). The MDS further revealed resident #38 was not coded for oxygen.

Review of progress note dated 05/22/24 revealed Resident #38 stated that she sat down on side porch steps to gather cigarette butts to smoke. The note further revealed Resident #38 was educated on safety practices of smoking cigarette butts and transferring while outside. Resident #38 was assisted back to her wheelchair back into the facility. The note indicated no injuries were noted, no pain or discomfort noted, and the Nurse Practitioner (NP) and Resident representative (RR) was notified.

Review of Resident #38's quarterly smoking assessments dated 06/29/24 revealed the resident was an unsafe smoker and required supervision. During an interview with the Director of Nursing (DON) on 07/18/24 at 11:15 AM it was revealed Resident #38 was deemed unsafe due to an incident on 5/22/24 when she got out of her wheelchair and was picking up used cigarettes off the ground.

Review of Resident #38's most recently signed smoking agreement was dated 03/13/24. The agreement revealed the resident was verbally educated on the smoking policy and how to store smoking materials. (This was just sent to me by the DON)

Review of progress note dated 07/13/24 revealed Nurse #3 smelled cigarette smoke in Resident #38's room during second shift. The note further revealed Resident #38 confirmed that she smoked in the room and the cigarette and lighter was taken and locked away by Nurse #3. The

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note indicated Resident #38 was reeducated on the facility smoking policy.

An interview conducted with Nurse #3 on 07/17/24 at 11:20 AM revealed it was during second shift on 07/13/24 and she passed Resident #38's room there was a strong odor of cigarettes. Nurse #3 further revealed she entered the room and a half-smoked cigarette and lighter were sitting on the bedside table put out. Nurse #3 indicated Resident #38 admitted to smoking in the room but did not

observe any ashes in the room. Nurse #3 stated she reported to Nurse Supervisor #2 who was the supervisor on duty and the residents' smoking materials were confiscated and locked up.

An interview conducted with Resident #38 in the residents' room on 07/17/24 at 10:35 AM revealed she used to be an independent smoker but was recently switched to a supervised smoker due to "getting into trouble". Observation revealed Resident #38 had a roommate with no oxygen found in the room. Resident #38 further revealed on 07/13/24 she went out to smoke during the supervised smoke break and staff had given her smoking materials and left the residents unsupervised. Resident #38 admitted she took her smoking materials back to her room because she does not like to be supervised and lit a cigarette in her room. Resident #38 indicated she knew she shouldn ' t smoke in the facility and would not do it again because nursing staff was not happy with her. Resident #38 stated staff often leave residents unsupervised during smoking times in the evenings.

An observation and interview with smoking

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residents (Resident #37, Resident #44, and Resident #50) who were cognitively intact on 07/17/24 at 11:00 AM revealed they were independent smokers but often smoked during supervised smoking times. It was further revealed staff often would hand out smoking materials and would leave during supervised smoking times.

A phone interview conducted with Nurse Supervisor #2 on 07/17/24 at 12:10 PM revealed on 07/13/24 around 7:30 PM Nurse #3 reported that Resident #38 had smoking materials in her room. Nurse Supervisor #2 indicated she observed a half-smoked cigarette and lighter on the Resident ' s nightstand. Nurse Supervisor #2 further revealed she took materials away from Resident #38 but did not report this incident to any upper management because she got busy on shift and forgot to report.

An interview conducted with Nurse Aide #3 on 07/17/24 at 1:05 PM revealed he was assigned on 07/13/24 to assist supervised smokers during smoking times during second shift. NA #3 further revealed he could not recall if Resident #38 was a supervised smoker. NA #3 stated he was not sure how Resident #38 had gotten back to her room with smoking materials because he had stayed with Resident #38 and supervised smokers and observed them smoking. NA #3 indicated he assumed Resident #38 had put smoking material in her pockets and does not recall if he took Resident #38 ' s smoking materials after the supervised smoking time during second shift

An interview conducted with the Director of Nursing (DON) on 07/18/24 at 11:15 AM revealed Resident #38 was a supervised smoker due to previous behaviors of hiding cigarettes and

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picking up cigarettes off the ground. The DON further revealed a resident that was assessed to be supervised has their smoking materials locked up and was to be observed while smoking. The DON stated she expected supervised smokers to not be able to retrieve smoking materials without staff present.

An additional interview conducted with the DON on 07/25/24 at 10:25 AM revealed she was made aware of the incident on 07/13/24 by Nurse Supervisor #2. The DON stated there was one resident on the first floor (100 Hall) and two residents on the third floor (300 Hall) who were ordered for oxygen. No residents had orders for oxygen on Resident #38 ' s floor. The DON explained all smokers have a locked box at the entrance of the smoking patio. It was indicated independent smokers have a key to their own box, but supervised smokers had to be opened by nursing staff. The DON revealed Resident #38 was able to light her own cigarette, but smoking materials were to be
confiscated after her smoking time to be locked up. Nurse Supervisor #2 on 07/13/24 indicated to the DON Resident #38 had smoking materials in her room but found no evidence of ashes and that she had smoked in her room. The DON the incident was reviewed on 7/15/24 during the morning clerical meeting. The DON further revealed she interviewed Resident #38 on 07/16/24 and the resident denied smoking in the room but admitted she had smoking materials on her bedside table. The DON stated it was undetermined how the cigarette and lighter got back to the resident's room. The DON indicated on 07/16/24 she educated Resident #38 and all smokers on the smoking policy, conducted a sweep of looking for smoking materials in facility,

