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PARKVIEW POST-ACUTE AND REHABILITATION CENTER	200 NURSING HOME LANE PIKEVILLE, KY 41501

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{F 755}	Continued From page 788 63). Review of the audits completed by the DM and/or CDM revealed they were completed as stated with no identified concerns. Interview with the Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, and Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed trays were audited for to ensure they arrived on the unit and were passed timely. 64). Review of verbal quizzes revealed ten (10) staff members were quizzed for one (1) week beginning on 8/15/2021 with no needed education. Further review of verbal quizzes revealed five (5) staff members were quizzed for four (4) weeks from 08/22/2021 and completed on 09/13/2021 with no identified concerns. A review of the verbal quiz revealed staff was quizzed on respiratory status, hypo/hyperglycemia, and SBAR/physician notification. Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, the Regional DON on 09/30/2021 at 4:17 PM, DON #2 on 09/30/2021 at 3:20 PM, and MDS Nurse #2 on 09/30/2021 at 1:31 PM revealed they performed verbal quizzes for identification and assessment of residents with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting a change in a resident's condition, notification of the physician and following physician orders. Interviews with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, revealed they participated in verbal quizzes with facility staff. 65). Interview with the Regional DON on	{F 755}		

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{F 755}	Continued From page 789 09/30/2021 at 4:17 PM revealed she completed audits of documented blood glucose levels Monday through Friday in the clinical meeting. She further revealed that with any blood sugar less than 60 and/or greater than 40, the facility staff were expected to notify the physician, Responsible Party, and Registered Dietician and follow physician orders. The Regional DON stated she identified one (1) resident on 08/12/2021 to have a blood glucose level of 430 and one (1) on 09/20/2021 to have a blood glucose level of 465 with no documented evidence the licensed nurse followed the facility process. She provided education to both RN #2 and LPN #5. A Review of audits revealed no further concerns. A Review of education revealed RN #2 and LPN #5 received education regarding the facility process. 66). Review of verbal staff quizzes revealed staff was verbally asked signs and symptoms of abuse when to report, signs and symptoms of wandering and wandering interventions. A review of the verbal quizzes revealed five (5) staff were verbally quizzed daily for one (1) week from 08/13/2021 to 08/19/2021 with no identified concerns. Further review revealed verbal quizzes were conducted three (3) times a week for two (2) weeks from 08/21/2021 to 09/02/2021 with no identified concerns. A review of verbal quizzes revealed that verbal quizzes were conducted one (1) time per week for four (4) weeks from the week of 09/03/2021 to 09/24/2021 with no identified concerns. Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, and MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed each assisted in the completion of verbal staff quizzes. Further interview revealed that each staff member was	{F 755}		

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{F 755}	Continued From page 790 verbally quizzed on the areas listed on the audit tool (signs and symptoms of abuse, when to report, signs and symptoms of wandering and wandering interventions), and any need for education was completed immediately with each quiz. Interviews with SRNA #11 on 09/29/2021 at 3:23 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM and Maintenance Assistant #1 on 09/30/2021 at 2:56 PM revealed they participated in verbal quizzes regarding abuse, when to report, wandering and wandering interventions. 67). Review of Resident #355 on 09/10/2021 revealed the resident had an admission wandering risk assessment completed on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. A review of re-admission for Resident #355 revealed the resident had an admission wandering risk assessment completed on 09/28/2021. The resident was not identified to be at risk for wandering. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed that MDS staff will schedule wandering risk assessments to ensure completion. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM and DON #2 on 09/30/2021 at 3:20 PM revealed all-new admissions would be reviewed in the morning clinical meeting to ensure	{F 755}		

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{F 755}	Continued From page 791 appropriate assessments, including the wandering risk assessment, had been completed. Further interviews revealed that residents identified as at risk for wandering would be discussed during this meeting and appropriate interventions implemented. 68). Review of interviews performed for residents with a BIMS score of 8 or greater revealed no identified concerns. Continued review revealed interviews were initiated on 08/13/2021 with ten (10) resident interviews completed for four (4) weeks then five (5) residents for eight (8) weeks. Interview with ISSD on 09/30/2021 at 2:23 PM, and MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed they were assisting in completing audits with residents with no concerns identified. Review of audits initiated on 08/13/2021 for review of random weekly skin assessments for residents with a BIMS score of less than eight (8) to ensure there are no injuries of unknown origin revealed no identified concerns. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and DON #2 on 09/30/2021 at 3:20 PM revealed they were completing audits as indicated with no identified concerns. Observation of skin assessment on 09/30/2021 of Resident #45 at 9:23 AM and on 09/30/2021 at 10:20 AM of Resident # 27 revealed no concerns with injuries of unknown origin. 69). Interview with the Registered Dietician on 09/30/2021 at 3:53 PM revealed she started audits on 08/25/2021 of resident diet orders from electronic medical records against orders entered in the diet/tray card software to ensure accuracy. Review of Resident #308's tray card on 09/29/2021 at 12:04 PM, Resident #39's tray card on 09/29/2021 at 12:06 PM, and Resident #334	{F 755}		

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{F 755}	Continued From page 792 tray card on 09/29/2021 at 12:30 PM revealed diets were served as ordered by the physician. A review of audits revealed audits were conducted weekly for four (4) weeks. 70). Review of completed audits revealed random meals were audited twice daily for one (1) week beginning 08/23/2021. Starting 08/30/2021, random meals were observed two (2) times per week for two (2) weeks and then weekly from 09/13/2021 for one (1) month. Interview with Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM, and 09/30/2021 at 1:52 PM revealed audits were performed as indicated. Further interviews revealed that meals were served as scheduled, including breakfast at 7:00 AM, lunch at 12:00 PM, and dinner at 5:00 PM. Observation on 09/28/2021 at 5:03 PM revealed the evening meal had been served on the third floor. Observation on 09/29/2021 lunch meal revealed meals arrived at the third floor at approximately 12:16 PM, the fourth floor at 12:16 PM and 12:24 PM, and the fifth floor at 12:34 PM and 12:49 PM. 71). Review of Resident #308's tray card on 09/29/2021 at 12:04 PM, Resident #39's tray card on 09/29/2021 at 12:06 PM, and Resident #334's tray card on 09/29/2021 at 12:30 PM revealed the meals honored resident preferences, including likes and dislikes. Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she would be responsible for obtaining food and beverage preferences within seventy-two hours of admission and entering the preferences into the system. A review of audits revealed snack intakes were audited daily for one (1) week from 09/15/2021 to 09/21/2021. Further review of the	{F 755}		

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{F 755}	Continued From page 793 audits revealed snacks were audited weekly beginning on 09/22/2021. Interview with the Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM revealed she audited snack intake and had not identified any concerns. 72). Interview with the Human Resource Director (HR) on 09/30/2021 at 10:48 AM revealed she completed audits for daily staff screening against time clock punches. She revealed no identified concerns. Observation of entry doors on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no concerns. 73). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, DON #2 on 09/30/2021 at 3:20 PM, and Interim Infection Control Nurse on 09/30/2021 at 3:10 PM revealed audits were being conducted with observations of handwashing, isolation signage and zones, donning/doffing PPE, mask compliance. Any variance or identified concerns will be addressed immediately. A review of the audits revealed they were conducted beginning 09/17/2021 on random shifts and units. 74). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she was responsible in addition to other members to review all residents on narcotics with the pharmacy to ensure that an active script is on file beginning 09/23/2021. A review of audits revealed no identified concerns. RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM,	{F 755}		

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{F 755}	Continued From page 794 LPN #11 on 09/30/2021 at 10:31 AM revealed no concerns with obtaining scripts for medications and/or receiving medications timely. Observation of medication pass on 09/29/2021 at 4:35 PM on the third floor and 09/30/2021 at 8:09 AM revealed no identified concerns with missing medications. In addition, observation of the narcotic count on the fifth floor on 09/30/2021 at 12:50 PM revealed no identified concerns. 75). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she was responsible for completing random medication pass observations beginning 09/25/2021. She stated she had not identified any concerns with residents not having medications or narcotic counts. A review of audits revealed the facility utilized the Centers for Medicare Services Critical Element Pathway for Medication Administration to conduct the medication pass observation of twenty-five medications. A review of audits revealed a minimum of twenty-five medications were observed daily from 09/25/2021 with no identified concerns. Further review of medication observations revealed that medication administration was observed on random shifts, including 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. 76). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM. The DON on 09/30/2021 at 3:20 PM revealed medication delivery tickets were being reviewed in clinical meetings Monday through Friday against ordered medications. A review of the audit revealed no identified concerns. 77). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, Regional Nurse	{F 755}		

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{F 755}	Continued From page 795 Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, and the DON on 09/30/2021 at 3:20 PM revealed staffing was being audited daily beginning 09/11/2021, to ensure adequate staffing was maintained. A review of the audits revealed no identified concerns. 78). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, and the Dietary Manager on 09/30/2021 at 1:30 PM revealed staffing was being monitored daily to ensure adequate staffing. A review of the audits revealed no identified concerns. 79). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Interim Administrator on 09/30/2021 at 5:05 PM revealed daily audits had been conducted daily from 09/11/2021. A review of the audits revealed no identified concerns. 80). Interview with the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed he completed observations on different shifts to identify any change in resident condition. Further interviews revealed if a change in condition was identified, staff would complete a stop and watch. An audit review revealed no concerns with the change of conditions not being addressed by facility staff. 81). Review of interviews performed on 09/25/2021 for residents with a BIMS score of 8 or greater revealed no identified concerns. A review of the questionnaire completed during interviews revealed residents were asked: Is everyone treating you well? Do you feel safe here? Do you have any concerns? Interview with	{F 755}		

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{F 755}	Continued From page 796 the Medical Records Staff on 09/29/2021 at 8:34 AM revealed she completed the interviews with residents on 09/25/2021, and she stated she identified no concerns.	{F 755}		
{F 802} SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service. Observation of the residents' meal, on 08/05/2021, for lunch and dinner revealed dietary	{F 802}	F 802 Sufficient Dietary Support Personnel Criteria 1: All residents with recommendations from registered dietician/ regional dietician and/or MD/ NP for fortified foods received these item on their meal trays as determined by observation on November 17th of the meal ticket and visual comparison of that	12/30/21

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{F 802}	Continued From page 797 staff failed to serve fortified foods (foods with an increased content of essential nutrients that have been added to improve nutritional content) as recommended by the Registered Dietitian (RD) for forty-two (42) of forty-two (42) residents out of one-hundred thirteen (113) residents, which received fortified foods. Staff interviews revealed they had not been educated on how to fortify foods. During the lunch meal on 08/05/2021, dietary staff failed to utilize the correct scoop size when plating the food; and, failed to weigh the protein portion of the meal to ensure the correct serving size. In addition, resident meals were consistently served late due to insufficient staffing in the kitchen. The findings include: Review of the facility's policy titled, "Food and Nutrition Services," last revised October 2017, revealed staff would provide residents with a nourishing, palatable, well-balanced diet that met the resident's daily nutritional/special dietary needs, with preferences of each resident taken into consideration. The policy also stated meals would be provided within forty-five (45) minutes of the scheduled mealtime. Review of the facility's policy titled, "Portion Control," undated, revealed portion size was determined by the nutritional needs of the residents, and portion sizes must be served according to the facility's menu and staff should weigh or measure ingredients as applicable.	{F 802}	ticket to the prepared meal tray by the Regional Director of Dietary Services Criteria 2: a) All residents with recommendations from registered dietician/ regional dietician and/or MD/ NP for fortified foods received these item on their meal tray on 11/22/2021. The regional director of dietary services reviewed the registered dieticians recommendation for fortified food, compared those recommendation to the meal tray ticket to ensure they matched and then observed the lunch meal tray line to ensure each ticket that had fortified food listed received the fortified food on tray. Criteria 3: Inservice education was provided for the dietary staff by the Regional Director of Dietary Services on 11/22/2021 on the preparation and serving of fortified foods in accordance with the resident meal tray tickets to include scoop size. The RD also in-serviced correct serving of protein. On 8/23/21 a new Dietary Manager was hired as part of the corrective actions that were taken. Criteria 4: Starting 11/22/2021 Dietary Manager/Dietary Consultant/Designee will complete tray preparation observations for all three meals weekly x 4 weeks and then monthly x 2 months to determine that fortified foods are prepared and served in accordance with resident orders/tray cards. Monitoring began 9/1/21 of late meals, ensuring the correct scoop size during plating of food, and ensure the correct protein serving. Two meals were	

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{F 802}	Continued From page 798 Review of the facility's Scoops/Ladles and Portion Servers guidance utilized in the facility's kitchen, undated, revealed a #10 scoop was equal to 3/8 cup, #8 scoop was equal to ½ cup and a #12 scoop was equal to 1/3 cup. Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed the facility had no policy related to fortified foods. However, she stated residents that were assessed to require fortified foods should be provided them, as well as any interventions the physician and/or the Registered Dietician (RD) had determined the resident needed to maintain their nutritional status. 1. Review of the menu for the lunch meal on 08/05/2021, revealed the residents were being served their meal of choice. Further review of the menu revealed the residents should receive three (3) ounces of protein for the lunch meal. According to the menu, a #8 (1/2 cup) scoop should be utilized when mashed potatoes were served and a four (4) ounce- {1/2 cup} serving of green beans or other vegetables should be provided to the residents. Review of the, "Diet Roster" provided by the facility indicated forty-two (42) residents had been assessed to need fortified foods with all three meals, to assist in ensuring their nutritional needs were met. Observations of the tray line for the lunch meal service, on 08/05/2021 at 1:15 PM, revealed staff were serving beef fritters with gravy, corn or green beans, mashed potatoes, chocolate pudding and a roll. Further observations of the tray line revealed no fortified foods had been prepared for the lunch meal for the residents.	{F 802}	visual audited beginning 8/23/21by DON or designee until 9/6/21. Beginning 9/11/21 all three meals are audited by Dietary Manager. Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance. Criteria 5: Date of compliance: 12/30/2021	

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{F 802}	Continued From page 799 The facility assessed 42 residents to receive fortified foods. Further observations of the tray line revealed Cook #2 used a #10 scoop (3/8 cup) to serve the residents mashed potatoes and a #12 scoop (1/3 cup) to serve the residents corn or green beans for the lunch meal. Cook #2 was asked to weigh the protein (meat) portion of the lunch meal; however, the kitchen had no functioning scale. Observations of the kitchen scale available for staffs use, on 08/05/2021 at approximately 3:00 PM, revealed the scale was metal, dusty with chipped paint, was dated and rusty in appearance. Continued observations revealed the scale was a manual scale and was visibly not calibrated at zero (0). Further observations of the tray line, on 08/05/2021, and review of the facility's "Diet Roster" revealed dietary staff failed to review resident tray cards to ensure their food preferences were honored. Interview with Cook #2, on 08/05/2021 at 5:20 PM, revealed she had worked full-time at the facility for approximately one (1) year. During her employment, the cook stated she had not been trained or directed to fortify residents' food. She also stated she had never seen a recipe at the facility, to provide any directions on how to fortify foods and she had never prepared fortified foods for the residents. Per the cook, she had been trained on scoop sizes to provide residents with appropriate portions. However, the cook acknowledged she utilized the wrong scoop sizes during the lunch meal. The cook stated the residents should have received larger portions of	{F 802}		

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{F 802}	Continued From page 800 mashed potatoes and vegetables. Per the cook, the facility had not trained her or directed her to weigh meat/protein or any other food items to ensure residents receive adequate portions. She acknowledged she did not review tray cards "like I should" during the tray line for resident meals because there was not "enough of us and meals would be even more off schedule." 2. Interview with Cook #2, on 08/05/2021 at 12:00 PM, revealed the facility was serving lunch to one-hundred and thirteen residents (113). Review of the facility's mealtime schedule indicated breakfast was served at 7:00 AM, lunch was served at 12:00 PM and the evening meal was served at 5:00 PM. Observations of the tray line for the lunch meal on 08/05/2021, revealed even though the meal time was scheduled for 12:00 PM, the first of three (3) tray carts hadn't exited the kitchen until 1:30 PM to go to the third floor. Further observation revealed the last tray cart exited the kitchen at approximately 2:45 PM (almost 3 hours late) which went to the 5th floor residents. Observations of the tray line for the supper meal on 08/05/2021, revealed even though the supper meal was scheduled to be served at 5:00 PM, staff did nit start the tray line until 6:15 PM. The first of three (3) tray carts did not leave the kitchen to be served to the residents until 6:50 PM. Continued observation revealed the last cart did not left the kitchen until 8:00 PM (three hours late) going to the residents on the 5th floor. Interview with Dietary Aide (DA) #1, on 08/17/2021 at 2:30 PM, revealed the dietary	{F 802}		

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{F 802}	Continued From page 801 department had been short staffed for months, meals were always late and there was not adequate time to review tray cards to ensure residents' preferences were honored because there should be three (3) dietary aides, but staff had worked with only two (2) for months. Interview with DA #2, on 08/17/2021 at 2:15 PM, revealed the dietary department was short staffed and they should be working with three (3) dietary aides. However, they had worked with only two (2) aides for approximately one (1) year. Interview with Cook #2, on 08/05/2021 at 5:20 PM, revealed she had worked full-time at the facility for approximately one (1) year. She stated she worked five (5) days a week and cooked all three (3) meals on the days she worked. She stated she had works this way for months due to short staffing. She also stated she worked "a lot" of overtime and had approximately 15-20 hours of overtime during the last pay period. She stated the meal services were late because they were short staffed in the kitchen. Per the cook, the facility had no Dietary Manager and they were short one (1) dietary aide and had been for months, which makes getting meals to residents on time, "impossible." She acknowledged she does not review tray cards "like I should" during tray line for resident meals "because there is not enough of us and meals would be even more off schedule." Interview with Dietary Manager (DM) #2, on 08/17/2021 at 3:00 PM, revealed she was employed at another facility the company owned, and had been asked approximately three (3) weeks ago, to come provide assistance/oversight and retrain dietary staff on dietary processes,	{F 802}		

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{F 802}	Continued From page 802	{F 802}		

because the facility had no DM and concerns had been identified in the kitchen. The DM stated she had visited the facility approximately three (3) times. According to the DM, when she initially visited the facility she identified that staff had not been trained/directed to fortify foods for the residents and there were no recipes available to guide staff on preparing fortified foods. The DM stated she had initiated training with staff; however, due to short staffing in the kitchen she had worked more hands on with staff and provided guidance on prepping certain food items before the meal time, to assist in getting the residents' food to them on time. Continued interview revealed she observed meal services at the facility, and meals were consistently late, due to inadequate staffing of dietary aides.

Interview with the RD, on 08/11/2021 at 4:10 PM and on 08/18/2021 at 10:30 AM, revealed she had been contracted to provide services at the facility for approximately one (1) year. The RD stated meals were always served late.

Interview with the Assistant Director of Nursing (ADON)/Interim Director of Nursing, on 08/18/2021 at 9:50 PM, revealed she was aware meals were consistently late, which made it difficult for staff and residents during the evening meal. She stated the food cart did not come to the floor until 7:00 PM or 8:00 PM in the evening.

Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed she was aware of residents' cold food complaints and that meals were served late to the residents. She stated there should be a Dietary Manager and at least four (4) other staff in the kitchen. However, the kitchen had worked with no Manager and only three (3) staff since

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{F 802}	Continued From page 803 she had been Administrator at the facility. She stated she was aware that was not enough staff in the kitchen to ensure meals were timely, and she was "working on it."	{F 802}		
{F 803} SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced	{F 803}		12/30/21

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{F 803}	Continued From page 804 by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to ensure menus were followed for one hundred eight (108) out of one hundred nine (109) residents who received a meal tray. Observation of the tray line for the lunch meal on 06/15/2021, revealed the residents were served green beans with small pieces of country ham in them, pinto beans with small pieces of country ham in them, fried potato chunks, cornbread, and white cake with marshmallows. Review of the menu for the lunch meal on 06/15/2021, revealed residents were to receive a country ham slice, pinto beans, buttered carrots, Texas sheet cake, and cornbread. The findings include: Review of the facility's policy titled,"Menu Substitutions and Alternatives", undated, revealed the food substitute would be consistent with the usual and ordinary food items. Review of the facility's policy titled, "Food and Nutrition Services," last revised October 2017, revealed staff would provide residents with a nourishing, palatable, well-balanced diet that met the resident's daily nutritional/special dietary needs, with preferences of each resident taken into consideration. 1. Review of the menu for the lunch meal, on 06/15/2021, revealed residents were to receive a country ham slice, pinto beans, buttered carrots, Texas sheet cake, and cornbread.	{F 803}	F 803 Menus Meet Resident Needs/Prep in Adv/Followed Criteria 1: Residents are served meals in accordance with the scheduled menus as determined by tray preparation observations completed by the Regional Director of Dietary Services on 11-17-2021. Criteria 2: All residents have the potential to be affected by this cited deficiency. All resident's meal trays were audited to ensure menus were followed on 11-17-2021. All residents' meals followed the menu. Criteria 3: The Dietary Consultant provided in-service education for the Dietary Manager, facility cooks, and dietary staff by reviewing the current scheduled facility menus to clarify how each item was to be served in accordance with the menu as completed on 11-22-2021 Criteria 4: Starting 11-22-2021 the Dietary Manager/Dietary Consultant/Designee will complete tray preparation observations to determine that meals are prepared and served in accordance with the scheduled menus. All three meals will be observed weekly x 4week then monthly x 2months. Beginning 12/20/2021 5 random resident will be interviewed to ensure that food is served timely, food temperature is appropriate, and if they receive snacks, meals are served timely, substitutes are	

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{F 803}	Continued From page 805 Observation of the tray line for the lunch meal service, on 06/15/2021 at 1:14 PM, revealed the residents were served green beans with small pieces of country ham in them, pinto beans with small pieces of country ham in them, fried potato chunks, cornbread, and white cake with marshmallows in it. Group interview conducted with six (6) residents (Residents #3, #16, #38, #51, #92, and #96), on 06/16/2021 at 10:13 AM, revealed their lunch meal on 06/15/2021 was not good. The residents stated they did not like both green beans and pinto beans served together. The residents stated they rarely got cake with icing. The residents also revealed menus were rarely followed. Observation and interview with Resident #27, on 06/16/2021 at 9:27 AM, revealed the resident was eating club crackers and stated that he/she did not know what was on the menu for lunch that day. The resident stated sometimes they asked for the alternate and sometimes they got it, but usually they did not. The resident laughed and stated that they asked for the alternate when the facility served mystery meat. Interview with Resident #307, on 06/16/2021 at 1:16 PM, revealed the resident lying in bed with a tray from lunch on the overbed table. The resident stated, "I would not feed a dog what they give me". The resident had a soda and peanut butter crackers beside his/her lunch tray. Interview with Resident #57, on 06/16/2021 at 10:25 AM, revealed the food was "horrible". Per interview, the milk was warm and the meat was too tough. The resident further stated that he/she would go hungry if it were not for food brought in	{F 803}	available and preferences are met. Interviews will be conducted weekly x 4 weeks then monthly x 2 months. Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance . Criteria 5: Date of compliance: 12/30/2021	

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{F 803}	Continued From page 806 from the outside. Interview with Cook #1, on 06/16/2021 at 2:00 PM, revealed she cooked green beans instead of carrots because she liked them herself. The Cook stated she did not have enough country ham so the Dietary Manager had instructed her to chop the country ham up and put it in the beans. The Cook stated she did not have chocolate cake mix and only had white cake mix, so she had made white cake with marshmallows instead of Texas sheet cake. The Cook stated she had only worked at the facility for four (4) weeks. Interview conducted with the former Dietary Manager (DM), on 06/16/2021 at 1:30 PM, revealed she had quit on 06/15/2021. The DM stated she had told the Cook to put the country ham in both the green beans and the pinto beans because there was not enough country ham. The DM stated she was responsible for ordering and ensuring there was enough food to prepare the food on the menu. The DM revealed she had not reported to the Registered Dietician (RD) that she could not prepare the menu as directed. Interview conducted with the RD, on 06/18/2021 at 4:18 PM, revealed she had been aware the facility was not following the menus she had approved. The RD stated she had previously spoken with the DM regarding her concerns of staff not following the menu and had been assured by the DM the situation had been corrected. The RD stated not following the menus could cause malnutrition, weight loss, and other health concerns. The RD stated staff were required to notify her anytime they changed the menu and they had not done so on 06/15/2021. The RD stated, "I work closely with the DM but I	{F 803}		

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{F 803}	Continued From page 807 have no authority over her. " Interview conducted with the Administrator, on 06/19/2021 at 1:30 PM, revealed she had only been the Administrator at the facility for two (2) weeks. The Administrator stated she had spoken with both the RD and the DM and had not been aware of the problems in the kitchen. The Administrator stated on 06/14/2021, she went into the kitchen and found the DM had not ordered the food to be prepared for 06/15/2021. The Administrator stated she went to the grocery store and had purchased the needed food. The Administrator stated it was not until then that she realized the DM was not ordering what was needed to prepare the meals needed in the kitchen.	{F 803}		
{F 804} SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to provide food at palatable and safe temperatures for the evening meal on 06/16/2021 and the lunch meal on 08/05/2021 for residents on two (2) of the three (3) resident floors/units.	{F 804}	F 804 Nutritive Value/Appear. Palatable/Prefer Temp. Criteria 1: Resident # 332 no longer resides at the facility. Resident # 39 received her evening meal on 11/2/21 on	11/30/21

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{F 804}	Continued From page 808 Observations on 08/05/2021 at 2:16 PM revealed the food temperatures on the test tray included: pureed meat at ninety (90) degrees Fahrenheit (F), potatoes ninety-two (92) degrees F, pureed green beans ninety (90) degrees F, pureed bread eighty (80) degrees F and chocolate pudding sixty (60) degrees F. The findings include: Review of the facility's policy titled,"Food: Quality and Palpability", undated, revealed food would be prepared by methods which conserve nutritive value, flavor, and appearance. According to the policy, food would be served at a safe and appetizing temperature. Observation of the evening meal, on 06/16/2021 at 6:05 PM, revealed a test tray on the third floor was obtained. The tray contained a chicken sandwich which tasted cool and bland at one hundred nine (109) degrees Fahrenheit, and coleslaw at sixty (60) degrees Fahrenheit which was cool, but tasted bland. Interview with the Acting Dietary Manager (DM), on 06/16/2021 at 6:05 PM, revealed cold foods should be less than forty-one (41) degrees. The DM stated she did random tray checks to ensure the food taste good and was at the appropriate temperature. The DM stated she was only helping out because the former DM quit on 06/15/2021. The DM stated she worked at another facility owned by the company and was only filling in. Observation on 08/05/2021 revealed the first fourth floor lunch meal cart arrived on the unit at 1:59 PM with twenty (20) trays on the cart.	{F 804}	time and it was within expected temperature. On 11/3/2021 residents with a BIMS greater than an 8 were interviewed to ensure they had no concerns about the portions they received or the availability of snacks Criteria 2: All residents have the potential to be affected by this deficient practice. Test tray results completed on 7/25/21 - 9/2/21 indicate that meals are served at palatable and safe temperatures for all resident floor/units. Resident meal trays were observed to be delivered timely to all units on 11/2/2021 Nourishment rooms on each unit were audited on 11/2/2021 to ensure snacks were available. Criteria 3: The dietary staff were provided in-service education by the Dietary Manager/Dietary Consultant by 9/1/21 on the need to maintain food temps within the required parameters during meal service and the process for the delivery of meal trays in a timely manner to prevent temperatures changing to outside the acceptable parameters. The dietary staff were provided in-service education by the dietary manager/dietary consultant on the process for stocking snacks in the nourishment room on 11/1/2021. Criteria 4: Beginning on 11/24/2021 The Dietary Manager/Dietary Consultant/Designee will complete weekly random tray pass audits until substantial compliance to determine that meals are prepared and served in accordance with the scheduled menus and required temperature parameters to include all	

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{F 804}	Continued From page 809 Further observation revealed Registered Nurse (RN) #8 was the only staff passing meal trays from 1:59 PM until 2:04 PM. Observation of the last tray (test tray) passed from the cart on 08/05/2021 at 2:16 PM, with the Regional Dietitian revealed the food temperatures on the test tray were: pureed meat at ninety (90) degrees Fahrenheit (F), potatoes ninety-two (92) degrees F, pureed green beans ninety (90) degrees F, pureed bread eighty (80) degrees F and chocolate pudding sixty (60) degrees F. Interview with the Regional Dietitian, on 08/05/2021 at 2:16 PM, revealed that cold foods should be at or below forty-one (41) degrees F and hot foods should be at or above one hundred and thirty-five (135) degrees F. She stated the temperatures of the food on the test tray were not in acceptable parameters. Observation on 08/05/2021 revealed the second fourth floor lunch meal cart arrived on the unit at 2:10 PM with fifteen (15) trays. Observation revealed only one (1) staff person was passing trays until 2:30 PM. The last tray passed was delivered at 2:35 PM. Observation of the test tray delivered, on 08/05/2021 at 2:35 PM, revealed food temperatures as follows: chicken fried steak with gravy one hundred and four (104) degrees F, whole kernel corn one hundred twelve (112) degrees F, mashed potatoes one hundred twenty-four (124) degrees F, 2% milk fifty-eight (58) degrees F, coffee one hundred eight (108) degrees F and chocolate pudding sixty-eight (68) degrees F.	{F 804}	three meals, one tray per floor for each meal per observation. Beginning on 11/24/2021 the dietary manager/ dietary consultant/ designee will complete a weekly audit that nourishment rooms on all three floors are stocked daily until substantial compliance. Beginning 11/4/2021 residents will be asked in each resident council meeting if they are being served their meals utilizing regular dishware. The Activity Director/Designee will notify the Dietary Manager for follow up of any residents who report they are not being served meals on regular dishware. Audits will be monthly x 3 months. Audits will be reviewed at QAPI monthly x3 months and then quarterly until in substantial compliance. Criteria 5: Date of compliance: 11/30/2021	

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{F 804}	Continued From page 810 Interview with Resident, #332 on 07/27/2021 at 11:00 AM, revealed the food was always cold. Interview with Resident #39, on 08/17/2021 at 1:20 PM, revealed he/she had "lost a lot of weight in the past year" because the facility's food was always late and the food was cold. Interview with RN #6, on 07/28/2021 at 10.00 AM, revealed residents on her floor frequently informed her they were "hungry" and the facility had failed to supply snacks on the floors for "about a year." The RN became tearful in interview and stated, the food that came from the facility kitchen was cold and late. RN #6 also stated she, as well as other co-workers, had informed the Administrator of the resident's complaints and requested she direct the dietary department to send up snacks to have available for the residents; however, "that hasn't happened yet." Interview with State Registered Nurse Aide (SRNA) #16, on 07/27/2021 at 8:10 PM, revealed the facility was short staffed, "especially at night." The SRNA stated there should be two (2) SRNAs for night shift; however, for months they had worked short staffed with only one (1) SRNA to almost forty (40) residents. She stated meal service was always late and sometimes it was 8:00 PM before the trays were delivered to the floor. The SRNA stated, "There's no way one aide can pass the trays and feed the residents that require assistance and do it right." She also stated residents frequently complain of cold food "because it's cold before they're getting it. There's not enough help." Interview with Dietary Manager (DM) #2, on	{F 804}		

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{F 804}	Continued From page 811 08/17/2021 at 3:00 PM, revealed all hot foods should be one-hundred, forty degrees (140) F when it reaches the resident. She also stated coffee should be served at one hundred (120) degrees F and milk be served between thirty-six to forty (40) degrees F. Interview conducted with the Registered Dietician (RD), on 06/18/2021 at 4:18 PM, revealed she completed a test tray once a month. The RD stated she had not had a concern with temperature, but food had very little taste. The RD stated cold food should be served at forty one (41) degrees Fahrenheit or less. The RD stated palatability concerns could lead to weight loss and malnutrition. Interview with the Assistant Director of Nursing (ADON)/Interim Director of Nursing (DON), on 08/18/2021 at 9:50 PM, revealed she had worked at the facility for approximately one (1) year and the facility had been inadequately staffed with nurses and aides during that time. She stated she was aware residents complained of cold food. However, she stated staff did the best they could with the number of staff at the facility. The ADON stated she was also aware meal times were consistently late, which made it difficult for staff and residents during the evening meal. She stated when the food cart did not come to the floor until 7:00 PM or 8:00 PM in the evening, it was difficult to serve and assist residents because there was only one (1) aide. She stated nurses were busy administering medications during that time and not everything could be completed timely. Per the ADON/IDON, she expected resident meals to be delivered timely and at the appropriate temperature.	{F 804}		

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{F 804}	Continued From page 812 Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed she was aware the facility was short staffed, there were not enough nurses and nurse aides. She stated there should be two (2) nurses and four (4) nurse aides on each floor for day shift (7:00 AM-7:00 PM) and two (2) nurses and three (3) aides for the night shift (7:00 PM-7:00 AM). However, the Administrator stated the facility had not met those staffing numbers since she had been at the facility. Continued interview with the Administrator revealed she was aware of residents' cold food complaints and meals were served late to the residents. She stated there should be a Dietary Manager and at least four (4) other staff in the kitchen; however, the kitchen had worked with no manager and only three (3) staff since she had been the Administrator at the facility. She stated she was aware there was not enough staff in the kitchen to ensure meals were timely, and was she "working on it."	{F 804}		
{F 806} SS=F	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by:	{F 806}		12/30/21

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{F 806}	Continued From page 813 Based on observation, interview, and record review, it was determined the facility failed to ensure one hundred and eight (108) out of one hundred nine (109) residents who received meal trays were offered appealing options (substitutes or alternates) of similar nutritive value when the residents chose not to eat food that was initially served. In addition, the facility failed to ensure food served accommodated residents' allergies, intolerance, and preferences for (3) of fifty-seven (57) sampled residents (Resident #350, #39 and #332) who were served food from the kitchen on 08/05/2021. Also, Resident #350 was to receive lactose free milk; however, the facility was out of the lactose free milk on 08/05/2021 and staff interviews revealed the facility was frequently out of the milk. The findings include: Review of the facility's policy titled, "Menu Substitutions and Alternatives" (not dated), revealed staff should ensure residents' nutritional needs were met and residents with known allergies, dislikes or who expressed a refusal of food were served a substitute of similar nutritive value. According to the policy, the resident's preference would be followed to the extent nutritionally/medically possible to encourage food acceptance, and food preference information would be placed on the tray card for use on the serving line. Review of the facility's policy titled, "Food and Nutrition Services," last revised October 2017, revealed staff would provide residents with a nourishing, palatable, well-balanced diet that met the resident's daily nutritional/special dietary needs, with preferences of each resident taken	{F 806}	F 806 Resident Allergies, Preferences, Substitutes Criteria 1: a) Residents #350, #39, and #332 are served food which accommodates their allergies, intolerance, and preferences. Resident #332 is served lactose free milk as requested. b) Substitutes are available for each meal as options for residents when they choose not to eat food that was initially served. Criteria 2: a) On 11/17/21 the regional director of dietary services printed each resident meal tray card and interviewed current residents with a BIMS greater than an 8 to determine that their meal tray cards accurately identify their allergies, intolerances, and preferences. Residents with a BIMS less than an 8 have had their allegies, intolerances and preferences reviewed with nursing. After interview were complete the tray card system was updated to reflect any preference changes. b) The Dietary Consultant and Dietary Manager have developed an always available menu for all threes meal for the residents to choose from when they choose not to eat food that was initially served. Criteria 3: The Regional Direcotor of Dietary Service/Dietary Manager or designee has provided in-service education for the dietary staff on: 11/22/2021 on the always available menu the need to follow the resident meal tray	

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{F 806}	Continued From page 814 into consideration. 1. Review of the menu for the lunch meal, on 06/15/2021, revealed residents were to receive a country ham slice, pinto beans, buttered carrots, Texas sheet cake, and cornbread. In addition to not serving what was listed on the menu, no alternate menu was listed or prepared. Observation of the tray line for the lunch meal service, on 06/15/2021 at 1:14 PM, revealed the residents were served green beans with small pieces of country ham, pinto beans with small pieces of country ham in them, fried potato chunks, cornbread, and white cake with marshmallows in it. Group interview conducted with six (6) residents (Resident #3, #16, #38, #51, #92, and #96) on 06/16/2021 at 10:13 AM, revealed their lunch meal on 06/15/2021 was not good. In addition, the residents stated they were not provided with an alternate menu if they did not like what was served to them. Interview with Cook #1, on 06/16/2021 at 2:00 PM, revealed she was not aware she had to prepare an alternate menu and she had not prepared one. Interview with the previous Dietary Manager (DM), on 06/16/2021 at 1:30 PM, revealed she had quit on 06/15/2021. The DM stated she had not directed the Cook to prepare an alternate menu but, she (the DM) was aware an alternate menu was required. The DM stated she did not know why she did not ask the cook to prepare alternate foods. Continued interview revealed the residents could have weight loss if they were	{F 806}	card for resident allergies, intolerances, and preferences Criteria 4: Beginning on 11/22/2021 the regional director of Dietary Services/Dietary Consultant/Designee will complete meal service observations on all three meals weekly X 4 weeks, then monthly x 2 months to determine that meals are prepared and served in accordance with the resident listed allergies, intolerances and preferences. Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance. Random residents are interviewed to ensure preferences beginning 12/6/21. 12/20/2021 5 random resident will be interviewed to ensure that food is served timely, food temperature is appropriate, and if they receive snacks, meals are served timely, substitutes are available and preferences are met. Interviews will be conducted weekly x 4 weeks then monthly x 2 months. Criteria 5: Date of compliance: 12/30/2021	

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{F 806}	Continued From page 815 served meals they would not eat. Interview with the Registered Dietitian (RD), on 06/18/2021 at 4:18 PM, revealed she was aware the facility was not following the menus and was not providing alternative menus. The RD stated she had previously spoken with the DM regarding her concerns of staff not following the menu and not providing an alternative menu. The RD stated the DM had assured her the situation had been corrected. The RD stated not providing an alternative to a resident who refused what was served could cause malnutrition, weight loss, and other health concerns. The RD stated, " I work closely with the DM but I have no authority over her." Interview with the Administrator, on 06/19/2021 at 1:30 PM, revealed she had only been the Administrator at the facility for two (2) weeks. The Administrator stated she had identified on Tuesday (06/15/2021) that no alternative menus had been prepared or served. She stated she had spoken with both the RD and the DM, but had not been made aware of the problems in the kitchen. The Administrator stated that on 06/14/2021, when she went into the kitchen she found that the DM had not ordered the food to be prepared for 06/15/2021. The Administrator stated she did not realize until 06/14/2021 that the DM was not ordering what was needed to prepare the meals needed in the kitchen. 2. Review of the tray line/tray cards and further review of the roster, indicated one (1) resident (Resident #350) required lactose free milk. However, there was no lactose free milk in the facility, so water and juice were provided to the resident instead.	{F 806}		