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F 689	Continued From page 43 and reviewed smoking assessments and did not identify any issues. The DON indicated interventions for Resident #38 was to continue to be a supervised smoker. The DON stated in-service was completed with all nursing staff by the ADON on 07/16/24 which reviewed the smoking policy, smoking times, extinguishing cigarettes in the proper area, and supervisions for supervised smokers. The DON stated nobody had notified her that residents had been left unsupervised during smoking times. An interview conducted with the Administrator on 07/18/24 at 3:05 PM revealed she was made aware of Resident #38 having smoking materials in her room on 07/15/24 during clerical morning meeting. It was further revealed verbal education was given to nursing staff to always keep constant visual on supervised smokers and Resident #38 was educated on the smoking policy. The Administrator stated she is not sure how Resident #38 was able to get back to her room with any smoking materials because the smoking materials are collected and locked up at the entrance of the smoking area. The Administrator further revealed Resident #38, or any supervised smoker should have not been able to go back to their room with any smoking materials.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must	F 693		8/19/24

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F 693	Continued From page 44 ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to follow a physician order of daily water flushes for a resident that was tube fed for 1 of 1 sampled resident (Resident #13). The findings included: Resident #13 was admitted to the facility on 04/05/23 with diagnoses which included cerebral infarction, hypertension, and hypotension. Review of Resident #13's quarterly Minimum Data Set (MDS) dated 07/03/24 revealed the residents were dependent of most activities of daily living (ADL). The MDS further revealed Resident #13 was coded for tube feeding. Review of Resident #13's baseline care plan revised on 03/18/24 revealed the resident is at risk for dehydration due to requiring tube feeding.	F 693	1. The facility failed to follow a physician order of daily water flushes for resident #13. On 7/16/24 Nurse #1 changed the pump setting to reflect physician order, verified by the Director of Nursing (DON), and notified the physician who ordered labs. Labs were obtained on 7/18/24 with no significant abnormalities noted. 2. On 7/16/24, an audit was conducted by DON of all residents receiving tube feeding via pump to ensure that flush setting was as ordered. No other concerns were noted. 3. Education began with all licensed nurses on 7/16/24 by Assistant Director of Nursing/Designee on policy regarding verifying accurate tube feeding pump setting per physician order. Any nurse not educated by 8/18/24 will be educated prior	

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F 693	Continued From page 45 The goal was for resident #13 to be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor daily through the next review date. Interventions included administering Resident #13's medications as ordered. Review of a physician order dated 01/09/24 revealed an order for Resident #13 to receive 150 milliliters (ml) water flush every four hours. An observation conducted on 07/15/24 at 10:50 AM revealed Resident #13's pump showed water flushes running at 75 ml every four hours. An observation conducted on 07/16/24 at 9:35 AM revealed Resident #13's pump showed water flushes running at 75 ml every four hours. An observation and interview conducted with Nurse #1 on 7/16/24at 10:35 AM revealed Resident #13's pump showed water flushes running at 75 ml every four hours. Nurse #1 reviewed Resident #13's physician orders and revealed the water flushes were set inaccurately on the pump. Nurse #1 indicated 3rd shift changed the tube feeding a hydration bag, but she should have double checked when she started her shift. Nurse #1 stated she would change the pump setting and notify the provider. A phone interview conducted with Nurse #2 on 07/18/24 at 11:55 AM revealed she worked third shift on 7/15/24 with Resident #13. Nurse 35 further revealed she recalled hanging Resident #13's tube feeding and hydration bag before around 6:00 AM on 07/16/24. Nurse #2 indicated she does not recall what Resident #13's pump was set at but must have accidentally not set	F 693	to the start of next shift. All newly hired nurses will be educated by Assistant Director of Nursing/Designee during orientation. 4. 4. An Ad-Hoc QAPI meeting was held with the Interdisciplinary Team on 8/14/24 to discuss this plan. Audits will be conducted by DON/Designee of all residents who receive continuous tube feeding for appropriate flush setting weekly times 4 weeks, then monthly for 3 months. Results of audits will be discussed at the monthly Quality Assurance Improvement meeting for 3 months or until substantial compliance is achieved.	

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F 693	Continued From page 46 pump to match the resident's order. An interview with the facility Registered Dietician (RD) on 07/17/24 at 3:30 PM revealed Resident #13's order revealed to be 150 ml of flushes every four hours. The RD further revealed Resident #13 received flushes with medicine, so the resident had not had any significant hydration concerns. The RD indicated even though there were no hydration concerns she expected Resident #13's orders to be followed. An interview conducted with the Director of Nursing (DON) on 07/18/24 at 11:05 AM revealed she expected nursing staff to check Resident #13's tube feeding pump every shift to ensure the pump is running as ordered. The DON further revealed the Nurse Practitioner (NP) and the RD were notified and labs were ordered. An interview conducted with the Administrator on 07/18/24 at 3:15 PM revealed Resident #13 water flushes should have been running at 150 ml every four hours instead of 75 ml per four hours as ordered. The Administrator further revealed she expected staff to follow resident orders.	F 693		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		8/19/24

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F 757	Continued From page 47 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Medical Director (MD), Nurse Practitioner (NP), and staff, the facility failed to discontinue aspirin (a non-steroidal anti-inflammatory medication used to treat pain and reduce the risk of a heart attack by thinning the blood) as recommended by the hospital for 1 of 6 sampled residents reviewed for the use of unnecessary medications (Resident #12). The findings included: Resident #12 was admitted to the facility 3/12/24 with diagnoses that included end stage renal disease, dependence on hemodialysis, chronic diastolic heart failure, and essential hypertension. A 3/13/24 physician order recorded Aspirin, low dose oral tablet, chewable 81 milligrams (mg), give one tablet by mouth one time a day for prophylaxis (a medication given to prevent disease). The order was discontinued on 5/29/24. A 3/19/24 admission Minimum Data Set	F 757	1. The facility failed to discontinue aspirin as recommended by the hospital on 5/23/24 for Resident #12. On 5/29/24 aspirin was discontinued and the provider was notified by the Director of Nursing (DON), with no new orders obtained. 2. An initial audit was completed by 8/18/24 by DON and Regional Clinical Educator on all newly admitted and re-admitted resident discharge summaries for 90 days to ensure recommended medication changes were implemented. No other issues were identified. 3. Education with all licensed nurses was initiated on 8/8/24 by Assistant Director of Nursing (ADON)/Designee on procedure for reviewing resident hospital discharge summaries for any noted medication changes, and ensuring accurate transcription in resident record. Any nurse not educated by 8/18/24 will be educated prior to start of next shift. All	

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F 757	Continued From page 48 assessment indicated Resident #12's cognition was moderately impaired, no falls since admission to the facility and she received dialysis services. A 3/25/24 Care Plan indicated Resident #12 had impaired cognitive function regarding her diagnosis of dementia, and cognitive communication deficits which placed her at risk for falls. Interventions included administering medications as ordered, monitoring, documenting and reporting any signs of bleeding or hemorrhaging. A 5/22/24 6:30 PM incident report documented that on 5/22/24 staff reported that Resident #12 fell and hit her head. The incident report recorded 911 (emergency medical services) was called and Resident #12 was taken to the hospital for evaluation. The incident report recorded injuries at the time of the incident as a hematoma to the top of her scalp. A 5/23/24 11:51 AM hospital discharge summary recorded Resident #12 admitted to the hospital on 5/22/24 for evaluation after a fall. The hospital course documented that a CT scan of the head (a computed tomography which is a diagnostic procedure that uses X rays and computers to create detailed cross-sectional images of the inside of the body) showed a tiny acute hemorrhage of the left lateral ventricle posteriorly (bleeding in and around the brain's ventricles), subcutaneous hematoma (collection of blood underneath the skin) of the right forehead, and her right eye was swollen and painful upon palpation (touch). The hospital discharge summary recorded a recommendation to discontinue Aspirin 81 mg due to her fall risk. The	F 757	newly hired licensed nurses will be educated during orientation by ADON/Designee. 4. An Ad-Hoc QAPI meeting was held with the Interdisciplinary Team on 8/14/24 to discuss this plan. Audits will be conducted by DON/Designee of all newly admitted and re-admitted discharge summaries for recommended medication changes to ensure recommendations were transcribed as ordered weekly times 4 weeks, then monthly for 3 months. All resident hospital discharge summaries will be reviewed in morning clinical meeting by DON/designee to ensure all recommended medication changes are transcribed as ordered. Results of audits will be discussed at the monthly Quality Assurance Improvement meeting for 3 months or until substantial compliance is achieved.	

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discharge medication list on the hospital discharge summary recorded discontinued medications, Aspirin 81 mg chewable tablet. Resident #12 discharged back to the facility on 5/23/24 in stable condition.

A 5/23/24 9:13 PM nurse progress note, written by Nurse #1 recorded Resident #12 returned to the facility at 4:45pm, denied pain, and was noted with a swollen right eye from a fall. There was no documentation in the progress note regarding review of the hospital discharge summary nor any change in orders.

A 5/23/24 9:01 PM nurse progress note, written by the Nurse Supervisor #1 recorded Resident #12 returned to the facility from the hospital, with no signs of acute distress. The Nurse Supervisor #1 documented that Resident #12 was noted with swelling to the right eye, no complaints of pain, pupils were reactive to light, and there were no new areas of concern. Nurse Supervisor #1 recorded staff would continue to monitor for changes related to mental and physical condition from a fall and that neuro checks were started. There was no documentation in the progress note regarding review of the hospital discharge summary nor any change in orders.

Review of Resident #12's May 2024 Medication Administration Record revealed Aspirin 81 mg was administered to Resident #12 at 9:00 AM on 5/24/24, 5/25/24, 5/26/24, 5/28/24 and 5/29/24.

Nurse #1 was interviewed on 7/18/24 at 12:31 PM with the Administrator, Director of Nursing (DON) and the Assistant Director of Nursing (ADON) present. Nurse #1 stated that when a resident returned to the facility from the hospital, the

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assigned nurse was responsible to assess the resident and document a progress note. Nurse #1 further stated that if a nurse supervisor was in the facility, the nurse supervisor would review the hospital discharge summary for any new orders and implement the new orders. Nurse #1 stated she was the assigned 3 PM - 11 PM nurse for Resident #12 on 5/23/24 when the Resident returned from the hospital, Nurse #1 assessed Resident #12 and wrote a progress note, but Nurse #1 did not review the hospital discharge summary or process any physician orders. Nurse #1 stated that the Nurse Supervisor #1 was also in the facility that day and she would have reviewed the hospital discharge summary and processed any new physician orders.