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{F 806}	Continued From page 816 Observations of the tray line for the lunch meal service, on 08/05/2021 at 1:15 PM, revealed staff were serving beef fritters with gravy, corn or green beans, mashed potatoes, chocolate pudding and a roll. Continued observation of the lunch meal service revealed Resident #350 did not have lactose free milk on his/her tray as indicated on the dietary tray card. Interview with Dietary Aide (DA) #1, on 08/17/2021 at 5:30 PM, revealed there was not enough food purchased and available to honor food preferences. The aide stated the facility was "always" out of multiple items the residents wanted and it had been this way since she started to work at the facility, a few months ago. According to the DA, lactose free milk wasn't a preference, "it was a need," however lactose free milk was rarely available for the resident. Interview with Certified Medication Aide #1, on 08/05/2021 at 2:45 PM, revealed she contacted the kitchen and requested lactose free milk be sent to the floor for Resident #350 and was told it was unavailable. She stated she contacted the Administrator and the kitchen sent a supplement for the resident. Interview with Dietary Manager (DM) #2, on 08/17/2021 at 3:00 PM, revealed she visited the facility on three (3) different occasions, and the facility had been out of lactose free milk on each occasion. She stated residents that required lactose free milk, should have that available at all times to assist in ensuring their dietary needs were met. 3. Review of Resident #332's medical record	{F 806}		

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{F 806}	Continued From page 817 revealed the facility admitted the resident on 03/12/2021 with diagnoses, which included Type 2 Diabetes, Chronic Kidney Disease, Gastro-esophageal Reflux Disease, Hypertension and Unspecified Atrial Fibrillation. Review of Resident #332's Quarterly MDS assessment, dated 06/19/2021, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15), indicating intact cognition. Further review revealed the resident was independent with eating and weighed one hundred eighty-four (184) pounds. Review of Resident #332's plan of care, dated 06/16/2021, revealed a focused area related to the resident's therapeutic diet with interventions to provide the resident with his/her ordered diet and to offer substitutions as requested or indicated. Review of Resident #332's physician ordered diet, dated 06/16/2021, revealed the resident was to receive a no added salt diet, regular texture, thin liquids consistency, with one (1) ounce extra protein with meals. Review of Resident 332's Dietary-Nutrition Data Collection assessment, completed on 03/16/2021 at 5:39 PM, revealed the resident's current intake was inadequate to meet the resident's needs. Further review revealed a recommendation to add fortified foods with meals to better meet the resident's energy needs. The dietary assessment stated the resident's ideal body weight was one hundred and ninety (190) pounds; however, the usual body weight was two hundred and one (201) pounds.	{F 806}		

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{F 806}	Continued From page 818 Review of Resident #332's Nutrition Progress Note, dated 04/11/2021 at 2:26 PM, revealed the resident had a nine (9) percent weight loss in thirty days. Further review revealed the resident's current intake was inadequate to meet the resident's needs. The Progress Notes stated the resident was receiving fortified foods and recommendations were made to liberalize the resident's diet to a regular diet, add large protein portions at dinner and add a snack at bedtime. Interview with Resident #332, on 07/27/2021 at 11:00 AM, revealed the food was always cold,. Further interview revealed the resident had lost weight and he/she was supposed to get a bologna sandwich on his/her tray for lunch and dinner. However, the facility did not send the sandwiches. The resident stated that he/she had requested bologna sandwiches and the facility stated they were out of bologna. Resident #332 stated the facility never had snacks, especially at night when he/she was hungry. The resident stated that staff tell him/her that he/she must wait until morning when the kitchen opens. Observation of Resident #332's tray, on 08/05/2021 at 7:28 PM, revealed the resident did not have a bologna sandwich or a large protein portion. Interview with Cook #2, on 08/05/2021 at 5:20 PM, revealed the facility was out of bologna, ice cream, lettuce, lactose free milk, tomato juice and have been out of those items for weeks at a time. The cook also stated the dietary department should prepare and send out snacks for residents, especially those that have or have the potential to experience weight loss. However,	{F 806}		

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{F 806}	Continued From page 819 Cook #2 stated, "We haven't sent out snacks in six months or longer." She stated there was not an adequate amount of food items purchased to fulfill the menu, and definitely not enough purchased at the facility to provide snacks to those that needed and wanted them. She also stated she had informed the Administrator on multiple occasions of the residents' requests/preferences which were included on the tray cards. However, the Administrator failed to ensure foods were purchased and available to honor the residents' preferences/requests. 4. Review of Resident #39's medical record revealed the facility admitted the resident on 04/03/2018 with diagnoses which included Type 2 Diabetes. Review of Resident #39's Quarterly MDS, dated 07/10/2021, revealed the facility assessed the resident to have a BIMS score of fifteen (15) out of fifteen (15), and was interviewable, was independent with meals and the assessment indicated it was unknown if he/she had experienced a significant weight loss. According to the MDS the residents most recent weight recorded was two hundred and fifty three (253) pounds. Review of Resident #39's comprehensive care plan, dated 06/17/2021, revealed the facility identified the resident was at risk for impaired nutrition related to receiving a mechanical soft diet and the diagnosis of Diabetes. Interventions implemented on 06/17/2021 included staff honoring the resident's food requests/preferences, monitoring the residents weight and providing the resident with "ordered diet".	{F 806}		

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{F 806}	Continued From page 820 Further review of Resident #39's weight record revealed documentation that the resident refused to allow staff to obtain weight in July 2021. Observation of staff weighing Resident #39, on 08/05/2021, revealed the resident weighed two hundred sixty-one and seven tenths (261.7) pounds. Review of Resident #39's weight record and Registered Dietician (RD) documentation revealed he/she weighed two hundred ninety-four (294) pounds on 01/04/2021 and two hundred fifty three (253) pounds on 06/22/2021, which the RD identified was a twelve and eight tenths (12.8) percent significant weight loss in the past one hundred eighty (180) days. Recommendations were made to honor his/her dietary preferences and fortify the resident's foods at meals. Interview with Resident #39, on 08/17/2021 at 1:20 PM, revealed the resident preferred salads for lunch, and he/she liked "Fruit Loops" (type of cereal). However, a salad had not been provided to the resident for lunch as requested. The resident stated he/she had "lost a lot of weight in the past year" because the facility's food was always late and the food was cold. Resident #39 stated even though he/she had requested salads for lunch "a long time ago" he/she had never received a salad. The resident stated he/she had asked staff in the past, why he/she never received salads and he/she stated, "It's always a different excuse, they forgot, or they're out of lettuce." Resident #39 stated he/she had also requested Fruit Loops cereal, as that was his/her favorite cereal before admission into the facility. However, Resident #39 stated "They won't give	{F 806}		

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{F 806}	Continued From page 821	{F 806}		

me that here either." He/she also stated, "Why would someone ask me what I liked or wanted to eat, if they're not gonna give it to me, makes no sense." According to the resident, breakfast was frequently cold and sometimes the resident was hungry until lunch. Resident #39 stated, If I could get me cereal I could eat that, I could make it myself."

5. Review of the tray line/tray cards for the noon meal on 08/05/2021, revealed three (3) residents had requested bologna sandwiches for lunch and dinner, and three (3) other residents had requested salads for the lunch meal. However, the facility was out of bologna and lettuce, and no other sandwiches or substitutes were provided to the residents. Review of the diet roster also indicated two (2) residents preferred Fruit Loops cereal for breakfast; however, there was no Fruit Loops in the facility.

Observations of the cold cereal available in the facility at 4:30 PM on 08/05/2021 revealed there was one (1), nine (9) ounce bag of unsweetened corn flakes available for the residents.

Interview with Cook #2, on 08/05/2021 at 5:20 PM, revealed she had worked full-time at the facility for approximately one (1) year. She stated the facility was frequently out of food items. The cook stated two (2) residents continuously asked for Fruit Loops cereal for breakfast. However, the Administrator refused to order the food items timely, or at all, to meet the residents' nutritional request and needs. She also stated she had informed the Administrator on multiple occasions of the residents requests/preferences which were included on the tray cards. Continued interview revealed the

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{F 806}	Continued From page 822 Administrator failed to ensure the foods were purchased and available to honor the residents' preferences/request. Interview with Dietary Aide (DA) #1, on 08/17/2021 at 5:30 PM, revealed there wasn't enough food purchased and available to honor food preferences. The aide also stated bologna, lettuce, ice cream and other food items the facility was out of, more than it was available for the residents. Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed she had been contracted to provide services at the facility for approximately one (1) year. The RD stated she had identified concerns with weight loss for the residents. Per interview, concerns of her recommendations not being addressed timely or at all, and resident choice/preference not honored. The RD stated these concerns had been discussed on multiple occasions with the Administrator. However, nothing had been done to correct the problem. Further interview revealed that even though the Administrator had been informed of residents that had ongoing requests for Fruit Loops, tomato juice, bologna and one (1) that required lactose free milk, those items continued to not be available for the residents. She stated if resident food preferences were honored and on-going interventions implemented, it could have prevented Resident #39's significant weight loss. Interview with Dietary Manager (DM) #1, on 08/18/2021 at 11:40 AM, revealed she was the DM at another facility and had assisted the facility and placed some food orders for the building. DM #1 stated she looked at the menu "best I can"	{F 806}		

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{F 806}	Continued From page 823 when she placed orders for the facility. She also stated she was not aware resident preferences weren't being honored or the menu was not always followed at the facility. The DM stated, if residents requested/preferred specific food/drink items or a certain cereal "we buy it," because we are "required to." The DM stated if the menu was not followed, weights were not monitored, RD recommendations were not implemented and resident preferences was not honored that could lead to further weight loss, resident decline and "lots of other problems" for the residents. Interview with the Administrator, on 08/11/2021 at 6:00 PM and 08/18/2021 at 3:30 PM, revealed she acknowledged residents had requested Fruit Loops cereal on multiple occasions. She stated, "We only offer two kinds of cereal here, Corn Flakes and Cheerios". She stated she planned on talking to the "RD about all the stuff that's on these tray cards." The Administrator declined to further discuss the need to talk with the RD related to honoring the residents' preference and again stated, "We only offer two kinds of cereal here." However, she acknowledged the facility's requirement to honor the residents' food preferences and also stated, "... as long as I feel" those preferences "are within reason." According to the Administrator, she as well as a DM from another facility placed the facility's food orders. The Administrator stated she had been notified of various things the kitchen had been out of and she felt like she provided everything staff had requested for the residents.	{F 806}		
{F 809} SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals	{F 809}		12/30/21

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{F 809}	Continued From page 824 §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy it was determined the facility failed to ensure each resident received meals at regular times comparable to normal mealtimes in the community or in accordance with the residents' needs, preferences, requests, and facility policy. In addition, the facility failed to provide nourishing alternative meals and snacks for residents who wanted to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident's plan of care. Observation on 07/27/2021 on two (2) of the three (3) resident floors/units revealed the refrigerator and snack storage area contained no resident snacks. Staff	{F 809}	F 809 Frequency of Meals/Snacks at Bedtime Criteria 1: a) Test tray results completed on 10/27/21 indicate that meals are served in a timely manner at palatable and safe temperatures for all resident floor/units. b) On 11/2/2021 resident unit/floor nourishment storage areas were verified by Dietary Manager as being stocked with snacks/drinks for staff to access when offering residents these items between regular mealtimes. Criteria 2: a) Test tray results completed on 10/27/21 indicate that meals are	

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{F 809}	Continued From page 825 and resident interviews revealed residents frequently did not receive snacks and, meals were later than scheduled for most meals. The findings include: Review of the facility's policy titled, "Food and Nutrition Services" last revised October 2017 revealed staff would provide residents with a nourishing, palatable, well-balanced diet that met the resident's daily nutritional/special dietary needs, with preferences of each resident taken into consideration. The policy also stated meals would be provided within forty-five (45) minutes of the scheduled mealtime. The policy stated reasonable efforts would be made to accommodate resident choices/preferences and nourishing snacks should be available to resident's twenty-four (24) hours a day. Per the policy, residents could request snacks as desired or snacks could be scheduled between meals to accommodate the resident's typical eating patterns. 1. Observation of the 3rd floor refrigerator and snack storage on 07/27/2021 at 11:30 AM revealed no snacks or drinks were available for residents on the unit. The refrigerator contained five (5) cartons of expired milk dated 07/25/2021 and one (1) half gallon of expired buttermilk dated 07/21/2021. Additional observation revealed two (2) pudding cups labeled for medication pass. No additional snacks were observed on the unit/floor. Observation of the 5th floor refrigerator and snack storage on 07/27/2021 at 12:05 PM revealed no snacks or drinks were available for residents on the floor. The refrigerator contained three (3) cartons of expired milk dated	{F 809}	served in a timely manner at palatable and safe temperatures for all resident floor/units. b) Starting 9-15-21 snacks are being offered daily morning and afternoon by the restorative or activity aides or designee to all residents. Intake will be documented on snacks in the electronic medical record. Criteria 3: By 9-15-21 the CDM educated the dietary manager on obtaining food preferences, Dining RD, placing order by menus for facility, stocking snack/hydration carts, snacks and hydrations, appropriate scoop sizes and/or portion sizes. Beginning on 11/24/2021 Nursing staff will be educated on when to provide snacks, what to do if snacks are not available and where to document snack intake. Beginning 11/24/2021 dietary staff will be educated by the Dietary Manager on assuring snacks are stocked daily. The CDM also in-serviced staff ensuring meals are serviced timely on 11/24/21 Criteria 4: a) Beginning on 11/24/2021 The Dietary Manager/Dietary Consultant/Designee will complete weekly random tray pass audits until substantial compliance to determine that meals are prepared and served in accordance with the scheduled menus and required temperature parameters to include all three meals, one tray per floor for each meal per observation. Beginning on 11/24/2021 the dietary manager/ dietary consultant/ designee will complete a weekly audit that nourishment rooms on all three floors are stocked daily until substantial compliance. b) Beginning	

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{F 809}	Continued From page 826 07/25/2021 and one container of expired thickened dairy dated 07/07/2021. Further observation revealed four (4) pudding cups, two (2) of which were undated, and two (2) dated 07/27/2021. No additional snacks were observed on the floor. Observation of the 4th floor resident refrigerator on 07/27/2021 at 11:30 AM revealed no snacks. Additional observation of the 5th floor refrigerator and snack storage on 08/05/2021 at 1:50 PM revealed the refrigerator contained one (1) carton of milk and one (1) carton of med pass with no snacks available. Interview with Resident #39, on 07/27/2021 at 10:45 AM, revealed no snacks were available for residents and the same food was served multiple nights a week. The resident stated the facility did not provide him/her with snacks when he/she was hungry. Interview with Resident #3, on 07/27/2021 at 11:00 AM, revealed when he/she would get hungry snacks were not always available due to the facility being out of snacks a lot of the time. Interviews with Resident #332, at 11:00 AM on 07/27/2021 and Resident #308 on 07/27/2021 at 11:10 AM, revealed snacks were not always available. Resident #308 stated he/she had requested "a snack of some kind" on more than one occasion since he/she was admitted to the facility, and staff had informed him/her nothing was available to give him/her. The resident also stated he/she would have requested to be discharged and "go home"; however, no one was able to assist him/her at home. Resident #308	{F 809}	11/24/2021 The Dietary Manager/Dietary Consultant/Designee will review physician prescribed snack intake documentation monthly X 2 to determine that residents are being offered snacks in accordance with the facility protocol. Beginning on 11/4/2021 residents are interviewed in monthly resident council meeting on whether they are receiving snacks and meals in a timely manner and if meal/snack proportions are enough Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance. b) Starting on 9/23/2021 Dietary Manager or designee will ensure and audit meals leaving the kitchen and reaching the units timely, audits will be conducted for random meals monthly until substantial until substantial compliance is achieved. c) Starting 9-11-21 the Dietary Manager or designee will time passing of meal trays to residents after arriving to the unit. All three meals will be observed monthly until substantial compliance is achieved. Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance. Criteria 5: Date of compliance: 12/30/2021	

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{F 809}	Continued From page 827 stated, "I have to stay here for now, I have no choice." Interviews on 07/27/2021 with Resident #45 at 11:30 AM, and Resident #309 at 11:40 AM, revealed snacks were not available, especially at night when they were hungry and requested something to eat. According to the residents, staff informed them they would have to wait until the morning when dietary staff arrived before they would be able to get something to eat. Observations and interview with Resident #343 on 07/27/2021 at 11:45 AM, revealed various food items, which included microwaveable soups, crackers and snack cakes were observed at the resident's bedside. The resident stated the meals were always late, food was cold and snacks had not been available to residents "for a long time." Resident #343 stated, "My sister brings me food to keep so I don't go hungry, if she didn't do that for me I would have starved to death in here a long time ago." Interview with State Registered Nurse Aide #1, on 07/27/2021 at 4:40 PM, revealed there were not enough snacks for the residents and no juice at times. The SRNA stated if juice was available, staff had to call the kitchen to get it delivered to the unit/floor. In addition, the SRNA stated, "When residents say they are hungry there are times the facility is completely out of snacks." Interview with SRNA #2, on 07/27/2021 at 5:00 PM, revealed when residents said they were hungry there were not many snacks available for the residents on the unit. She stated there were issues with getting juice for residents and it was frequently not available.	{F 809}		

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{F 809}	Continued From page 828 Interview with SRNA #4, on 07/28/2021 at 7:35 PM, revealed staff was not provided enough snacks to give to the residents on the floor and often the kitchen only sent two (2) sandwiches and two (2) bowls of pineapple to the floor with nearly forty (40) residents on the unit. She further stated Administration was aware of the situation, and the kitchen staff said they did not have enough snacks available. SRNA #4 stated the facility was out of juice for a while and the residents were being served cold sandwiches two (2) to three nights out of the week. She stated staff often bought snacks out of their own pocket to give to the residents due to not having any available for them when they were hungry. Interview with Certified Medication Aide (CMA) #1, on 08/05/2021 at 1:30 PM, revealed the facility did not have snacks available for residents. She stated usually there were no snacks. CMA #1 stated that she and other staff would buy the residents snacks and drinks with their own money when they told them that they were hungry. Interview with Registered Nurse #6, on 07/28/2021 at 10:00 AM, revealed residents on her floor frequently informed her they were "hungry" and the facility had failed to supply snacks on the floors for "about a year." The RN became tearful in interview and stated, the food that came from the facility kitchen was cold, late and if staff didn't purchase and provide snacks to the residents "they wouldn't have any." RN #6 also stated that she, as well as other co-workers, had informed the Administrator of the residents' complaints and requested she direct the dietary department send up snacks to have available for	{F 809}		