A 7/18/24 1:10 PM phone interview with Nurse Supervisor #1 revealed she was the 3 PM - 11 PM shift Supervisor on 5/23/24 when Resident #12 returned to the facility from the hospital after evaluation from a fall, but that she no longer worked at the facility. Nurse Supervisor #1 stated that she assessed Resident #12 when the Resident returned to the facility, she did not think Resident #12 returned with any orders, but that she did not remember. Nurse Supervisor #1 stated that if Resident #12 did return to the facility with new orders, the Nurse Supervisor would have reviewed the hospital discharge summary and processed any physician orders. Nurse Supervisor #1 further stated that she did not recall processing an order to discontinue Aspirin 81 mg for Resident #12 because the Resident may have returned to the facility without "an after-visit summary." Nurse Supervisor #1 stated that on more than one occasion residents returned from the hospital without "an after-visit summary" and Nurse Supervisor #1 had to call

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the hospital to get the "after visit summary" faxed, but that the Nurse Supervisor also knew the DON could pull the hospital discharge summary to see if there were any medication changes. Nurse Supervisor #1 stated she did not process an order to discontinue Aspirin 81 mg for Resident #12 because she did not think Resident #12 returned with "an after-visit summary." Nurse Supervisor #1 stated that if Resident #12 did return with medication changes, Nurse Supervisor #1 would process the orders for any medication changes because she usually would read the hospital discharge summary for any new orders. The Nurse Supervisor #1 stated that it was her typical practice to review the hospital discharge summary when a resident returned to the facility from the hospital and process any new physician orders and if there were any new orders to process, Nurse Supervisor #1 stated "I would do that."

A 7/18/24 9:33 AM interview with Unit Manager (UM) #1 revealed she was notified during the morning clinical meeting on 5/23/24 that Resident #12 was in the hospital for evaluation of a hematoma from a fall. UM #1 stated that when a resident returned to the facility from the hospital, the nurse or nurse manager should review the discharge summary for any new physician orders, discuss any new orders with the MD and implement the orders per the MD review. UM #1 stated that it was the responsibility of the UM to also complete a review of the hospital discharge summary to ensure all physician orders were implemented, but that Aspirin 81 mg that was recorded on the hospital discharge summary to be discontinued for Resident #12 was not discontinued until 5/29/24 when "someone" caught the error and discontinued the medication.

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The DON was interviewed on 7/18/24 at 11:57 AM with the Administrator and the ADON present. The DON stated when a resident returned to the facility from the hospital, the nurse or nurse manager should review the hospital discharge summary for any medication changes, discuss these changes with the MD or NP and review the order with the MD or NP for approval. The DON stated that she was not sure why the Aspirin 81 mg was not discontinued for Resident #12, per the hospital discharge summary, but that the DON saw the error when she reviewed the 5/23/24 hospital discharge summary and saw that the Aspirin 81 mg had not been discontinued. The DON stated she discontinued the order for the Aspirin 81 mg on 5/29/24 when she saw the error. The DON stated that the physician order for the Aspirin 81 mg should have been discontinued per the hospital discharge summary when Resident #12 returned to the facility because Resident #12 was still at risk of a continued intracranial bleed even though Aspirin 81 mg was a low dose. The DON stated she could not recall re-educating the nurse or nurse manager about the error.

A 7/18/24 12:16 PM phone interview with the NP with the Administrator, DON, and ADON present. The NP stated that she reviewed the 5/23/24 hospital discharge summary and agreed to discontinue the Aspirin 81 mg but she did not recall the date. The NP stated that continued use of the Aspirin 81 mg, even though it was a low dose and presented a low risk for a continued intracranial bleed, there was still a risk, nevertheless. The NP stated that she would expect the Aspirin 81 mg to be discontinued when Resident #12 returned from the hospital and would need to be re-evaluated by the provider to

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F 757	Continued From page 53 determine if the medication wound need to be restarted. The NP stated that the Aspirin 81 should not have continued for administration when Resident #12 returned from the hospital because the order to discontinue was on the 5/23/24 hospital discharge summary. A phone interview with the MD occurred on 7/18/24 at 8:31 PM. The MD stated he was notified on the day of the fall when Resident #12 fell on the transportation van. The MD said he was certain staff told him that she sustained a hematoma and was sent to the hospital. The MD also stated that he did agree to discontinue Aspirin 81 mg, though it's administration would not pose a great risk, nonetheless the continued administration of Aspirin for someone diagnosed with an intracranial bleed still posed a small risk for continued bleeding and due to the Resident's history of falls, Aspirin 81 mg should have been discontinued when Resident #12 returned from the hospital on 5/23/24 with no further administration.	F 757		
F 805 SS=E	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 observations, record review and staff interviews, the facility failed to provide food in a form to meet the individual needs of residents with a physician order for mechanically chopped or ground meats. The deficient practice occurred	F 805	1. The facility failed to provide food in a form to meet the individual needs of residents with a physician order for mechanically chopped or ground meats. The deficient practice occurred for 6 of 6	8/19/24