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{F 809}	Continued From page 829 the residents. However, "that hasn't happened yet." Interview with RN #9, on 07/29/2021 at 9:30 PM, revealed the residents complained of being hungry to staff and stated, "That's been going on for so long and its pitiful." The RN stated she had informed the Administrator of the residents' complaints. The RN stated she worked the night shift, and no access or no one here to ask for food for the residents when "I am here." She stated she had purchased $84.00 worth of food/snacks from her personal funds and brought into the facility for staff to keep on her floor. Per the RN, she bought the snack so staff would have food/snacks to provide to the residents; however stated "someone told the Administrator I did that and she then informed me it was illegal and wouldn't allow me to keep the food here, she made me take it back home." Interview with State Registered Nurse Aide (SRNA) #19, on 08/17/2021 at 1:50 PM, revealed she was also a restorative aide at the facility. She stated the facility "use to have snacks" provided/prepared by the dietary department, which was given to facility residents daily at 10:00 AM, 2:00 PM and at night. However, she stated there has not been snacks available/provided to residents "for months" at the facility. Interview with SRNA #1, on 07/27/2021 at 11:35 AM, revealed there was no snacks on the unit. She further revealed the staff did not have access to snacks unless the dietary department send them to the unit. Interview with SRNA #13, on 07/28/2021 at 6:28 AM, revealed there are not enough snacks on the	{F 809}		

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{F 809}	Continued From page 830 units. She stated that the dietary department will bring up four (4) to five (5) sandwiches for the entire unit and staff have to determine who gets the snacks. She states that residents state they are hungry but the staff cannot get into the kitchen to get any additional food. Interview with Dietary Aide (DA) #1, on 08/17/2021 at 2:30 PM, and DA #2 on 08/17/2021 at 2:15 PM revealed the facility was out of ice cream, tomato juice, lactose free milk and bologna "constantly." The aides also stated two (2) residents request fruit loop cereal, which is also on their tray cards, "all the time"; however, that type of cereal was not purchased and available for the residents, even though the Administrator has been informed on multiple occasions of the residents' request. Interview with Cook #2, on 08/05/2021 at 5:20 PM, revealed she had worked full-time at the facility for approximately one (1) year. The cook also stated the dietary department should prepare and send out snacks for residents, especially those that have or have the potential to experience weight loss; however, "we haven't sent out snacks in six months or longer." She stated there is not an adequate amount of food items purchased to fulfill the menu, and definitely not enough purchased at the facility to provide snacks to those that need and want them. Interview with Dietary Manager (DM) #2, on 08/17/2021 at 3:00 PM, revealed she was employed at another facility the company owns, and had been asked approximately three (3) weeks ago, to come provide assistance/oversight and retrain dietary staff on dietary processes, because the facility had no DM and concerns had	{F 809}		

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{F 809}	Continued From page 831 been identified in the kitchen. She has visited the facility approximately three (3) times, and each time the facility had been out of ice cream, tomato juice, lactose free milk and bologna and other things she was unable to recall. She also stated resident preference was not honored at the facility and stated two (2) residents request fruit loop cereal, as well as other items and she had personally went through the residents tray cards and made a list of needed food items to ensure the nutritional needs/preferences of the residents were met in the facility, and provided the list to the Administrator. However, the Administrator informed the DM, she "wasn't buying all those items and the residents could eat what was here." She also stated since she had been providing assistance to the facility, she had went to the grocery store on two (2) separate occasions and purchased food items for the residents, out of her own pocket, because the Administrator refused to purchase what the residents needed to eat/drink. She also she had purchased items on her own, because "I couldn't walk out of here knowing resident's weren't getting what they needed." Interview with the Administrator, on 08/11/2021 at 6:00 PM and 08/18/2021 at 3:30 PM, revealed she had been the facility Administrator since 06/07/2021 and she was not aware snacks were not being provided. She also acknowledged residents had requested fruit loop cereal on multiple occasions and stated "we only offer two kinds of cereal here, corn flakes and cheerios" and stated she planned on talking to the "RD about all the stuff that's on these tray cards." When asked to elaborate on why discussions needed to occur with the RD, when the RD was attempting to honor the residents preference she stated "we only offer two kinds of cereal here"	{F 809}		

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{F 809}	Continued From page 832	{F 809}		

however, acknowledged the facilities requirement to honor the resident's food preferences and also stated "as long as I feel" those preferences "are within reason." According to the Administrator, she as well as a DM from another facility placed the food orders for the facility, and stated she had been notified of various things the kitchen had been out of and stated she felt like she provided everything staff had requested for the residents.

2. Interview with Cook #2, on 08/05/2021 at 12:00 PM, revealed the facility was serving lunch to one-hundred and thirteen residents (113).

Review of the facility mealtime schedule indicated breakfast was served at 7:00 AM, lunch was served at 12:00 PM and the evening meal was served at 5:00 PM.

Review of the menu for the lunch meal on 08/05/2021, revealed the residents were being served the residents meal of choice. Observations of the tray line for the lunch meal service on 08/05/2021 at 1:15 PM, revealed staff were serving beef fritters with gravy, corn or green beans, mashed potatoes, chocolate pudding and a roll.

Observations of the lunch meal also revealed even though the meal time was scheduled for 12:00 PM the first of three (3) tray carts hadn't exited the kitchen until 1:30 PM to go to the third floor, and the last tray cart exited the kitchen at approximately 2:45 PM (almost 3 hours late) which went to the 5th floor residents.

Review of the facility menu and Observations conducted of tray line for the supper meal on 08/05/2021, revealed the facility was serving a

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{F 809}	Continued From page 833 barbeque riblett sandwich, tater tots, three bean salad and two (2) gooey butter cookies. Continued observations revealed even though the supper meal was scheduled to be served at 5:00 PM, staff was not observed to start tray line until 6:15 PM. The first of three (3) tray carts had not left the kitchen to be served to the residents until 6:50 PM and the last cart had not left the kitchen until 8:00 PM (three hours late) going to the residents on the 5th floor. Interviews on 07/27/2021 with Resident #332 at 11:00 AM, and Resident #308 at 11:10 AM indicated meals were never provided to the residents at the scheduled time in the facility. Interviews on 07/27/2021 with Resident #45 at 11:30 AM, and Resident #309 at 11:40 AM, revealed meals were always served late in the facility. Interview with Family Member #3 on 08/02/2021 at 5:30 PM revealed she arrived to the facility at 10:45 AM on 07/18/2021 for a scheduled visit with Resident #321. She stated when she left at approximately 3:00 PM, Resident #321 had not received the lunch meal. Interview with State Registered Nurse Aide (SRNA) #16, on 07/27/2021 at 8:10 PM, revealed the facility was short staffed, "especially at night." She stated meal service was always late and was sometimes 8:00 PM before trays were delivered to the floor. The SRNA stated, "There's no way one aide can pass the trays and feed the residents that require assistance and do it right." She also stated residents frequently complain of cold food "because it's cold before they're getting it. There's not enough help."	{F 809}		

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	185256	A. BUILDING _____ B. WING _____	R 09/30/2021

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{F 809}	Continued From page 834 Interview with LPN #2, on 07/28/2021 at 6:52 AM, revealed meal trays were often late. She stated at times it has been 8:00 PM before the supper trays have made it to the unit. She stated late meals messed with giving residents their medications like insulin. Interview with SRNA #16, on 07/28/2021 at 8:00 PM, revealed she primarily worked floor five (5). She stated the supper trays would come out to the floors as late as 9:00 PM and there was not enough staff to pass them timely. Interview with SRNA #18, on 07/28/2021 at 9:54 PM, revealed meal trays came to the unit at times at 8:00 PM. Interview with RN #7, on 08/01/2021 at 11:40 AM, revealed meal trays were often late. She stated at times it has been 8:00 PM before the supper trays have made it to the unit. She stated it messed with giving residents their medications like insulin. Interview with RN #6, on 07/28/2021 at 10:00 AM, revealed residents on her floor frequently informed her they were "hungry" and the facility had failed to supply snacks on the floors for "about a year." The RN became tearful in interview and stated, the food that came from the facility kitchen was cold/late. Interview with RN #9, on 07/29/2021 at 9:30 PM, revealed she worked the 6 PM-6 AM shift and sometimes supper trays were not delivered to her floor until 7:30 PM - 8:00 PM. The RN stated most of the time, there was only one (1) aide to pass trays and assist the residents, which makes	{F 809}		

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{F 809}	Continued From page 835 it "impossible for the residents to have a good meal service like that." The RN stated she assisted the aide with meal service the best she could; however, stated she was the only nurse to approximately 40 residents, and that was also a medication administration time and the residents "have to have their medicines too." Interview with Cook #2, on 08/05/2021 at 5:20 PM, revealed she had worked full-time at the facility for approximately one (1) year. She stated she works five (5) days a week and cooks all three (3) meals on the days she works, and has for months due to short staffing in the facility. She also stated she worked "a lot" of overtime and had approximately 15-20 hours of overtime during the last pay period. She stated the meal services were late because they were short staffed in the kitchen. Per the cook, the facility had no dietary manager and were short one (1) dietary aide and had been for months, which makes getting meals to residents on time, "impossible." She acknowledged she does not review tray cards "like I should" during tray line for resident meals because there is not enough of us and meals would be even more off schedule. She also stated the facility was frequently out of food items. She also stated the facility was out of bologna, ice cream, lettuce, lactose free milk, tomato juice and have been out of those items for weeks at a time. Interview with the RD, on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed she had been contracted to provide services at the facility for approximately one (1) year. The RD stated meals are always served late, and there is not enough food purchased to provide snacks to the residents.	{F 809}		

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{F 809}	Continued From page 836 Interview with the Assistant Director of Nursing (ADON)/Interim Director of Nursing, on 08/18/2021 at 9:50 PM, revealed she had worked at the facility for approximately one (1) year and the facility had been inadequately staffed with nurses and aides since during that time. The ADON stated she was also aware that meal times were consistently late, which made it difficult for staff and residents during the evening meal. She stated when the food cart did not come to the floor until 7 PM-8 PM in the evening, it was difficult to serve and assist residents because there was only one (1) aide. She stated nurses were busy administering medications during that time and not everything could be completed timely. Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed she was aware the facility was short staffed, with not enough nurses and nurse aides. The Administrator stated she was aware of residents' cold food complaints and that meals were served late to the residents. She stated there should be a Dietary Manager and at least four (4) other staff in the kitchen; however, the kitchen had worked with no Manager and only three (3) staff since she had been Administrator at the facility. She stated she was aware that was not enough staff in the kitchen to ensure meals were timely, and was "working on it."	{F 809}		
{F 812} SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	{F 812}		11/30/21

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{F 812}	Continued From page 837 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to prepare and serve food under sanitary conditions. Observation of the lunch tray line on 06/15/2021, revealed uncovered cake was sent on the residents' meal trays to the units. In addition, approximately two (2) inches of dried food was observed around the inside of the deep fryer. The deep fryer oil was observed to be dark brown. Observation on 07/27/2021 of two (2) of the three (3) resident units/floors (3rd and 5th floor) refrigerators revealed each refrigerator contained expired milk, which was available for resident use. The findings include: Review of the facility's policy titled,"Cleaning and Sanitation of Dining and Food Service Areas,"	{F 812}	F 812 Food Procurement, Store/Prepare/Serve □ Sanitary Criteria 1: a) All food items are properly covered when sent out on the resident meal trays to the units. b) The deep fryer was emptied and deep cleaned inside and out. c) All resident unit/floor refrigerators have been cleaned with all expired food/drink items thrown away and replaced as indicated. Criteria 2: All residents have the potential to be affected by this cited deficiency. On 10/27/2021 the kitchen was inspected, and all food items were covered, the deep fryer was clean inside and out and resident/unit floor refrigerators were clean and had no expired items. Criteria 3: The Dietary Consultant/Dietary	

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{F 812}	Continued From page 838 undated, revealed the food and nutrition services staff would maintain the cleanliness and sanitation of the dining room and food service areas through compliance with a written, comprehensive cleaning schedule. Review of the facility's policy titled,"Food: Quality and Palatability", undated, revealed the Cook would prepare food in a sanitary manner. Interview with the Administrator on 08/10/2021 at 1:50 PM revealed the facility had no policy/process in place to ensure foods/fluids stored in the refrigerators, which were available for resident use were safe for consumption. 1. Observation of the tray line for the lunch meal service on 06/15/2021 at 1:14 PM, revealed staff was observed to place uncovered cake on resident meal trays and send them to the units/floors. In addition, approximately two (2) inches of dried food was observed around the inside of the deep fryer which was being used to deep fry potato chunks for the lunch meal. The deep fryer oil was observed to be dark brown and in need of changing. Review of the facility's daily cleaning log, revealed the deep fryer was not listed on the cleaning schedule. Interview with Cook #1, on 06/16/2021 at 2:00 PM, revealed she kept a razor blade in the kitchen to cut off the dried food particles on the inside of the deep fryer. The Cook stated she had only worked at the facility for four (4) weeks. She stated she had only cleaned the deep fryer one time since she had worked there. Continued interview revealed she was aware the deep fryer	{F 812}	Manager have in-serviced the dietary staff on: checking for expired foods, the need to properly cover all food sent out on the resident meal trays to the units; the need to follow the established cleaning schedule to include cleaning for the deep fryer; and the schedule for checking of the resident unit/floor refrigerators to maintain food/drink that is within date range, as completed on 11/01/21 Criteria 4: The dietary sanitation compliance tool for the monitoring of dietary sanitation will be utilized Weekly x 4 weeks then monthly x 2 months beginning on 11/22/2021 under the supervision of the Dietary Manager/Dietary Consultant/ or Designee. These audits will include monitoring of trays before leaving dietary to ensure they are properly covered, and ensuring the deep fryer is cleaned per cleaning schedule. Unit/floor refrigerators are currently being monitored daily beginning on 11/1/2021. Audits will be reviewed monthly in QAPI x3 months then quarterly until in substantial compliance. Criteria 5: Date of compliance: 11/30/2021	

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{F 812}	Continued From page 839 should be cleaned after every use. The Cook stated she was also unaware the cake should have been covered prior to sending it out to the residents. Interview with the Dietary Manager (DM), on 06/16/2021 at 1:30 PM, revealed she had quit on 06/15/2021. The DM stated she had trained the Cook. The DM stated the deep fryer should be cleaned after every use and the cake should have been covered. The DM stated the deep fryer should have been on the cleaning scheduled. Interview with the Registered Dietitian (RD), on 06/18/2021 at 4:18 PM, revealed she had cleaned the deep fryer once in the past month because it was dirty. The RD stated cake should be covered prior to leaving the kitchen and being delivered to residents. The RD stated she was not aware the cleaning schedule did not list the deep fryer and stated it should have. Interview conducted with the Administrator, on 06/19/2021 at 1:30 PM, revealed she had only been the Administrator at the facility for two (2) weeks. She stated the deep fryer had been covered previously when she was in the kitchen. . The Administrator stated she had spoken with both the RD and the DM and had not been made aware of the problems in the kitchen, until 06/15/2021. 2 Observation of the 3rd floor refrigerator and snack storage on 07/27/2021 at 11:30 AM revealed the refrigerator contained five (5) cartons of expired milk dated 07/25/2021 and one (1) half gallon of expired buttermilk dated 07/21/2021.	{F 812}		

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{F 812}	Continued From page 840 Observation of the 5th floor refrigerator and snack storage on 07/27/2021 at 12:05 PM revealed the refrigerator contained three (3) cartons of expired milk dated 07/25/2021 and one container of expired thickened dairy dated 07/07/2021. Further observation revealed four (4) pudding cups, two (2) of which were undated, and two (2) dated 07/27/2021. Interview with Dietary Aide (DA) #2, on 08/17/2021 at 2:15 PM and DA #1 on 08/17/2021 at 2:30 PM, revealed neither aide had been trained/instructed to stock or monitor food/fluids in the refrigerators located on all three (3) floors to ensure they were in date and safe for resident consumption. Interview with the Administrator, on 08/10/2021 at 1:50 PM, revealed food/fluids that were available for resident consumption should be in date and safe for residents. She also stated she was not sure who was responsible to monitor food/fluid items stored in the refrigerators on the units.	{F 812}		
{F 835} SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	{F 835}		12/30/21

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{F 835}	Continued From page 841 Based on interview, record review, and review of the Administrator's and the Director of Nursing (DON) Job Description, the facility failed to be administered in a manner that enabled effective use of its resources to attain and maintain the highest practicable physical, mental and psychosocial well-being for each resident, and to ensure quality care and services were provided that met the needs of the residents (Refer to F580, F600, F655, F656, F657, F684, F686, F692, F725, F744, F755, F867 and F880). Record review and staff interviews revealed the facility failed to have systems in place to ensure changes in resident changes in condition were addressed timely; failed to ensure residents were free from abuse; failed to ensure baseline and comprehensive care plans were developed and implemented; failed to ensure resident care was delivered in accordance with professional standards of practice; failed to ensure residents received care to prevent/treat and promote healing for pressure sores; failed to ensure residents maintained acceptable parameters of nutritional status and/or body weight; and failed to ensure the facility had adequate numbers of direct care and dietary staff. Staff interviews revealed the Administrator was aware of the failures, but had taken no action to correct the failures, and conditions were worse. The facility's failure to be administered in a manner that enabled effective use of its resources to attain and maintain the highest practicable physical, mental and psychosocial well-being for each resident, and to ensure quality care and services were provided that met the needs of the residents, has caused or is likely to cause serious injury, harm, impairment or death	{F 835}	F 835 Administration Criteria 1: An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021 on (F580, F600, F655, F656, F684, F686, F692, F755, F880). However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified for (F725, F835, F837, F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. An acceptable allegation of compliance was received on 09/25/2021, which alleged removal of the Immediate Jeopardy on 9/26/2021. The State Survey Agency determined the Immediate Jeopardy was removed as alleged during a revisit conducted on 09/28-30/2021, which lowered the scope and severity to D for all tags, while the facility monitors the effectiveness of systemic changes and quality assurance activities. Criteria 2: Effective 9/13/21 an Interim administrator replaced current administrator. Interim administrator received daily oversight and guidance from the Regional Vice President and/or Regional Director of Operations and Regional Clinical Nurse for 30 days. At the end of this time the administrator was evaluated by Regional Administrative Team and determined to continue daily oversight as needed. On October 1st, 2021, a permanent Administrator was placed in the facility and monitored for the	

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{F 835}	Continued From page 842 to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021. An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing. A second acceptable allegation of compliance was received on 09/25/2021, which alleged removal of the Immediate Jeopardy on 09/26/2021. The State Survey Agency determined the Immediate Jeopardy was removed as alleged during a revisit conducted on 09/28-30/2021, which lowered the scope and severity to "D" 42 CFR 483.10 Resident Rights (F580), 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686), 42 CFR 483.35 Nursing Services (F725), and 42 CFR 483.45 Pharmacy Services (F755); and to "E" at 42 CFR	{F 835}	following 30 days by the Regional Vice President and/or Regional Director of Operations and Regional Clinical Nurse. On 10/1/21 the Divisional Vice President and/or the Regional Director of Operations educated the new Administrator on the IJs, other tags, and the submitted AOC/POC. Administration has direct oversight and responsibility to direct, discipline, and communicate areas of concern and process improvement. Criteria 3: Beginning 9-13-21 through 9-17-21 the interim administrator educated all staff on his contact information and role as the abuse coordinator. Also, at the same time all staff were in-service on staffing schedules, and who to notify when unable to work. Any staff missing in-services will receive the education when they return to work. Other education provided was reviewed by the QAPI Committee listed below and provided for staff. On 9/16/2021 the Administrator, Medical Director, and QAPI Committee have reviewed procedures for who to call if unable to work, Answering Call Lights, ADL Care, Serving Meal Tray Timely, incontinence care, turning and repositioning, the four P□s, Abuse Prevention Program, Care plans, and Infection Control. Criteria 4: Beginning on 09-13-2021, the interim administrator started monitoring daily, weekly, and monthly audits for F580, F600, F655, F656, F684, F686, F692, F755, F880, F725, F835, F837, and F867. The Administrator will monitor all	