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F 805	Continued From page 54 for 6 of 6 residents (Resident #338, #337, #41, #27, #7, and #57) reviewed for mechanically altered diets. The findings included: Review of the menus and recipes revealed the facility followed the National Dysphagia Diet (NDD) for residents with diet orders for a mechanical soft/ground diet texture. The NDD recorded a mechanical soft/ground diet required foods that were moist, soft-textured and easily formed into a bolus (a small ball-like mixture of food formed when swallowed). Meats are ground or minced no larger than one-quarter-inch pieces, no hard lumps and easily mashed with fork pressure. Moist ground meat must be served with gravy or sauce. 1a. Resident #338 admitted to the facility 7/3/24. Diagnoses included dementia, oropharyngeal dysphagia, cognitive communication deficits, and mixed receptive-expressive language disorder. A 7/1/24 hospital Speech Therapy Treatment note recorded a diet recommendation after discharge from the hospital for thin liquids, minced and moist solids. A 7/5/24 diet order, written by the Speech Therapist recorded regular diet, mechanical soft texture, thin liquid consistency. A 7/9/24 Registered Dietitian (RD) #2 progress note recorded Resident #338's diet order as mechanical soft, with thin liquids to ease chewing/swallowing. The progress note indicated that Resident #338's diet was recently upgraded from a puree diet to a mechanical soft diet and	F 805	residents (Resident #338, #337, #41, #27, #7, and #57) reviewed for mechanically altered diets. On 7/15/24, an alternate meal that consisted of appropriate mechanical texture was prepared and offered to Resident #338, #41, #27, #7, and #57. No other residents were identified as being affected. 2. On 7/15/24, Regional Dietary Manager pulled tray tickets and reviewed all residents requiring a mechanically altered diet and an alternate meal that consisted of appropriate mechanical texture was prepared and offered. 3. On 7/15/24 education was provided to all dietary staff on duty, including Dietary Manager by the Regional Dietary Manager on proper texture of mechanically altered diets. On 8/6/24, Corporate Executive Chef began education with all dietary staff on mechanically altered diets to include how to assess proper texture and food size. Any dietary staff not educated on 8/6/24 will be educated by the Dietary Manager/Designee prior to the next shift. Any newly hired dietary staff will be provided education during orientation by Dietary Manager/Designee. 4. An Ad-Hoc QAPI meeting was held with the Interdisciplinary Team on 8/14/24 to discuss this plan. Audits will be conducted by Dietary Manager/Designee on 5 random test trays to ensure appropriate texture and size of	

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that since the upgrade, Resident #338's intake had improved. The RD assessed his intake as 76 -100% on average.

A 7/10/24 admission Minimum Data Set assessment recorded Resident #338 with severely impaired cognition, adequate hearing, adequate vision, usually understood, usually understands, clear speech, rejected care, required partial to moderate assistance with meals, and received a mechanically altered diet.

A 7/11/24 Care Plan and Care Area Assessment recorded Resident #338 was at risk for nutritional problems regarding a diet order for a mechanically altered diet related to difficulty swallowing. Interventions included providing/serving diet as ordered and monitoring for refusing foods.

Resident #338 was observed on 7/15/24 at 12:25 PM while feeding himself lunch in the 1st floor dining room. His tray card recorded a diet order for a regular mechanically altered ground diet. Resident #338 received green peas, boiled potatoes and large pieces of stew beef that were larger than one-quarter inch pieces and difficult to cut with a fork. Resident #338 attempted to cut the stew beef with a fork but was unsuccessful and had difficulty chewing the large pieces of stew beef. Resident #338 ate less than 25% of his stew beef. Resident #338 ate the green peas and boiled potatoes without difficulty. At the end of his meal, staff offered to cut up the stew beef, but Resident #338 stated, "Not now, you should have already done that. I'm finished."

A 7/17/24 phone interview at 10:15 AM with family revealed that when the family visited for meals,

mechanically altered food items. Audits will be conducted weekly times 4 weeks, then monthly for 3 months. Results of audits will be discussed at the monthly Quality Assurance Improvement meeting for 3 months or until substantial compliance is achieved.

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Resident #338 received foods that were no longer "mashed up" but solid foods that was not always "cut up." The family stated that he ate better since his foods were no longer "mashed up", but that he still required his food to be "cut up."

1b. Resident #337 was admitted to the facility 7/3/24. Diagnoses included dysphagia, oropharyngeal phase, and cognitive communication deficit.

A 7/3/24 hospital Speech Therapy Discharge note recorded a diet recommendation for a dysphagia diet, with honey thickened liquids due to difficulty swallowing, and cognitive deficits.

A 7/4/24 diet order, written by the Speech Therapist recorded regular diet, mechanical soft texture, honey thickened fluids consistency.

A 7/9/24 nurse progress note recorded Resident #337 was noted non-compliant with his diet order when he ate food received from his family that was not per his diet order. Resident #337 and his family were educated on the importance of diet compliance.

A 7/10/24 admission Minimum Data Set assessment recorded Resident #337 with intact cognition, adequate hearing, adequate vision, understood, understands, clear speech, swallowing problems evidenced by holding food in his mouth, required set up assistance with meals, and received a mechanically altered diet.