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{F 835}	Continued From page 843 483.12 Freedom from Abuse (F600), 42 CFR 483.25 Quality of Care (F692), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867), and 42 CFR 483.80 Infection Control (F880), while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the "Administrators Manual" dated May 2021 revealed the facility corporation was committed to serving residents and their family members and would strive to create a homelike atmosphere, where the needs of the residents were of utmost importance. The manual also stated the facility offered dynamic services and the individual needs of each resident would be evaluated and services would be provided accordingly. According to the policy, the Administrator's primary purpose was to direct the day-to-day functions of the facility in accordance with current federal, state and local standards, guidelines and regulations that govern nursing facilities to ensure the highest degree of quality care was provided at all times to the residents. The Administrator was required to make daily rounds of the facility and evaluate the overall appearance of facility/equipment, evaluate care provided to the residents, and evaluate resident/family satisfaction. The manual also stated the Administrator's duties included developing and maintaining written policies/procedures and professional standards of practice which govern the operation of the facility. Further review revealed the Administrator's daily duties included ensuring the Interdisciplinary	{F 835}	audits on a weekly and/or until substantial compliance is met and monthly thereafter as recommended by the QAPI committee. Any findings that were not within regulations and addressed immediate and/or not reported immediately will result in disciplinary action in accordance with facility policy and procedures that can result in termination. All findings and progress will be presented to QAPI Committee consisting of at a minimum of: Administrator, Medical Director, Director of Nursing, Dietary Manager, Social Service Director, and two other staff members to update progress and/or findings to determine recommendations or feedback to continue current plan in place. When the 11/01/21oversight ended, the Corporate oversite was provided by the RDO and a Regional Clinical Nurse Consultant every day. The Divisional Vice President oversight is reviewing audits to ensure they are done and any actions needed have been done. When Divisional Vice President is not on site the RDO will be on-site to ensure audits are done and any actions needed have been done. Criteria 5: Date of compliance: 12/30/2021	

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PARKVIEW POST-ACUTE AND REHABILITATION CENTER	200 NURSING HOME LANE PIKEVILLE, KY 41501

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{F 835}	Continued From page 844 Team Meetings (IDT) were occurring; review/manage staffing; observe facility systems, which included dining; and ensure personal assistance was provided to the residents. The Administrator's weekly duties included monitoring residents, which had identified problems, and reviewing weight and pressure ulcer reports for facility residents. Monthly Administrator duties included ensuring follow up had occurred for consultant reports, which included dietary reports; and to ensure QAPI meetings were conducted monthly as required. The manual also stated the Administrator would review all incident reports, would coordinate all investigations in the facility, and would ensure compliance for reporting of all events to State and Federal agencies. The Administrator should listen to and know their residents and ensure the individual needs of the residents were met. According to the manual, the Administrator should ensure menus were posted daily and that nourishments were offered to the residents. 1. Review of Incident Reports revealed Resident #82's ongoing behaviors resulted in resident-to-resident abuse incidents. On 05/18/2021, Resident #82 grabbed Resident #322 causing a skin tear. On 06/04/2021, Resident #82 grabbed Resident #64's wrist and would not let go. On 06/30/2021, Resident #317 held Resident #82's wrist because Resident #82 wandered into his/her room and would not leave. On 07/15/2021, Resident #82 hit Resident #86 with a shoe causing a large bruise to the resident's upper arm. On 07/31/2021, Resident #82 hit Resident #64 on the left wrist. Interview with Resident #86 on 07/27/2021 revealed he/she was afraid when he/she went to sleep because Resident #82 still came in his/her room and the	{F 835}		

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{F 835}	Continued From page 845 facility had taken no action to protect the resident. Interview with the Administrator, on 08/11/2021 at 6:00 PM, revealed she was the Abuse Coordinator and was aware Resident #86 was afraid of Resident #82. She stated she was also aware Resident #82 wandered into other residents' rooms, triggering resident-to-resident abuse incidents. However, there was no evidence the Administrator had taken any action to protect residents from abuse. 2. Review of the facility's mealtime schedule indicated breakfast was served at 7:00 AM, lunch was served at 12:00 PM and the evening meal was served at 5:00 PM. Review of Resident #321's medical record revealed the resident had a diagnosis of Diabetes and required staff to monitor the resident's blood glucose. Review of Resident #321's Nursing Notes dated 07/18/2021 at 3:20 PM, revealed at approximately 7:30 AM on 07/18/2021, Resident #321's blood glucose was 67 mg/dL (milligrams per deciliter) (less than 70 is considered a low blood glucose result). Interview with LPN #6, on 07/30/2021 at 11:30 AM, revealed she cared for Resident #321 on 07/18/2021. She stated the resident had two (2) hypoglycemic episodes, once at approximately 7:30 AM as noted in the nursing notes. The second episode was late afternoon on 07/18/2021 (exact time unknown). She stated she found the resident unresponsive, with a blood glucose level "around 40 mg/dL". Continued review of Resident #321's Nursing Notes revealed on 07/19/2021 at 12:23 AM, staff	{F 835}		

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{F 835}	Continued From page 846 found the resident un-responsive and clammy. The resident's documented blood glucose and it was 32 mg/dL. Staff administered medication to raise the resident's blood glucose; however, the resident remained un-responsive and experienced labored breathing. Continued review of the Nursing Notes revealed at 1:00 AM, Emergency Medical Services (EMS) transported Resident #321 to the hospital. Review of the hospital record revealed the resident was diagnosed with hypoxemia (not enough oxygen to sustain life), Pneumonia, Acute Metabolic Encephalopathy, and acute respiratory failure, secondary to prolonged hypoglycemia (low blood sugar). Interview with Administrator, on 08/10/2021 at 1:50 PM, revealed the facility had no system to monitor to ensure residents with Diabetes were receiving basic and consistent care to ensure the resident's blood glucose levels remained within acceptable parameters and did not have a system to ensure resident changes in condition were identified/addressed timely. The Administrator further stated there should always be two (2) nurses and two (2) aides on fifth floor at night. 3. Record review revealed the facility admitted Resident #65 on 03/23/2021 without pressure ulcers. Continued review of the record revealed Resident #65's was at risk for pressure ulcers and required assistance of staff for turning and repositioning, and incontinent care. However, the facility failed to turn and reposition the resident. On 05/02/2021, Resident #65 developed a deep tissue injury to the coccyx. The facility failed to assess the pressure ulcer (measurements,	{F 835}		

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{F 835}	Continued From page 847 appearance, drainage, odor, etc.). Subsequently, the facility also failed to identify the pressure ulcer had worsened. On 05/28/2021, Resident #65 was transferred to the Emergency Department (ED) due to worsening of the pressure ulcer. Resident #65 was admitted to the hospital related to the sacral pressure ulcer that had worsened and was, "clinically septic with large decubitis [pressure] ulcer with associated infection including cellulitis and possible abscess". Resident #65 underwent debridement on 05/30/2021, when all necrotic tissue was removed the "excision was down to the bone". Resident #65 was readmitted to the facility. However, the facility continued to fail to turn and reposition Resident #65; and, failed to conduct weekly skin and/or pressure ulcer assessments. Resident #65 developed five (5) more pressure ulcers: a Stage I (one) to the left heel on 06/23/2021; a DTI (deep tissue injury) to the right heel on 06/26/2021; an unstageable pressure ulcer to the back of the left, lower leg on 08/12/2021; and, two (2) Stage II (2) pressure ulcers to the left hip on 08/26/2021. Further review revealed a wound care specialist assessed Resident #65's sacral pressure ulcer on 08/26/2021 at 9:00 AM, and documented the wound had worsened. Interview with SRNA #4, on 07/28/2021 at 7:35 PM, SRNA #1 on 8/5/2021 at 5:15 PM, SRNA #10 on 08/27/2021 at 11:15 AM, and SRNA #11, on 08/27/2021 at 3:00 PM, revealed there was not enough staff to turn and reposition residents, nor provide incontinence care every two (2) hours. SRNA #10 stated the ADON/Interim DON and Administrator knew "we can't get our every two	{F 835}		

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{F 835}	Continued From page 848 hours turns and repositions and checks and changes in" and "they don't help us with anything". SRNA #11 stated there were usually one (1) or two (2) nurse aides to provide care for over 40 residents and residents were only turned every two (2) to three (3) hours. SRNA #4 stated, "It can't be done by one person". Interview with the Administrator on 08/11/2021 at 6:00 PM, revealed she was required to review staffing daily. She stated she was aware there was not enough staff to provide nursing and related services to maintain the highest practicable physical, mental, and psychosocial well-being for residents; however, stated she was still admitting new residents at the facility, even though she knew the facility was not adequately staffed to meet the resident's needs. The Administrator stated was also responsible to ensure resident care was provided in accordance with professional standards of practice and that the facility operated within the regulatory guidelines. However, according to the Administrator she had had no systems in place to monitor the care delivered to residents in the facility. She also stated she had not conducted any oversight meetings, which included daily, weekly or monthly Quality Assurance meetings since she became the Administrator (June 2021), to ensure care plans were developed and implemented and care delivered to residents with pressure sores and at risk for pressure sores met professional standards of practice. 4. Observation of the lunch meal on 08/05/2021, and review of the menu for the lunch meal on 08/05/2021, revealed the residents should have received three (3) ounces of protein, 1/2 cup of mashed potatoes, and ½ cup of vegetable.	{F 835}		

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{F 835}	Continued From page 849 However, observations revealed staff served the residents 1/3 cup of mashed potatoes and 3/8 cup of vegetable. In addition, when staff was asked to weigh the protein to ensure it was adequate, there was no functioning scale in the kitchen to weigh the meat. The "Diet Roster" provided by the facility indicated forty-two (42) residents required fortified foods, including Residents #90, #327, #82, #39, #332, #81, and #65. However, there was no food prepared and designated as "fortified". Continued observation revealed three (3) residents were supposed to get sandwiches with meals including Residents #332 and #81, and three (3) other residents were supposed to get salads for the lunch meal including Resident #39. However, continued observation and interview with dietary staff revealed the facility did not have lunchmeat, lettuce, or other sandwich ingredients available. In addition, observations revealed that although the meal due to be served to residents at approximately 12:00 PM, the last food tray did not exit the kitchen until 2:45 PM. Review of Resident #65, Resident #90, Resident #327, Resident #82, Resident #330, Resident #39, Resident #332, and Resident #81's medical records revealed each of the residents sustained significant weight loss as a result of the facility's failure to have a systemic procedure in place to monitor resident weight loss. The facility failed to obtain resident weights according to policy, failed to notify the Registered Dietitian (RD) when a resident sustained weight loss, failed to provide dietary recommendations to prevent further weight loss, failed to honor resident food preferences to prevent weight loss, and/or failed to ensure residents were served adequate portions to prevent weight loss.	{F 835}		

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{F 835}	Continued From page 850 Interview with the RD on 08/11/2021 at 4:10 PM and 08/18/2021 at 10:30 AM, revealed she had been contracted to provide services at the facility for approximately one (1) year and had never been provided a list of resident to evaluate for weight loss or because the resident had a pressure ulcer. The RD stated she had identified concerns with weight loss for the residents, concerns that her recommendations were not being implemented, resident choice/preference not honored, and communication with nursing staff. The RD stated she had discussed the concerns on multiple occasions with the Administrator. However, she stated the facility had taken no action to correct the problems. The RD stated meals were always late and there was not enough food purchased to provide snacks to the residents. The RD stated she was not aware staff did not know how or did not have "instruction" on fortifying foods. The RD stated not fortifying foods, not utilizing the correct scoop size to portion out residents servings, failing to provide snacks, not weighing protein portions, not supplying supplements she had recommended such as ice cream, and not serving residents their preferences, could all lead to weight loss and malnutrition for the residents. Interview with the Administrator on 08/11/2021 at 6:00 PM and on 08/18/2021 at 3:30 PM, revealed she had been the facility's Administrator since 06/07/2021. The Administrator stated the facility had no systems in place to monitor resident weight loss or nutritional needs, but stated the facility "was working on getting one in place". The Administrator confirmed the facility had not conducted NAR (Nutritional at Risk) meetings since she had been the Administrator, but stated	{F 835}		

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{F 835}	Continued From page 851 she was working on getting those established. The Administrator could not voice any monitoring or tracking she did to ensure the facility was doing everything possible to prevent resident weight loss. Further interview with the Administrator revealed she was aware the dietary department was "a mess". She stated there was not enough kitchen staff to ensure meals were provided timely and was aware food was not available to ensure menus were followed. In addition, the Administrator was aware food preferences were not met/followed and snacks were not available for residents and stated she was "working" on a plan to correct the problems in the facility. **The facility alleged the following was implemented to remove Immediate Jeopardy effective 09/26/2021: 1). Braden Scale Assessments were completed on all residents by facility nurses on 08/28/2021 and comprehensive full body skin assessments were completed on all residents on 09/11/2021. The facility utilized the Braden Scale Assessment and comprehensive full body skin assessment to review and update care plans of residents who had pressure injuries by 09/17/2021. 2). The wound care physician evaluated Resident #65 on 08/25/2021. Staff assessed and measured all pressure injuries, and staff evaluated all current treatments and reported them to the Medical Director/Physician #1 by 09/17/2021. 3). Beginning 09/17/2021, upon admission a skin assessment and Braden Scale assessment will be completed, and the baseline care plan will be	{F 835}		

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{F 835}	Continued From page 852 developed within 48 hours to include any pressure ulcer or potential for pressure ulcer. A comprehensive care plan will be developed within 21 days of admission to include pressure ulcers or potential pressure ulcers and include interventions to prevent pressure ulcer development or worsening of pressure ulcers. 4). Residents #45, #65, #308, #309, #311, #314 and #320 were bathed including a shower, nail care and moisturizing lotion applied post shower, and assisted with dressing in clean appropriate clothing. Clean linens were placed on the residents' beds on 09/11/2021. The residents were evaluated by social services on 09/15/2021. 5). All residents were offered a shower and interviewed to obtain shower/hygiene preferences by the Director of Nursing (DON) or designee. New bath/shower schedules were implemented by nursing staff to accommodate resident preference. Resident preferences for hygiene were obtained and incorporated into resident care plans and State Registered Nurse Aide (SRNA) care plans by the Regional Nurse Consultant were completed on 09/13/2021. 6). On 08/28/2021, the Registered Dietitian (RD) began reviewing all residents' diets and made recommendations for meal changes or supplements to promote healing and to address any weight loss issues. 7). All residents with the diagnoses of Diabetes and Chronic Obstructive Pulmonary Disorder (COPD), Asthma and Pneumonia were assessed by licensed nurse and/or Respiratory Therapist with no concerns were identified completed 08/13/2021.	{F 835}		

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{F 835}	Continued From page 853 8). The Regional Nurse reviewed all residents with orders for glucose monitoring by 07/30/2021 and orders were amended to include mandatory entry of glucose values on the Medication Administration Record (MAR). 9). The Regional Certified Dietary Manager (CDM) observed the meal service for breakfast, lunch and dinner on 09/11/2021, all three meals were delivered on time. 10). Direct Care staffing was increased through recruitment efforts with additional staffing provided through agency and travel contracts. Direct care nursing staff schedules for the next day will be reviewed daily by the Director of Nursing and the Administrator to ensure staffing levels are adequate to meet the acuity of the residents. The staff will be validated as present on the unit at the start of each shift by the Director of Nursing, Nursing Supervisor, Administrator or designee. Direct care nursing staff call offs will be replaced by calling other qualified staff to see if they can fill the opening, and/or calling agencies to see if they have qualified staff to fill the opening. If direct care staff cannot be replaced the Director of Nursing, Assistant Director of Nursing, or member of the nursing management team will fill the shift. If appropriate staffing levels cannot be met, the center will prioritize resident care that can be achieved during emergency staffing, prioritize required task including administration of medication, no showers- sponge baths, care provided to incontinent residents, turn residents that cannot turn self, meals served timely, and assist residents with meal if needed.	{F 835}		

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{F 835}	Continued From page 854 11). The facility has increased dietary staffing through recruitment efforts and appropriate staffing levels have been achieved to ensure meals are prepared and delivered timely. 12). On 08/11/2021, all residents including #64, #86 and #322, were reassessed for psychosocial and physical forms of abuse with Brief Interview for Mental Status (BIMS) score of eight (8) or above and skin integrity reviews for residents with BIMS less than eight (8) were completed by Licensed Nurse. Residents with a diagnosis of Dementia had their Care Plan reviewed and revised, as necessary by the Minimum Data Set (MDS) Coordinator on 09/07/2021. No new residents were identified as indicating any psychosocial and/or physical harm. 13). The Regional Nurse Consultant completed a wandering risk assessment on all residents by 08/16/2021. All residents who were identified as at risk for wandering had care plans reviewed and updated by the MDS Coordinator. A list of all identified active wander risk residents were placed at each nursing station with a list of potential interventions for nursing to reference. 14). Residents #39, #65, #81, #90, #330 and #332 were weighed by 09/17/2021. The Registered Dietician (RD) completed a comprehensive nutrition assessment and RD recommendations were reviewed for recommendations by the Director of Nursing (DON) or designee on 09/17/2021. Further, the DON or designee, spoke with the attending Medical Doctor (MD) and validated the diet orders and recommendations. Recommendations were entered into the electronic medical record and on the tray card. The Registered Dietician and	{F 835}		

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{F 835}	Continued From page 855 Director of Nursing (DON), reviewed diet orders in electronic medical record to ensure both the record and tray card reflected accurate information on 09/17/2021. 15). Beginning 09/15/2021, staff began offering snacks to all residents daily in the morning and afternoon by the restorative nurse aide, activity aides, or designee. Snacks ordered by a physician will be documented by the restorative aide, dietary aides and/or licensed nursing staff. 16). The facility evaluated the COVID-19 unit on 08/11/2021, located on the 5th floor of the facility for compliance with CDC guidelines and implemented yellow and red zones. The DON identified two (2) residents who had been exposed to positive residents and a yellow zone was designated with erection of a plastic zip wall barrier and those two (2) residents were moved to this zone on 08/11/2021. 17). The facility had three (3) residents who were in the red zone on 08/11/2021(Residents #327, #328 and #329). Residents #327, #328 and #329 have completed quarantine per facility policy and physician orders. Residents #311 and #314 completed quarantine per COVID-19 policy and physician's order. Residents #311 and #314 were no longer in isolation. 18). All staff eligible for testing were tested for COVID-19 on 09/16/2021. The facility did not identify any new cases based on the employee testing on 09/16/2021. All residents eligible were tested for COVID-19 on 09/17/2021. The facility did not identify any new positive cases. 19). The facility was conducting ongoing	{F 835}		