A 7/10/24 Care Plan and Care Area Assessment recorded Resident #337 was at risk for nutritional problems, swallowing problems and choking regarding a diet order for a mechanically altered

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diet with thickened liquids related to difficulty swallowing, holding foods in his mouth, and diet non-compliance. Interventions included providing/serving diet as ordered and monitoring for refusing foods.

A 7/10/24 Registered Dietitian (RD) #2 progress note recorded Resident #337's diet order as mechanical soft, with honey thickened liquids due to swallowing problems per Speech Therapy recommendations. The progress note indicated Resident #337 was at risk for malnutrition due to decreased food intake from a mechanically altered diet with honey thickened liquids.

Resident #337 was observed and interviewed on 7/15/24 at 12:30 PM in his wheelchair feeding himself lunch in his room with a family member present. Nurse Aide (NA) #2 was observed setting up his meal tray and then left the room. His tray card recorded a diet order for a regular mechanically altered ground diet and honey thickened fluids. Resident #337 received honey thickened fluids, green peas, boiled potatoes and large pieces of stew beef that were larger than one-quarter inch pieces. Resident #337 attempted to cut the stew beef with a fork but was unsuccessful and had difficulty chewing the large pieces of stew beef. Resident #337 ate less than 25% of his stew beef. At the end of the meal, when asked by the surveyor with a staff member present if he needed assistance with his meal, Resident #337 stated "yes" and stated that his meat was tough, and the pieces of meat were too large to chew. NA #2 assisted Resident #337 with the remainder of his meal.

Resident #337 was observed and interviewed on 7/16/24 at 8:35 AM in his room in bed feeding

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himself breakfast and ate his breakfast meal without any difficulty. He stated during the observation that at times he received meat, "like yesterday" that was not cut up enough and that he was unable to eat it.

A 7/17/24 12:45 PM interview with Nurse Aide (NA) #2 revealed Resident #337 received "large pieces of beef" for lunch on Monday, 7/15/24 that was "difficult" for him to chew, so she tried to cut it up for him when he said he needed help. NA #2 stated that after she cut up the beef, it was still too tough for him to chew.

A 7/17/24 12:33 PM interview with Nurse #1 revealed Resident #338 and Resident #337 received a mechanical soft diet and required their food to be "cut up", especially the meat. Nurse #1 stated that food did not always come from the kitchen "cut up or chopped" for residents on a mechanical soft diet. Nurse #1 stated that at times Resident #338 refused to allow staff to "cut up" his food if the food did not initially come already "cut up."

The Speech Therapist stated in an interview on 7/18/24 at 10:09 AM that she rounded in the facility Tuesdays - Thursdays. The Speech Therapist stated that she was not in the facility on Monday, 7/15/24 so she did not see the meat served for the lunch meal, but that it was described to her by the dietary staff. The Speech Therapist stated that the facility followed the NND for residents with diet orders for mechanical soft/ground diet which required moist pieces of meat served that were no larger than one-quarter inch pieces and could be mashed with a fork. The Speech Therapist further stated that Resident #338 received a pureed diet in the hospital that

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was upgraded to mechanical soft/ground diet before admission to the facility. The Speech Therapist stated that due to his difficulty chewing and a history of swallowing problems, it was important that he received a mechanical soft/ground textured diet. The Speech Therapist also stated that Resident #337 had a history of "pocketing" foods which she had observed during speech therapy sessions. The Speech Therapist stated that Resident #337 should receive meats that were moist and soft to reduce "pocketing" and his risk for choking. The Speech Therapist stated that based on the description of the stew beef served for lunch on Monday, the stew beef did not meet the requirements for a mechanical soft/ground textured diet.

An interview was conducted with the Certified Dietary Manager on 7/16/24 at 12:55 PM. She stated on 7/15/24 the large cubes of stewed beef were the only meat prepared for lunch and were not chopped or ground. She indicated the stewed beef was usually tender and soft and considered appropriate for a mechanical soft diet. She revealed that when staff notified the kitchen the cubes of stewed beef were tough and difficult to cut, meatballs and gravy were prepared and made available for residents who required a substitution. She stated in a follow up interview on 7/17/24 at 1:56 PM that dietary staff prepared foods based on the corporate recipe and followed this guidance on how to prepare meats for different textures.

The Regional Vice President (VP) of Operations for the dietary contract stated in an interview on 7/17/24 at 5:00 PM that the dietary staff prepared the stew beef per the recipe but that the recipe did not turn out as tender as it should which she

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attributed to the quality of meat received from the food vendor. The VP of Operations stated that once dietary staff identified the stew beef could not be shredded with a fork as it should be, the dietary staff provided a substitute to residents that the dietary staff were made aware of who needed a substitution in the type of meat received.

Registered Dietitian (RD) #1 stated in an interview on 7/17/24 at 2:25 PM that a resident with a diet order for a mechanical soft diet should receive food cut up, chopped or ground, but based on the NDD followed in the facility, food should be ground. The RD #1 stated that she was not the Speech Therapist, so diet texture was not her subject matter, but that she expected residents to receive food that was mechanically altered, that could be mashed with a fork. RD #1 further stated that when the dietary staff were notified of the texture of the stew beef for lunch on Monday, 7/15/24, residents received a substitution.