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{F 835}	Continued From page 856 surveillance testing as recommended for COVID-19. Positive COVID-19 residents will be placed in isolation zone (red zone) and placed in droplet precautions with use of personal protective equipment. The facility will provide physician notification, family notification and care plan revisions. The DON or designee will review newly positive COVID-19 residents to ensure isolation precautions have been initiated. In addition, any resident exposed will be placed in droplet precaution in isolation zone (yellow). The facility will provide physician notification, family notification and care plan revisions. The facility employee testing protocol will be twice weekly on designated days effective 08/16/2021. The facility requires all staff must be tested on designated days. If the employee is not tested, the facility will not allow the employee to work without a current negative COVID-19 test. During testing, the employee will be tested prior to entering the facility by the Infection Prevention Nurse or designee. All testing dates and times will be posted to the employee page, time clock and common areas. 20). The facility screens all residents once a shift for signs and/or symptoms of COVID-19 and documented on the Medication Administration Record (MAR). The facility implemented monitoring for signs and/or symptoms on all residents on 09/17/2021. 21). Resident #9, Resident #321, Resident #324, Resident #326 and Resident #351, medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021. 22). The facility stated all residents will receive	{F 835}		

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PARKVIEW POST-ACUTE AND REHABILITATION CENTER	200 NURSING HOME LANE PIKEVILLE, KY 41501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 835}	Continued From page 857 their medication as ordered beginning 09/23/2021 and implemented pharmacy and physician notification if any medication was unavailable. The facility will abide by new orders from the physician regarding the unavailable medication. 23). The facility formulated an agreement on 09/23/2021, with the facility's pharmacy to provide the facility with a three (3) day supply of medications that requires the facility's approval for cost authorization while pending cost review. 24). New admissions and re-admissions entering the facility after normal business hours and on weekends will have discharge orders submitted, entered into the electronic medical record and submitted to pharmacy through pharmacy integration. The facility implemented the use of fax transmittal as a backup to the electronic pharmacy integration by entering the order in the electronic medical record to receive medications. If the facility does not receive medications in a timely manner the pharmacy will be notified, and the facility will utilize the emergency medication kit. If an emergency arises and medication is unavailable, the physician will be notified for substitution and/or new orders. 25). The Regional Nurse Consultant, Director of Nursing, and licensed nursing staff completed an audit of all residents' ordered medications and verified all medications were available in the facility by 09/25/2021. 26). The facility conducted a Quality Assurance Performance Improvement (QAPI) meeting on 08/12/2021. The facility reviewed education, facility process, and audited implementation to ensure compliance with the AOC and all audits.	{F 835}		

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{F 835}	Continued From page 858 The Administrator oversees the QAPI committee. The QAPI committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy, Maintenance, Dietary and Environmental Services. 27). The facility appointed an Interim Administrator on 09/13/2021 to replace the current Administrator. The facility's Interim Administrator will receive daily oversight and guidance from the Regional Vice President or Regional Director of Operations and Regional Clinical Nurse for 30 days. Upon completion of the thirty-day oversight, the Regional Administrative Team will audit the Administrator to determine if continued daily oversight is needed. The administration has direct oversight and responsibility to direct, discipline, and communicate areas of concern and process improvement. 28). The Administrator, Medical Director, and QAPI Committee reviewed procedures for a contact person for call-ins, answering call lights, Activities of Daily Living (ADL) Care, serving, and timeliness of meal trays incontinence care and turning and repositioning on 09/15/2021. 29). The Vice President of Operations, Director of Clinical Operations and Regional Nurse Consultants conducted a conference call on 09/15/2021 with a contract company for a consultation to review the following: (1) the outcomes of the survey; (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations; (3) determined a plan for the following communication/monitoring tools: Infection Control (COVID 19 Isolation), enough	{F 835}		

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{F 835}	Continued From page 859 staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee. 30). The Administrator and Regional Nurse Consultant reviewed and revised the QAPI Plan beginning 09/16/2021 and presented the reviews and/or revisions to the QAPI Committee during the 09/16/2021 meeting. The facility developed a standardized plan to ensure all topics were reviewed as needed at the QAPI meetings. The agenda included reviewing pressure ulcers, Foley catheters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, hospital readmission rate, rehabilitation management, social services, concerns of grievance, activities, resident council, and family council concerns, grievances, admissions, discharges, census, staff development, vacant positions, employee orientation, dietary variances, tray audit report, weight loss, work injuries, terminations, employees on family medical leave, a leave of absence, new hires, medical record compliance review, pharmacy reports, restorative nursing, business office, and admission actions. The QAPI Committee and Medical Director approved the standardized agenda on 09/16/2021 to include, but not limited to, the topics presented during the meeting. 31). The Regional Director of Operations and Vice President of Operations met with the Administrator, the DON, and the Medical Director	{F 835}		

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{F 835}	Continued From page 860 on 09/16/2021 regarding the duties of the Governing Body, including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body. During the meeting, the QAPI processes, the need to participate regularly in the QAPI process, the need to identify root causes with the utilization of the five (5) why approaches and, auditing systems per the QAPI Calendar. The Administrator will notify the medical Director of future QAPI Committee meetings. 32). The Administrator will collect all monitoring reports before each QAPI Committee meeting beginning 09/15/2021 for review to ensure compliance with the deficiencies cited during the 09/10/2021 survey. QAPI Meetings were held on 09/16/2021 to discuss abatement and develop interventions to remove the jeopardy. The facility implemented QAPI meetings weekly, times four (4) weeks, as needed, and monthly. The Administrator will forward all QAPI Meeting minutes to the Governing Body members, including the Vice President of Operations, Regional Vice President of Operations, and the Regional Nurse Consultant, to review the audit results. The QAPI committee will review the audits at the QAPI meetings. Committee for review. The Administrator oversees the QAPI Committee. The QAPI Committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy, Maintenance, Dietary and Environmental Services. 33). The Governing Body will provide the facility's Administrator with resources and education materials for QAPI, including but not limited to the	{F 835}		

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{F 835}	Continued From page 861 QAPI Tool Kit, QAPI at a Glance, and a resource guide to effectively implement the QAPI plan beginning 09/16/2021. The Governing Body will meet quarterly for the upcoming year and reevaluate for frequency after one (1) year. 34). The Administrator will increase the frequency of QAPI Committee meetings to weekly for four (4) weeks and, as needed effective 09/16/2021, to ensure the quality of care is monitored and complies with the standard of care and compliance with State and Federal requirements is demonstrated. 35). All nursing staff were educated by the Director of Nursing, MDS Coordinator, or designee on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician by 09/17/2021. 36). On 09/13/2021, the Regional Certified Dietary Manager (CDM) educated the Dietary Manager on the provision of timely nutritional assessment to ensure diet order accuracy, on diet order accuracy, and on when to enter diet orders into the electronic medical record. The CDM educated the Dietary Manager to enter resident diet orders into the tray care system. If the nurse enters the order, the nurse will send a written communication to the dietary staff, including diet and texture. In the morning clinical meetings, staff will review diet orders from the previous day to ensure accuracy. 37). Therapy provided education to all nursing staff on turning and positioning range of motion, and transfer of resident from bed to chair and chair to bed beginning on 08/19/2021 and	{F 835}		

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{F 835}	Continued From page 862 completed on 09/17/2021. The facility employed and assigned additional staff through recruitment and agency contracts to ensure adequate staff to turn and reposition all residents who cannot reposition themselves. 38). The Regional Director of Nursing educated all nursing staff on pressure ulcer prevention, including turning and repositioning, adequate hydration and nutrition, positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, physician, and RP of a new skin impairment by 09/17/2021. The facility nursing staff will call or email the Registered Dietitian, Physician, and Resident Representative of any new skin changes. 39). The DON or designee educated all staff on timely call light response. In addition, direct care staff, including nurses and certified nursing assistants, were provided education on providing timely hygiene per the resident's plan of care, timely toileting, dressing residents in their choice of clean clothing, and timely delivery of meal trays. The DON or designee will educate any facility staff not working during education upon returning to work. 40). On 08/31/2021, The Regional Director of Nursing educated all licensed nursing staff, the Registered Dietician, the Social Service Director, and the MDS Nurses on entering new care plans into the electronic medical record, including goals and interventions. In addition, the Regional Director of Nursing educated staff to update the existing care plan in the electronic medical record with new goals and interventions for any new skin impairments identified during their shift.	{F 835}		

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{F 835}	Continued From page 863 41). The facility's Respiratory Therapist educated Licensed nurses on identifying and assessing residents with a change in respiratory status on 08/12/2021. In addition, on 08/12/2021, the DON and/or designee educated all licensed nurses on identifying signs/symptoms of hyperglycemia/hypoglycemia, the facility's diabetic protocol, documenting a resident's change in condition, documentation of blood sugar in the medical record, notification of the physician and following physician orders. The facility licensed nursing staff will not be allowed to work until they have received this education. The DON educated all clinical staff on documentation of glucose levels on 08/19/2021 and 08/20/2021 during mandatory in-services. 42). Beginning 08/12/2021, the DON educated licensed nurses on completing a baseline Care Plan with interventions and goals relevant to diabetes and a respiratory diagnosis within 48 hours of admission, reviewing and providing a copy to the resident and/or the responsible party. Licensed nursing staff not working during education was notified of ongoing education and will not be allowed to work until they have received this education. 43). Beginning 08/12/2021, the DON educated all staff on the facility's "call off" procedure. The call-off procedure for the facility included: in the event a person needs to call out of work for dayshift, they are to notify their immediate supervisor two hours before the start of the shift. If staff needs to call off on the night shift, they are to notify their immediate supervisor four hours before the start of their shift. If the facility does not have appropriate staffing levels, the	{F 835}		

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{F 835}	Continued From page 864 immediate supervisor and/or designee will call other qualified staff to replace the person calling off. If emergency staffing is required, the Administrator and/or designee will call for assistance from staffing companies. Staff not working will be in-serviced upon return to work. 44). All staff were provided re-education by the Administrator and/or designee on 08/12/2021 on the process of identifying, preventing, and reporting abuse, as well as identifying and implementing immediate interventions for wandering residents. 45). All nursing staff were educated by the Director of Nursing, MDS Coordinator, or designee on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician by 09/17/2021. On 09/13/2021, the CDM educated the Dietary Manager on diet order accuracy and timely nutritional assessment to ensure diet order accuracy. When staff enters diet orders into the electronic medical record, the nurse entering the order will send the written communication to the dietary staff. The Dietary Manager will enter the order into the tray care system. The facility will review diet orders from the previous day in the clinical meeting to ensure accuracy. 46). The Regional CDM educated the Dietary Manager on 09/13/2021 on facility policy regarding meal service times and the use of recipes including recipes for those requiring fortified diets to ensure all meals meet the nutritional needs of residents in accordance with established national guidelines to reflect religious, cultural and ethnic needs of the population.	{F 835}		

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{F 835}	Continued From page 865 47). As of 09/15/2021, the Regional CDM completed education with the dietary manager on obtaining food preferences, the facility's tray card system, ordering food based on menus, stocking snack/hydration carts, snacks, and hydrations procedures, appropriate scoop sizes, and/or portion sizes. 48). The Director of Nursing or Regional Director of Nursing educated nurses and the Dietary Manager on the process for entering, activating, and/or implementing the registered dietician's recommendations for dietary orders on 09/17/2021. 49). All staff were provided re-education by the DON and/or designee by 09/17/2021 on the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), yellow and red zones. In addition, the DON/designee educated, licensed staff on monitoring residents for Covid-19 symptoms beginning. 08/12/2021, the DON/designee educated all staff, including contract staff, who were not working. During the QAPI meeting on 08/12/2021, the Covid-19 policy, the handwashing policy, donning and doffing PPE, red and yellow zones, and monitoring residents for signs/symptoms of the Covid-19 were reviewed. 50). Staff were provided re-education on 08/20/2021 by the DON, Regional DON, or Regional Nurse Consultant to enter COVID-19 symptom monitoring orders on all new admissions into the resident's record. 51). All licensed nursing staff have been educated on the five (5) rights of medication	{F 835}		

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{F 835}	Continued From page 866 administration, including right medication, right patient, right dose, right time, and right route. The Regional DON/DON/designee educated all licensed nursing staff working on 09/23/2021 on the process to follow when a medication was not available for administration as ordered. The education included calling the pharmacy to obtain the medication, obtaining the anticipated medication delivery time, notify the MD if an ordered medication will either be omitted or given outside of the ordered medication time. The education also included following new orders given by the MD, documenting the conversation, and new orders from the MD in the electronic medical record. All other licensed nursing staff will be provided training as scheduled for shifts. 52). On 09/25/2021, the DON /Regional Nurse Consultant educated all licensed nursing staff, including new hires and/or agency staff, on the use of the emergency medication kit, the system in place for ensuring medications are in-house, or notifying the physician for new orders for new or re-admitting residents, including on weekend and after-hours. 53). The Interim Administrator educated all staff on his contact information and role as the Abuse Coordinator from 09/13/2021 through 09/17/2021. In addition, education on staffing schedules and who to notify if unable to work their scheduled shift. 54). The facility will audit weekly resident head-to-toe skin assessments daily, Monday through Friday, for three (3) months effective 09/17/2021 to ensure they have been completed weekly on each resident. In addition, the facility will notify the physician, Registered Dietician, and	{F 835}		

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{F 835}	Continued From page 867 Responsible Party of any new skin impairment and those new interventions have been put in place to prevent decline. 55). Central supply audited all lab supplies for the expiration date on 08/28/2021. Audits will be conducted weekly for all lab supplies for four (4) weeks effective 09/17/2021 and then monthly for three (3) months. 56). The Director of Nursing, Assistant Director of Nursing (ADON), or Nursing Supervisor will audit resident progress notes for daily four (4) weeks effective 09/13/2021, then weekly for one (1) month. Staff will review Progress notes for Saturday and Sunday on Monday. The Nursing Supervisor conducted audits to ensure any new areas of skin impairment identified had a care plan implemented to include new interventions. 57). Beginning on 09/11/2021, the facility's leadership staff and/or designee began visual rounding of residents assessing hygiene, toileting, incontinence, and resident repositioning. All residents will be visually rounding on once each shift daily for two (2) weeks, fifty percent of the residents each shift for four (4) weeks, and twenty-five percent of residents each shift for four (4) weeks. The facility has two (2) shifts, 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. 58). On 09/11/2021, the facility's leadership staff began visual monitoring and timing of call light response times, including the length of time call lights are answered, across all shifts. Leadership staff will conduct ten (10) call light observations each shift for two (2) weeks and then five (5) call light observations each shift for eight (8) weeks.	{F 835}		

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{F 835}	Continued From page 868 59). On 08/13/2021, the DON and/or Designee began monitoring respiratory assessments and Situation Background Assessment and Recommendation (SBAR) communications for acute change in respiratory status Monday through Friday in the clinical morning meeting. The facility reviewed any acute change in respiratory status for Physician notification and implementation of any physician order. Care Plans were reviewed and updated as needed. Audits will be daily for one (1) week, then five (5) times a week for four (4) weeks. 60). The MDS Nurse, DON, and/or Designee began audits on 09/15/2021 of baseline care plan completion for all new admissions and re-admissions to ensure staff completed the baseline Care Plan within 48 hours of admission. 61). All residents admitted within the last thirty days with a diagnosis of Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Asthma, or current Pneumonia had their baseline Care Plan reviewed and updated as needed by the MDS Nurse(s) and/or designee. New interventions will be added to the care plan in the morning meeting by the DON, ADON, and/or nursing designee. 62). Beginning on 08/19/2021, the MDS Nurse, DON, and/or Designee will monitor new admissions and re-admissions to audit baseline care plans for completion, accuracy, and review with the resident and/or responsible party. Any variance or identified concern was addressed immediately. Audits will be conducted Monday through Friday for all admissions/re-admissions to the facility for four (4) weeks, fifty percent of admissions for a week for two (2) weeks, and	{F 835}		

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{F 835}	Continued From page 869 then ten percent of admissions weekly for four (4) weeks. 63). On 09/11/2021, the Dietary Manager and/or designee began auditing how long it took to pass meal trays to residents after arriving at the unit. All three (3) meals will be observed on all three (3) units daily for two (2) weeks, two (2) meals on all three (3) units daily for two (2) weeks, and one (1) meal on all three (3) units daily for four (4) weeks. 64). On 08/15/2021, the DON and/or Designee began audits of staff's knowledge with a verbal quiz of identification and assessment of residents with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia, the facility's diabetic protocol, documenting a change in a resident's condition, notification of the physician and following physician's orders. Leadership will quiz staff randomly across all shifts; ten (10) staff for one (1) week and five (5) staff a week for four (4) weeks. 65). On 08/13/2021, the DON and/or Designee began monitoring all documented blood sugar results Monday through Friday in the clinical morning meeting. The DON/designee will review any blood sugar results outside of the normal range for MD notification and implementation of any Physician's Orders. Care plans will be reviewed and updated as needed. The DON or designee will complete a visual rounding on diabetic residents across both shifts and all three (3) units to identify any resident with apparent signs and symptoms of hypoglycemia/hyperglycemia to ensure the resident was immediately assessed by licensed staff. Any variance or identified concerns will be	{F 835}		

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{F 835}	Continued From page 870 addressed immediately. Audits will be daily for one (1) week, then five (5) times a week for four (4) weeks. 66). On 08/13/2021, the Administrator and/or designee implemented an employee questionnaire on abuse and identification of residents with wandering behavior to determine the proper reporting of abuse across all shifts and units. The employee questionnaire will be completed for five (5) staff daily for one (1) week, then three (3) times a week for two (2) weeks, and then weekly for four (4) weeks. Any variance or identified concerns will be addressed immediately. 67). Beginning on 08/13/2021, the Director of Nursing and/or designee will review each resident's wandering risk assessment upon admission and quarterly with their Minimum Data Set (MDS) assessment. Any resident identified as wandering will be discussed in the clinical morning meeting to review and initiate new interventions. Any variance or identified concerns will be addressed immediately. New interventions will be care planned in the morning meeting by the Director of Nursing, Assistant Director of Nursing, or nursing designee. 68). Beginning on 08/13/2021, the Social Services Director or designee will perform random interviews of residents with a BIMS score of eight (8) or greater to ensure they feel safe in the facility and have not been subject to or witnessed abuse. The DON or designee will review random weekly skin assessments for residents with a BIMS score of less than eight (8) to ensure no injuries of unknown origin beginning 08/13/2021. Any variance or identified concerns	{F 835}		

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{F 835}	Continued From page 871 will be addressed immediately. 69). On 08/25/2021, the Registered Dietician conducted audits of resident diet orders from the electronic medical record against orders entered in the diet/tray card software to ensure accuracy. 70). Beginning on 08/23/2021, the Dietary Manager will ensure and audit meals leaving the kitchen and reaching the units timely. Audits will be conducted for random meals twice daily for one (1) week, twice per week for two (2) weeks, and then weekly for one (1) month. Once meal trays arrive at the unit, management staff will assist in passing trays to ensure residents receive meal trays, and certified nursing assistants assist residents promptly. The Dietary Manager or designee will audit the time it takes to pass meal trays to residents after they arrive on the unit beginning 09/11/2021. All three (3) meals will be observed on each unit daily for two (2) weeks, two (2) meals on each unit daily for two (2) weeks, one (1) meal on each unit daily for four (4) weeks. 71). The dietary manager or designee will review admitted/re-admitted residents' food and beverage preferences within 72 hours of admission and enter them into the diet/tray card system for listing on their tray cards beginning 09/16/2021. Review of food preferences will be completed bi-annually and as needed for all residents. Physician-ordered snack intakes will be audited by the Dietary Manager daily for one (1) week, weekly for four (4) weeks, and monthly after that for four (4) months beginning 09/15/2021. 72). Daily COVID-19 screenings for staff will be	{F 835}		