The RD #2 stated in a phone interview on 7/17/24 at 10:28 AM that for a diet order of a mechanical soft texture, the meat, by definition, should be a ground consistency. RD #2 stated that dietary staff should review the menu/recipe to know how to prepare the meat for a mechanical soft/ground textured diet.

The Administrator stated in an interview on 7/17/24 at 4:20 PM, that she expected dietary staff to provide residents with the texture of food consistent with the facility policy for a mechanical soft diet. She stated in a follow up interview on 7/18/24 at 2:53 PM that residents should receive their food in the texture and consistency ordered by the physician. The Administrator revealed

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chopped and ground meats should be prepared and available at every meal.

2a. Resident #41 was admitted to the facility on 8/24/21 with diagnoses including dementia and dysphagia.

The quarterly Minimum Data Set (MDS) dated 5/3/24 revealed Resident #41 had severe cognitive impairment and received a mechanically altered diet.

A review of the physician orders indicated Resident #41 had an active order dated 2/13/24 for a mechanical soft diet with ground meats.

An observation in the dining room on 7/15/24 at 12:56 PM revealed Resident #41 was served large cubes of stewed beef on her lunch tray. Resident #41's meal ticket read, mechanically altered diet with ground meats. Resident #41 was observed chewing a piece of stewed beef, removing it from her mouth, and placing it back on her plate. At 1:50 PM the kitchen sent up meatballs in gravy that were cut into small pieces. Resident #41 was offered the meatballs but stated she had enough to eat and did not want them.

2b. Resident #27 was admitted to the facility 5/10/24 with diagnoses including Alzheimer's disease and dysphagia.

The admission MDS dated 5/20/24 indicated Resident #27 had severe cognitive impairment and received a mechanically altered diet.

A review of Resident #27's physician orders revealed an active order dated 5/13/24 for a diet

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with mechanical soft textures.

An observation in the dining room on 7/15/24 at 12:30 PM revealed Resident #27 received large cubes of stewed beef on her meal tray. Resident #27's meal ticket read, mechanical soft diet. Staff assisted Resident #27 with setting up her tray but were unable to cut the stewed beef into smaller pieces. Resident #27 proceeded to eat the other items on her tray. At 1:50 PM the kitchen sent up meatballs in gravy that were cut into small pieces. Staff offered Resident #27 a bowl of meatballs which she accepted and was observed eating with no difficulty.

2c. Resident #57 was admitted to the facility 6/13/21 with diagnoses including Alzheimer's disease and dysphagia.

The annual MDS dated 7/8/24 revealed Resident #57 had severe cognitive impairment and required a mechanically altered diet.

A review of the physician orders indicated Resident #57 had an active order dated 4/19/23 for a mechanical soft diet with chopped meats.

An observation in the dining room on 7/15/24 at 1:30 PM revealed Resident #57 received large cubes of stewed beef on his meal tray. Resident #57's meal ticket read, mechanically altered chopped meats. Resident #57's Resident Representative (RR) was observed cutting the stewed beef into smaller pieces which he ate with no difficulty.

An interview was with Resident #57's RR on 7/15/24 at 1:30 PM revealed Resident #57 had dementia and would not comply with wearing his

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dentures. The RR stated Resident #57 had no difficulty with swallowing, but the chopped meats were easier for him to chew. The RR indicated she was able to cut the pieces of stewed beef which he ate with no difficulty.

2d. Resident #7 was admitted to the facility 4/1/23 with diagnoses including Alzheimer's disease and dysphagia.

The quarterly MDS dated 4/17/24 revealed Resident #7 had severe cognitive impairment and received a mechanically altered diet.

A review of the physician orders indicated Resident #7 had an active order dated 10/11/23 for a mechanical soft diet with ground meats.

An observation in the dining room on 7/15/24 at 1:14 PM revealed Resident #7 was served large cubes of stewed beef on her meal tray. Resident #7's meal ticket read, mechanically altered diet with ground meats. Staff were observed setting up her meal tray and had difficulty cutting the stewed beef. Staff set the stewed beef to the side and Resident #27 proceeded to eat the other items on her tray. At 1:50 PM the kitchen sent up meatballs in gravy that were cut into small pieces. Staff placed a bowl of meatballs in front of Resident #7, but she pushed them aside and did not eat them.

An interview was conducted with the Certified Dietary Manager (CDM) on 7/16/24 at 12:55 PM. She stated on 7/15/24 the stewed beef was the only meat prepared for lunch. She revealed the stewed beef was usually soft, tender and fell apart with a fork and met the criteria for mechanical soft. The CDM indicated there were

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no previous issues with the stewed beef being tough, so it was not ground or chopped. She stated the kitchen was notified by a staff member from the 300-hall that the stewed beef was difficult to cut, so they prepared meatballs with gravy that were sent as a substitute.

An interview conducted on 7/16/24 at 2:55 PM with the Speech Therapist (ST) revealed she began working at the facility in April 2024. She indicated there were 3 food forms ordered for residents regular, mechanical soft or pureed. She stated mechanically altered meats (both chopped and ground) should be in ¼ inch pieces and soft enough to mush with a fork. The ST revealed a resident that was ordered a mechanical soft diet may not have swallowing issues but could have difficulty chewing related to missing teeth or dental issues. She stated the ST evaluations for Residents #41, #27, #57 and #7 were completed by the former Speech Therapist and she could not say why those residents were ordered a mechanical soft diet. The ST indicated large pieces of meat that were tough and difficult to cut would not be an appropriate texture for residents on a mechanical soft diet.

An interview was conducted on 7/17/24 at 5:00 PM with the Regional Vice President of Operation for the contracted dietary service. She stated the stewed beef that was prepared on 7/15/24 was not as tender as it should have been due to the quality of meat received from the food vendor. She further stated the dietary staff were notified the stewed beef could not be shredded with a fork and a substitute was prepared and sent to the residents that were ordered a mechanically soft diet.

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F 805	Continued From page 65 An interview was conducted with the Administrator on 7/18/24 at 2:53 PM. She stated residents should receive their food in the texture and consistency ordered by the physician. The Administrator revealed chopped and ground meats should be prepared and available at every meal.	F 805		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to close the doors to dumpsters containing waste and to ensure the area surrounding the dumpsters was free of trash for 2 of 2 dumpsters reviewed. These failures had the potential to impact sanitary conditions and to attract pests and rodents. The findings included: An initial observation of the dumpster area with the Certified Dietary Manager (CDM) on 7/15/24 at 10:08 AM revealed 2 commercial dumpsters both with the side doors open and there was an incontinent brief lying on the ground in front of the dumpsters. An interview conducted with the CDM on 7/15/24 at 10:08 AM indicated maintenance was responsible for cleaning the area around the dumpsters and making sure the dumpster doors were closed. An observation of the dumpster area on 7/16/24	F 814	1. The facility failed to close the doors to dumpsters containing waste and to ensure the area surrounding the dumpsters was free of trash for 2 of 2 dumpsters reviewed. These failures had the potential to impact sanitary conditions and to attract pests and rodents. Dumpster doors were closed by the Maintenance Director on 7/18/24. Debris on surrounding ground was cleaned from the dumpster site. 2. These are the only two dumpsters on facility grounds. Initial audit was conducted on facility grounds to ensure both dumpsters have closed doors and lids, and no other debris was present on the ground by the Maintenance Director on 8/13/24. Any noted debris was disposed of in a proper receptacle. 3. On 8/7/24, the Regional Maintenance Director educated the facility Maintenance Director on the requirement to keep	8/19/24

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F 814	Continued From page 66 at 8:45 AM revealed the lids and side doors on both dumpsters were open, both contained waste, there were blue latex gloves scattered on the ground and the area was odorous. An observation of the dumpster area on 7/17/24 at 11:15 AM with the Director of Maintenance revealed the lids and side doors on both dumpsters were open, both dumpsters contained waste, the area was odorous and there were blue latex gloves scattered on the ground. An interview was conducted with the Director of Maintenance on 7/17/24 at 11:15 AM. The Director of Maintenance stated the Maintenance Assistant was responsible for monitoring and cleaning the dumpster area. He further stated he was not aware the area had not been cleaned and that the dumpster doors were left open. A follow up interview was conducted with the Director of Maintenance on 7/18/24 at 8:41 AM. He stated the Maintenance Assistant worked from 10:00 AM to 6:00 PM and checked the dumpster area 3-4 times during his shift. He further stated the facility was undergoing renovation and the Maintenance Assistant was busy overseeing construction on 7/16/24 and did not have a chance to make his normal rounds. He indicated the Maintenance Assistant arrived to work on 7/17/24 at 12:00 PM and cleaned the dumpster area and closed the dumpster doors. He revealed the Maintenance Assistant was on vacation the rest of this week and the Floor Technician was responsible for monitoring and cleaning the dumpster area in his absence. The Maintenance Director further stated that all staff should be monitoring the area to ensure there was no garbage on the ground and the dumpster	F 814	dumpster doors and lids closed and the surrounding area free of trash/debris to prevent unsanitary conditions. Education began with Maintenance Staff, Housekeeping, and Dietary Staff on 8/13/24 by the Maintenance Director/designee on the requirement to keep dumpster doors and lids closed and the surrounding area free of trash/debris to prevent unsanitary conditions. All newly hired maintenance, housekeeping, and dietary staff will be educated by the Maintenance Director/Designee upon orientation. 4. An Ad-Hoc QAPI meeting was held with the Interdisciplinary Team on 8/14/24 to discuss this plan. Audits will be conducted by Maintenance Director/Designee to ensure all dumpster doors are closed and there is not any garbage or debris on the surrounding ground, weekly times 4 weeks, then monthly for 3 months. Results of audits will be discussed at the monthly Quality Assurance Improvement meeting for 3 months or until substantial compliance is achieved.	

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F 814	Continued From page 67 doors were closed. An interview was conducted with the Floor Technician on 7/18/24 at 9:35 AM. He stated he worked from 7:00 AM to 3:00 PM and was responsible for taking out the trash at the beginning of his shift, midday and at the end of his shift. He indicated when he took out the trash, he made sure the area was clean and the dumpster doors were closed. The Floor Technician revealed he did not clean the dumpster area on 7/16/24 because he was not working that day. He stated in his absence all staff should be monitoring the dumpster area to ensure there was no trash on the ground and the dumpster doors were closed. An interview conducted with the Administrator on 7/18/24 at 2:53 PM revealed maintenance and housekeeping staff were responsible for monitoring and cleaning the dumpster area. She stated all the dumpster doors should be closed and the ground surrounding the dumpsters should remain clean and free of trash.	F 814		