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{F 835}	Continued From page 872 audited beginning on 08/25/2021 by the Human Resources (HR) Director against time clock punches to ensure screening before beginning their shift. Audits will be completed Monday through Friday for four (4) weeks by the HR Director, and weekends audited on Mondays. Any staff not screened will be re-educated immediately on the COVID-19 Screening Policy by the HR Director. The HR Director was educated on the COVID-19 policy by the Regional Nurse, an infection control preventionist. All entry doors will remain locked. Visitors must be allowed entry by staff and screened by staff at the time of entry. 73). Beginning on 09/17/2021, the DON and/or designee will round seven (7) times each week for eight (8) weeks, five (5) times weekly for four (4) weeks to audit infection control compliance on differing shifts and units. Audits will include observation of handwashing; isolation signage and zones; donning/doffing (putting on/taking off) PPE; and mask compliance. Any variance or identified concerns will be addressed immediately by the auditor. 74). The DON, ADON, and/or Designee will review all residents on narcotics with the pharmacy to ensure an active script is on file beginning 09/23/2021. Staff will notify the physician within two (2) days of the prescription's expiration. 75). The Regional Nurse Consultant, Pharmacy, and/or Director of Nursing will conduct random medication pass observations effective 09/25/2021 on random shifts daily until immediate jeopardy removed to ensure timeliness and accuracy of medications. The facility utilized the	{F 835}		

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{F 835}	Continued From page 873 CMS Critical Element Pathway for Medication Administration to conduct the medication pass observation of twenty-five medications. 76). Beginning 09/25/2021 Monday through Friday, the DON, ADON, and/or Designee will audit medication delivery tickets against ordered medications daily to ensure that all narcotics needing a renewal have been sent to the pharmacy. Audits will continue until the Immediate Jeopardy is removed. 77). Beginning 09/11/2021, the Administrator and/or DON will be responsible for monitoring nursing staff daily for four (4) weeks to ensure adequate staffing is maintained. 78). Beginning 09/11/2021, the Administrator and Dietary Manager will be responsible for reviewing dietary staffing daily for four (4) weeks to maintain adequate staffing. 79). Beginning 09/11/2021, the Divisional Vice President of Operations and/or designee will monitor and audit the Administrator daily for 30 days to ensure compliance. 80). Visual rounding will be conducted beginning 09/23/2021 to monitor for residents' change of condition and identification of need for "Stop and Watch" (change of condition) communication. 81). Beginning 09/11/2021, the Administrator or designee performed interviews of residents with a BIMS score of eight (8) or greater to ensure they felt safe in the facility and had not been subjected to or witnessed abuse. No residents had any concerns. Interviews will continue to be conducted of residents by the Administrator or	{F 835}		

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{F 835}	Continued From page 874 designees weekly until immediate jeopardy is removed. **The State Survey agency validated the facility's actions to remove the Immediate Jeopardy on 09/26/2021 as alleged by : 1). Review of Head-to-Toe Skin Assessments revealed staff assessed all residents in the facility on 09/11/2021. A review of the skin assessments revealed eight (8) residents (Residents #65, #324, #45, #14, #357, #27, #74, and #358) had current pressure ulcers with a total number of pressure injuries of twenty (20). A review of the comprehensive care plans for Residents #65, #324, #45, #14, #357, #27, #74, and #358 revealed staff updated the care plans to reflect the resident's current pressure injuries. The facility completed the review on 09/17/2021. A review of the facility's census on 08/28/2021 revealed staff assessed all residents at risk for pressure ulcers with the Braden Scale. Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she completed head-to-toe skin assessment on all residents on 09/11/2021. She further revealed that the facility identified twenty (20) total pressure injuries. She further stated that the facility completed the Braden Scale assessments on all residents on 08/28/2021. Continued interviews revealed the Interdisciplinary Team utilized the skin assessments and Braden Scale assessments to update the residents' care plans. She stated that Resident #65, #324, #45, #14, #357, #27, #74 and #358's care plans were updated to reflect current pressure injuries by 09/17/2021. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed she updated all residents' care plans to	{F 835}		

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{F 835}	Continued From page 875 reflect current pressure injuries by 09/17/2021. In addition, she completed a review of walking rounds on 09/15/2021 with Therapy Personnel, the Registered Dietician, the Medical Director, the DON, and the MDS Nurse for Residents #65, #324, #45, #14, #357, #27, #74 and #358. A review revealed the Interdisciplinary Team reviewed each resident's orders, current skin breakdown, care plan, and implemented changes as needed. 2). Review of Resident #65's medical record revealed the Medical Director assessed the resident on 08/25/2021 at 1:45 PM and noted a Stage four (4) pressure ulcer on the sacrum; a deep tissue injury (DTI) to the left and right heels; and a skin tear to the left inner leg. Review of Resident #65's wound care note dated 08/26/2021 at 9:00 AM, revealed the sacrum wound measured, "13 cm (centimeter) (length) by 12.3 cm width and 0.2 cm depth with undermining at 10 o'clock measuring 2 cm and undermining at 12 o'clock that measures 1 cm, muscle exposed. No palpable bone, slough is present, partially removed with wound cleanser." The facility continued to treat the resident's sacral pressure ulcer with Aquacel Ag. A review of a wound evaluation completed on 09/15/2021 revealed Resident #65 had six (6) pressure ulcers, including a stage two (2) to the left superior calf measuring 1.2 cm (length) by 1.4 cm (width) by 0.1 cm (depth), stage one (1) to the right hip measuring 2.5 cm by 2 cm by less than 0.1 cm, stage two (2) to left hip measuring 1.2 cm by 0.8 cm x less than 0.1 cm, stage two (2) to left scapula measuring 1 cm by 0.2 cm by less than 0.1 cm, unstageable to right heel measuring 0.6 cm by 0.6 cm. and four (4) areas to the sacrum measuring 12 cm by 11.6 cm by 0.4 cm.	{F 835}		

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{F 835}	Continued From page 876 Interventions in place for the resident included heel protectors while in bed, diet as ordered, weekly documentation of the wound, an air mattress to bed, nutritional supplements, and turning/repositioning. Observation of wound care for the sacral pressure ulcer on 09/29/2021 at 10:21 AM revealed the wound measured 13 cm by 11 cm by 0.3 cm with a scant amount of drainage and 95 percent granulation tissue. Resident #65 declined would not consent to the observation of other pressure areas. A medical record review revealed that on 09/21/2021 at 2:19 PM, Physician #1 determined the resident's weight loss and wounds were unavoidable. On 09/28/2021, Resident #65's family declined in-house wound care visits. Further review of the record revealed on 09/29/2021, staff notified the physician of the decline in the resident's wound with no new orders. The resident was diagnosed with Failure to Thrive. 3). The facility admitted Resident #355 on 09/10/2021, completed a skin assessment on 09/10/2021, completed a Braden Scale on 09/10/2021, and completed a baseline care plan on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. Further review of the medical record revealed staff developed the comprehensive care plan on 09/21/2021. A review of Resident #355's re-admission revealed the resident had an admission skin assessment completed on 09/28/2021, Braden Scale on 09/28/2021, and a baseline care plan developed on 09/28/2021. 4). Observation of Resident #45 on 09/28/2021 at 1:48 PM, Resident #65 on 09/28/2021 at 1:40 PM, Resident #308 on 09/29/2021 at 11:10 AM, Resident #309 on 09/29/2021 at 11:26 AM,	{F 835}		

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{F 835}	Continued From page 877 Resident #311 on 09/29/2021 at 11:52 AM, Resident #314 on 09/29/2021 at 11:30 AM and Resident #320 on 09/29/2021 at 11:13 AM revealed the residents appeared clean, well-kempt, and clean linens were on the residents' beds. Interviews with the residents during the time of the observations revealed no identified concerns. A review of Progress Notes for Residents #45, #65, #308, #309, #311, #314, and #320) revealed the Interim Social Service Director interviewed the residents on 09/15/2021 and had no concerns with resident hygiene. Interview with the ISSD on 09/30/2021 at 2:23 PM revealed she interviewed Residents #45, #65, #308, #309, #311, #314, and #320 on 09/15/2021 with no identified concerns regarding hygiene. 5). Observation of residents during the initial tour on 09/28/2021 from 1:33 PM to 2:32 PM revealed no identified concerns. Interviews and record reviews revealed Residents #45, #65, #308, #309, #311, #314, and #320 each had their shower preference and hygiene preference obtained and included on their care plan. A review of the resident's medical record, including the comprehensive care plan and SRNA care plan, revealed staff updated each resident's plan to reflect the resident's preference. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM revealed she assisted with obtaining resident preferences. She stated each resident was interviewed for shower and hygiene preference, and the facility updated each resident's care plan. A review of resident interviews revealed their shower/hygiene preference was obtained. A review of the facility's shower schedule revealed that the resident shower/hygiene preferences were honored.	{F 835}		

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{F 835}	Continued From page 878 6). Interview with the Dietician on 09/30/2021 at 3:53 PM revealed she began reviewing all resident diets on 08/28/2021. She further stated that she implemented new and/or additional recommendations for residents to address weight loss and/or wound healing. A review of the documentation revealed the Registered Dietician reviewed all residents' diets, and the Regional DON reviewed all diets and recommendations. Interview with the RDO on 09/30/2021 at 4:17 PM revealed she completed the review of all diets and recommendations. 7). A review of facility assessments completed by 08/13/2021 revealed thirty-nine (39) residents with a diagnosis of Diabetes were assessed for signs and symptoms of hypoglycemia/ hyperglycemia and the need for immediate intervention. Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she assessed the residents and did not identify immediate concerns. Observations of Resident #348 on 09/28/2021 at 1:36 PM, Resident #320 on 09/29/2021 at 11:13 AM, and Resident #311 on 09/29/2021 at 11:52 AM revealed no visible signs/symptoms of hypoglycemia/hyperglycemia. A review of facility assessments completed on 08/12/2021 revealed fifty (50) residents with a diagnosis of Chronic Obstructive Pulmonary Disorder (COPD), Asthma and Pneumonia were assessed by Respiratory Therapist #1. Interview with Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM revealed she assessed all residents with diagnoses of Chronic Obstructive Pulmonary Disorder (COPD), Asthma, and pneumonia 08/12/2021 with no identified concerns. Observation of Resident #45 on 09/28/2021 at 1:48 PM, Resident #65 on 09/28/2021 at 1:40	{F 835}		

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{F 835}	Continued From page 879 PM, and Resident #43 on 09/28/2021 at 2:03 PM. revealed no respiratory distress. 8). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she reviewed all residents with a diagnosis of Diabetes and the resident's orders for glucose monitoring. She stated the facility amended all resident orders to include mandatory entry of glucose values on the MAR. Review of Resident #3, #41, and #357's orders revealed each order required staff to enter the glucose value on the resident's MAR. Further review revealed no concerns with residents having glucose levels less than 60 and/or greater than 400. 9). A review of audits completed on 09/11/2021 revealed meals were delivered timely. Interview with the Regional Certified Dietary Manager (RCDM) on 09/28/2021 at 2:26 PM, and 09/30/2021 at 1:52 PM revealed lunch was observed on 09/11/2021 and arrived at the unit within five (5) to ten (10) minutes of the scheduled times. 10). A review of the facility's staffing for 09/28/2021 from 6:00 AM to 6:00 PM revealed two (2) licensed nurses and three (3) nursing assistants were scheduled for each floor of the facility. A review of the facility's staffing revealed one (1) licensed nurse and two (2) certified nursing assistants for each floor from 6:00 PM to 6:00 AM. A review of the staffing for 09/29/2021 and 09/30/2021 revealed two (2) licensed nurses, and three (3) certified nursing assistants on each floor from 6:00 AM to 6:00 PM. Further review of staffing revealed one (1) licensed nurse and two	{F 835}		

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{F 835}	Continued From page 880 (2) certified nursing assistants for each floor from 6:00 PM to 6:00 AM. Observation of facility staffing on 09/28/2021 from 1:20 PM to 5:30 PM; on 09/29/2021 from 8:11 AM to approximately 6:00 PM and 09/30/2021 from 7:55 AM to 5:17 PM, revealed call lights were being answered timely, residents appeared clean/well-groomed, staff was offering and assisting residents with baths/showers, turning/repositioning was being conducted timely, and meal trays were passed timely. Interviews with RN #1 on 09/29/2021 at 11:55 AM and on 09/30/2021 at 12:58 PM; RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM; LPN (Licensed Practical Nurse) #6 on 09/30/2021 at 12:44 PM; LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM; LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM; State Registered Nurse Aide (SRNA/certified nurse aide) #1 on 09/29/2021 at 3:40 PM; SRNA #11 on 09/29/2021 at 3:23 PM; SRNA #7 on 09/29/2021 at 3:29 PM; SRNA #19 on 09/29/2021 at 4:10 PM; SRNA #21 on 09/29/2021 at 3:04 PM; SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed staffing had improved, and each staff member revealed they had time to perform duties as assigned. 11). Review of the staffing schedule for 09/28/2021, 09/29/2021, and 09/30/2021 revealed each day consisted of one (1) day cook, one (1) evening cook, one (1) prep cook, two (2) day aides, and two (2) evening aides. Observation of the kitchen on 09/28/2021 at 2:26 PM reflected the staffing was accurate per the schedule. Interview with Cook #3 on 09/29/2021	{F 835}		

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{F 835}	Continued From page 881 at 1:12 PM, and Dietary Aide #3 on 09/30/2021 at 2:10 PM revealed kitchen staffing had improved, and they were able to complete their duties during their shift. 12). A review of assessments for being withdrawn, crying, or other abuse symptoms was conducted for Residents #64, #86, and #322 on 08/11/2021. No concerns were identified. A review of skin assessments completed revealed no identified concerns. Observation and interviews conducted on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no identified concerns with psychosocial and/or physical abuse, including observations of Residents #64, #86, and #322. Interview with Resident #322 on 09/29/2021 at 11:54 AM revealed no concerns with abuse. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed all residents with a diagnosis of Dementia had their care plans reviewed and revised as necessary. Interview with the RDON on 09/30/2021 at 4:17 PM revealed she completed skin assessments on 08/11/2021, for all residents, with the assistance of licensed nursing staff. No concerns were identified. A review of audits completed by the Social Service Director (SSD) for residents with a BIMS score of eight (8) or above revealed no identified concerns. 13). A review of assessments for residents that wander, revealed all residents had received a wandering risk assessment by 08/16/2021. Review of the elopement/wandering binder at each nursing station on 09/29/2021 revealed a binder on each floor that contained information including a description, a photo and potential interventions for each resident identified at risk.	{F 835}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 835}	Continued From page 882 14). Review of Resident #39, #65, #81, #90, #330 and #332's medical record revealed all of the residents had been weighed by 09/17/2021. Interview with the Registered Dietician on 09/30/2021 at 3:53 PM revealed she completed a comprehensive nutritional assessment on Residents #39, #65, #81, #90, #330 and #332. Review of the medical record revealed the RD completed a comprehensive nutritional assessment on 09/16/2021 for Resident #39, 09/16/2021 for Resident #65, 09/16/2021 for Resident #81, 09/16/2021 for Resident #90 and 09/16/2021 for Resident #330 with no dietary recommendations made. Resident #332 was discharged. Interview with the Registered Dietician on 09/30/2021 at 3:53 PM, the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, the Regional DON on 09/30/2021 at 4:17 PM and DON #2 on 09/30/2021 at 3:20 PM revealed each resident had received a comprehensive nutritional assessment and review of the recommendations by nursing staff. Further interview with the RD and Regional DON revealed both the record and tray card were reviewed to reflect accurate information. 15). Observation of the third floor on 09/28/2021 at 2:22 PM, the fourth floor on 09/28/2021 at 2:00 PM and the fifth floor on 09/28/2021 at 2:06 PM revealed snacks including but not limited to oatmeal pies, goldfish crackers, cookies and drinks were present, including soda, milk, and juice. Observations on 09/29/2021 at 10:30 AM revealed snacks were being passed on third floor. Review of Resident #331, Resident #65 and Resident #14's record revealed documented intake of snacks. Interview with SRNA #19 on 09/29/2021 at 4:10 PM revealed she was educated on documentation of snacks.	{F 835}		

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{F 835}	Continued From page 883 16). Observation of the facility's red zone and yellow zone on 09/28/2021 at 2:12 PM revealed no identified concerns. The zones contained no residents. 17). Review of Residents #327, #328 and #329 revealed the residents were isolated per CDC guidance. Observation of Resident #328 on 09/29/2021 at 11:41 AM and Resident #329 on 8/30/2021 at 10:36 AM revealed no obvious signs or symptoms of COVID-19. Resident #327 had been discharged from the facility. 18). Review of facility staff testing revealed all staff working on 09/16/2021 were tested for COVID-19 with no identified new cases. Further review of resident testing for COVID-19 on 09/17/2021, revealed no new cases. 19). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021	{F 835}		

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{F 835}	Continued From page 884 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed the facility is testing staff two (2) times weekly. Interview with Interim Infection Control Nurse on 09/30/2021 at 3:10 PM revealed she was conducting testing two (2) times weekly following CDC guidance. Review of facility staff tested revealed tested is being conducted two (2) times weekly. 20). Review of Resident #329, #328, #311, #65 and #90's medical record revealed that each resident had COVID-19 monitoring orders implemented. In addition, review of each resident's MAR revealed staff was completing the monitoring as ordered by the physician. 21). Interview with the Medical Director on 09/30/2021 at 3:25 PM revealed Resident #9, Resident #321, Resident #324, Resident #326 and Resident #351's medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021. 22). Observation of a medication pass on 09/29/2021 at 4:35 PM on 3rd floor and 09/30/2021 at 8:09 AM on 3rd floor revealed no identified concerns with missing medications. In addition, observation of a narcotic count on 5th floor on 09/30/2021 at 12:50 PM revealed no identified concerns. Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, N #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and	{F 835}		

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{F 835}	Continued From page 885 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM and LPN #11 on 09/30/2021 at 10:31 AM revealed no concerns with unavailable medications. 23. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Co-Owner/President of Pharmacy on 09/30/2021 at 3:11 PM revealed both parties made a formal agreement that the pharmacy will supply the facility with a three-day supply for medication requiring cost review. Review of the facility's pharmacy agreement revealed for any medication requiring a cost review the pharmacy would send the facility a minimum of a three-day supply of the medication while being reviewed. The facility would communicate any changes or continuance guidance to the pharmacy within 72 hours. The Director of Operations of Guardian Pharmacy and the Vice President of Operations of the facility signed the agreement. 24). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4 on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education and was aware of the process for obtaining medications from the pharmacy. In addition, they revealed they were aware that the nurse would notify the physician if the pharmacy could not deliver a medication to the facility. 25). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and Regional DON on 09/30/2021 at 4:17 PM revealed an audit was completed of all residents' ordered medications	{F 835}		

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{F 835}	Continued From page 886 and verified all medications were available in the facility by 09/25/2021. Observation of medication pass on 09/29/2021 at 4:35 PM on the third floor and 09/30/2021 at 8:09 AM revealed no identified concerns with missing medications. 26). Review of a QAPI signature sheet revealed the facility conducted a meeting on 08/12/2021 with the Regional DON, Regional Nurse Consultant, Human Resources, SSD #2, Medical Records, the Housekeeping Supervisor, Central Supply, MDS Nurse #1, MDS Nurse #2, the Therapy Manager, the Admissions Coordinator, the Administrator, the Activities Director, the Dietary Manager, and other members of the administration team. 27). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Interview with the Interim Administrator on 09/30/2021 at 5:05 PM revealed the facility appointed the current Interim Administrator on 09/13/2021. Further interview with the VP of Operations revealed she had provided the Interim Administrator with daily oversight since 09/10/2021. 28). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM, the Medical Director on 09/30/2021 at 3:25 PM and members of the QAPI committee, including the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, revealed procedures for contacting staff for call-ins, answering call lights, ADL Care, serving and delivering meal trays timely, incontinence care and turning/repositioning were reviewed on 09/15/2021. 29). Interview with the Vice President of	{F 835}		

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{F 835}	Continued From page 887 Operations on 09/30/2021 at 4:10 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and the Med-Net Concepts Nurse Consultant on 09/28/2021 at 3:00 PM revealed the facility conducted a conference call to review the following: (1) the outcomes of the survey, (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations, (3) determined a plan for the following communication/monitoring tools: Infection Control and COVID-19 isolation, enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee. 30). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM, and Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed reviewed and revised the QAPI Plan and presented the reviews and/or revision to the QAPI Committee during the 09/16/2021 meeting. The facility developed a standardized plan to ensure all topics were reviewed as needed at the QAPI meetings. The plan included pressure ulcers, Foley catheters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, the hospital re-admission rate, rehabilitation management, social services, concerns of grievance, activities, resident council, and family council concerns and/ or grievances, admissions, discharges, census, staff development, openings by department/position, employee orientations, dietary variance tray audit report, weight losses,	{F 835}		

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{F 835}	Continued From page 888 work injuries, terminations, employees on family medical leave of absence or leave of absence, new hires, medical record compliance review, pharmacy reports, restorative nursing, business office, and admission actions. The QAPI Committee and Medical Director approved the standardized agenda on 09/16/2021 to include but not be limited to the topics presented during the meeting. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Medical Records on 09/29/2021 at 8:34 AM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM and Central Supply on 09/29/2021 at 2:40 PM, revealed the information was presented at the QAPI meeting held on 09/16/2021. 31). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, the Interim Administrator on 09/30/2021 at 3:40 PM, DON #2 on 09/30/2021 at 3:20 PM, and the Medical Director on 09/30/2021 at 3:25 PM revealed a meeting was conducted on 09/16/2021 regarding the duties of the Governing Body including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body. During the meeting, the QAPI processes, the need to participate regularly in the QAPI process, the need to identify root causes of system problems, utilization of the "5 why" approach and auditing systems per the QAPI Calendar were reviewed.	{F 835}		

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{F 835}	Continued From page 889 32). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed he collected all monitoring reports before each QAPI meeting and reviewed the data for compliance. A review of QAPI attendance sheets revealed the facility conducted meetings on 09/16/2021, 09/23/2021, and 09/30/2021. Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed they were members of the governing body, and QAPI meetings had been forwarded to them. 33). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed the governing body provided the Administrator with resources and education material for QAPI. Further interviews revealed the governing body would meet quarterly for the upcoming year. Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed he had been provided with resources and education regarding QAPI. 34). Interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed QAPI meetings were conducted weekly effective 09/16/2021 to ensure the quality of care is monitored and complied with the standard of care and compliance. Further interview with the Vice President of Operations on 09/30/2021 at 4:10 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, Former Activities Director/Dietary Manager	{F 835}		

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{F 835}	Continued From page 890 #3 on 09/30/2021 at 1:30 PM, Medical Records on 09/29/2021 at 8:34 AM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Respiratory Therapist (RT) #1 on 09/30/2021 at 12:45 PM and Central Supply on 09/29/2021 at 2:40 PM revealed they had participated in the weekly QAPI meetings conducted on 09/16/2021 and 09/23/2021. In addition, an interview with the Medical Director/Physician #1 on 09/30/2021 at 3:25 PM revealed he participated in the weekly QAPI meetings on 09/16/2021 and 09/23/2021. Further interview with the Interim Administrator on 09/30/2021 at 3:40 PM revealed the weekly QAPI meeting had been conducted on 09/30/2021. A review of the facility QAPI meeting attendance sheet reflected the above interviews with no identified concerns. 35). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on 09/17/2021. Interview with nursing staff revealed they verbalized understanding of weighing residents, obtaining, documenting, and reporting the weights to the Registered Dietician (RD). Interview with Regional DON on 09/30/2021 at 4:17 PM revealed staff was provided with	{F 835}		

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{F 835}	Continued From page 891 education on 09/17/2021 on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician. 36). Interview with Former Activities Director and current Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on 09/13/2021 by the Regional Certified Dietary Manager (CDM) on diet order accuracy and timely nutritional assessments to ensure diet order accuracy. When staff enter diet orders into the electronic medical record, the nurse entering the order sends written communication to the dietary staff, which includes diet and texture. She further revealed that she entered the order into the tray card system to reflect the resident's diet orders. She stated that all diet orders from the previous day would be reviewed in the clinical meeting. Interview with the Regional CDM on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM revealed she completed education with Former Activities Director/Dietary Manager #3. In addition, she stated that she had been on site to provide additional assistance during the transition to her new role. 37). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on	{F 835}		

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{F 835}	Continued From page 892 09/29/2021 at 4:10 PM, revealed they received education on turning/repositioning, range of motion and transferring residents from bed to chair and from chair to bed. Observations of turning, positioning, and wound care with RN #11 on 09/29/2021 at 10:21 AM for Resident #65 revealed no identified concerns. Interview with the Therapy Manager on 09/30/2021 at 1:18 PM revealed she provided staff with education beginning on 08/19/2021 regarding turning/repositioning, range of motion, and transferring a resident from bed. 38). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on pressure ulcer prevention including turning and repositioning, adequate hydration and nutrition, Positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, MD and RP of a new skin impairment. The nurse will call or email the Registered Dietitian, the physician, and the resident's representative with any changes. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM and the Regional DON on 09/30/2021 at 4:17 PM revealed they educated staff on pressure ulcer prevention including turning/repositioning,	{F 835}		

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{F 835}	Continued From page 893 adequate hydration and nutrition, Positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, physician and RP of a new skin impairment. With any change to skin impairment, the nurse will call or email the Registered Dietitian for new recommendations, MD, and resident's representative. 39). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on timely call light response. In addition, interviews with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on timely call light response, providing timely hygiene per resident plan of care, timely toileting, ensuring	{F 835}		

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{F 835}	Continued From page 894 staff dress residents in their choice of clean clothing and timely delivery of meal trays. Further interview with Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, and Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on meal service times. 40). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they received education on ensuring new care plans were entered into the electronic medical record. Observation of RN #1 on 09/29/2021 at 11:55 AM revealed the nurse was able to demonstrate knowledge of the education with no identified concerns. 41). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they received education on identification and assessment of residents with a change in respiratory status and	{F 835}		

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{F 835}	Continued From page 895 on identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting resident change in condition, documentation of blood sugar in the medical record, notification of the physician and following physician orders. In addition, interviews revealed they received education on documentation of glucose levels. 42). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, revealed they received education on completing a baseline Care Plan with interventions and goals relevant to the diagnosis of diabetes and a respiratory diagnosis within forty-eight hours of admission, and reviewing and providing a copy to the resident/responsible party. 44). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1	{F 835}		

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{F 835}	Continued From page 896 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 Aide on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they were educated on the process of identifying, preventing, and reporting abuse as well as identifying and implementing immediate interventions for wandering residents. 45). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM and LPN #11 on 09/30/2021 at 10:31 AM revealed they received education on proper weighing techniques, obtaining, documenting, and reporting of weight changes to the Registered Dietician. In addition, an interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she had received education on diet order accuracy and provision of timely nutritional assessment to ensure diet order accuracy. When the diet orders are put into the electronic medical record, the nurse entering the order will send a written communication to the dietary staff that will include diet and texture. She further revealed all diet	{F 835}		

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{F 835}	Continued From page 897 orders from the previous day are reviewed in the clinical meeting, which occurs Monday through Friday, to ensure accuracy. 46). Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on facility policy regarding meal service times and the use of recipes, including recipes for fortified diets to ensure all meals meet the nutritional needs of residents in accordance with established national guidelines to reflect religious, cultural, and ethnic needs of the population. 47). Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she received education on obtaining food preference, facility tray card system, order placement for meals, snack/hydration pass, appropriate scoop sizes and/or portion sizes, stocking snack/hydration carts and snacks and hydrations. 48). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM and Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they received education on the process for entering, activating, and/or implementing the registered dietician's recommendations for dietary orders. 49). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, DON #2 on 09/30/2021 at 3:20 PM, Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1	{F 835}		

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{F 835}	Continued From page 898 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN #6 on 09/30/2021 at 12:44 PM, LPN #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM, Cook #3 on 09/29/2021 at 1:12 PM, Dietary Aide #3 on 09/30/2021 at 2:10 PM, Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed they had received education on the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), yellow and red zones. Observation of the red facility zone and yellow zone on 09/28/2021 at 2:12 PM revealed no identified concerns. No residents were in the red or yellow zones. Observations conducted on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no identified concerns with the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), or the yellow/red zones. 50). Interview with RN #1 on 09/29/2021 at 11:55 AM, and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN	{F 835}		

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{F 835}	Continued From page 899 (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education entering COVID-19 symptom monitoring orders on all new admissions. A review of newly admitted Resident #355 on 09/10/2021 revealed the resident had COVID-19 symptom monitoring entered in the resident orders. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. A review of re-admission for Resident #355 revealed the resident had a COVID-19 symptom monitoring entered in the resident orders. In addition, a review of Resident #329, #328, #311, #65, and #90's medical records revealed each resident had COVID-19 monitoring orders implemented. 51). Interview with RN #1 on 09/29/2021 at 11:55 AM, and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education on the five (5) rights of medication administration including right medication, right patient, right dose, right time, and right route. In addition, they were educated on the process to follow when a medication was not available for administration, which included calling the pharmacy to obtain the medication, obtaining the anticipated medication delivery time, notifying the physician if an ordered medication would either be omitted or given outside of the ordered medication time. The education also included following new orders given by the physician, documenting the conversation, and	{F 835}		

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{F 835}	Continued From page 900 new orders from the MD in the electronic medical record. 52). Interview with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed they had received education on the use of the emergency medication kit (e-kit). Observation of floor three (3) on 09/29/2021 at 3:10 PM, floor four (4) on 09/29/2021 at 2:57 PM, and floor five (5) on 09/29/2021 at 2:50 PM revealed each medication administration room was equipped with an emergency medication kit. Interview with LPN (LPN) #9 on 09/30/2021 at 2:27 PM revealed she was a new hire to the facility and had received education regarding the emergency medication kit. 53). Interview with DON #2 on 09/30/2021 at 3:20 PM, MDS Nurse #1 on 09/30/2021 at 1:39 PM, MDS Nurse #2 on 09/30/2021 at 1:31 PM, Maintenance Assistant #1 on 09/30/2021 at 2:56 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on 09/30/2021 at 10:48 AM, Senior Marketing Liaison on 09/30/2021 at 10:55 AM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31	{F 835}		

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{F 835}	Continued From page 901 AM, SRNA #1 on 09/29/2021 at 3:40 PM, SRNA #11 on 09/29/2021 at 3:23 PM SRNA #7 on 09/29/2021 at 3:29 PM, SRNA #19 on 09/29/2021 at 4:10 PM, SRNA #21 on 09/29/2021 at 3:04 PM, SRNA #22 on 09/29/2021 at 3:17 PM and SRNA #23 on 09/29/2021 at 4:10 PM revealed they were educated on the Interim Administrator's contact information and role as Abuse Coordinator. Observation of the facility on 09/28/2021, 09/29/2021, and 09/30/2021 revealed signage posted with the Interim Administrator's contact information and title of Abuse Coordinator posted throughout the facility. 54). Review of audits beginning 09/17/2021 of weekly head-to-toe skin assessments revealed no identified concerns. Observation of Resident #27 skin and wound assessment on 09/30/2021 at 10:20 AM revealed no identified concerns. A review of the medical record for Resident #65, #324, #45, #14, #357, #27, #74, and #358 revealed the weekly wound assessments completed with physician and responsible party notifications. Interview with the Dietician on 09/30/2021 at 3:53 PM revealed she was notified of new and/or worsening pressure ulcers and reviewed the residents as indicated. Interview with Medical Director on 09/30/2021 at 3:25 PM revealed that he was notified of new and/or worsening skin impairments and new interventions to prevent decline. He further revealed that he participated in QAPI meetings and discussed ongoing audits and care of residents. Interview with the Interim Administrator on 09/30/2021 at 5:05 PM revealed the QAPI team discussed all audits in QAPI meetings, including new and/or worsening pressure injuries and interventions implemented.	{F 835}		

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{F 835}	Continued From page 902 55). Interview with Central Supply on 09/29/2021 at 2:40 PM revealed she completed the audits of all laboratory supplies on 08/28/2021. She further revealed that the audits were conducted weekly for four (4) weeks and then monthly for three (3) months. A review of audits revealed no concerns. Observation of floor three (3), four (4), and five (5) supplies and review of the audits revealed no identified concerns. 56). Interview with the Regional DON on 09/30/2021 at 4:17 PM, and DON #2 on 09/30/2021 at 3:20 PM revealed progress notes were audited during morning clinical meetings to ensure all new areas of skin impairment had been care planned with interventions to address the area of concern. A review of audits revealed no identified concerns. 57). Interview with the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed he completed visual rounding of residents assessing hygiene, toileting, incontinence, and resident repositioning in addition to other leadership staff. Review of audits revealed staff were auditing nails, clothes, body odor, incontinent clean and dry, toileted as requested or every two (2) hours, hair clean and combed, sheets and blankets clean, call light within reach, facial hair shaved if applicable and turned and repositioned. 58). Interview with the Vice President of Operations on 09/30/2021 at 4:10 PM and the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed they participated in visual monitoring, and monitoring call light response times including the length of time call lights go unanswered. Interviews revealed any call activated more than five (5) minutes were	{F 835}		

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{F 835}	Continued From page 903 addressed with the staff. A review of audits revealed they were completed on different units and different shifts. 59). Interview with the RDON on 09/30/2021 at 4:17 PM revealed she completed audits of respiratory assessments and SBAR communication Monday through Friday in the clinical meeting. She further revealed that she assessed to ensure that any acute change in respiratory status and/or SBAR assessments completed had physician notification and/or implementation of physician orders. Review of Resident #315 SBAR completed on 09/26/2021, #324 SBAR completed on 09/27/2021, and #326 completed on 08/15/2021 revealed assessment, physician notification, interventions, and care plans updated as indicated. A review of audits revealed no identified concerns. 60). Review of Resident #355, who the facility admitted on 09/10/2021, revealed the resident had a baseline care plan developed on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. Further review of the medical record for Resident #355 revealed staff completed the comprehensive care plan on 09/21/2021 (eleven (11) days after admission). A review of re-admission for Resident #355 revealed the resident had a baseline care plan developed on 09/28/2021. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM and MDS Nurse #2 on 09/30/2021 at 1:31 PM revealed all new admissions and re-admissions to the facility were being reviewed during the morning clinical meeting Monday through Friday to ensure completion.	{F 835}		

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	185256	A. BUILDING _____ B. WING _____	R 09/30/2021

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{F 835}	Continued From page 904 61). Review of the admissions for the last thirty days from 07/16/2021-08/16/2021 revealed no concerns with baseline care plans. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed new/admission baseline care plans were being updated as needed in morning meetings. 62). Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed new admission baseline care plans were being audited Monday-Friday for completion, accuracy, and to ensure a review was conducted with the resident and/or responsible party within 48 hours of admission/re-admission. Further interviews revealed the audits were conducted Monday through Friday. A review of the audits completed revealed they included resident name, admission date, baseline care plan completion, care plan delivered to resident and/or responsible party, and education as needed. A review of the audits revealed no identified concern with completion dates as indicated. 63). Review of the audits completed by the DM and/or CDM revealed they were completed as stated with no identified concerns. Interview with the Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM, and Dietary Manager #3 on 09/30/2021 at 1:30 PM revealed trays were audited for to ensure they arrived on the unit and were passed timely. 64). Review of verbal quizzes revealed ten (10) staff members were quizzed for one (1) week beginning on 8/15/2021 with no needed education. Further review of verbal quizzes revealed five (5) staff members were quizzed for four (4) weeks from 08/22/2021 and completed	{F 835}		

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{F 835}	Continued From page 905 on 09/13/2021 with no identified concerns. A review of the verbal quiz revealed staff was quizzed on respiratory status, hypo/hyperglycemia, and SBAR/physician notification. Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, the Regional DON on 09/30/2021 at 4:17 PM, DON #2 on 09/30/2021 at 3:20 PM, and MDS Nurse #2 on 09/30/2021 at 1:31 PM revealed they performed verbal quizzes for identification and assessment of residents with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia, facility diabetic protocol, documenting a change in a resident's condition, notification of the physician and following physician orders. Interviews with RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, revealed they participated in verbal quizzes with facility staff. 65). Interview with the Regional DON on 09/30/2021 at 4:17 PM revealed she completed audits of documented blood glucose levels Monday through Friday in the clinical meeting. She further revealed that with any blood sugar less than 60 and/or greater than 40, the facility staff were expected to notify the physician, Responsible Party, and Registered Dietician and follow physician orders. The Regional DON stated she identified one (1) resident on 08/12/2021 to have a blood glucose level of 430 and one (1) on 09/20/2021 to have a blood glucose level of 465 with no documented evidence the licensed nurse followed the facility process. She provided education to both RN #2 and LPN #5. A Review of audits revealed no further concerns. A Review of education revealed	{F 835}		

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{F 835}	Continued From page 906 RN #2 and LPN #5 received education regarding the facility process. 66). Review of verbal staff quizzes revealed staff was verbally asked signs and symptoms of abuse when to report, signs and symptoms of wandering and wandering interventions. A review of the verbal quizzes revealed five (5) staff were verbally quizzed daily for one (1) week from 08/13/2021 to 08/19/2021 with no identified concerns. Further review revealed verbal quizzes were conducted three (3) times a week for two (2) weeks from 08/21/2021 to 09/02/2021 with no identified concerns. A review of verbal quizzes revealed that verbal quizzes were conducted one (1) time per week for four (4) weeks from the week of 09/03/2021 to 09/24/2021 with no identified concerns. Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, and MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed each assisted in the completion of verbal staff quizzes. Further interview revealed that each staff member was verbally quizzed on the areas listed on the audit tool (signs and symptoms of abuse, when to report, signs and symptoms of wandering and wandering interventions), and any need for education was completed immediately with each quiz. Interviews with SRNA #11 on 09/29/2021 at 3:23 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, RN #4/Wound Care Nurse on 09/30/2021 at 2:54 PM, Medical Records on 09/29/2021 at 8:34 AM, Central Supply on 09/29/2021 at 2:40 PM, Therapy Manager on 09/30/2021 at 1:18 PM, Housekeeping Supervisor on 09/30/2021 at 1:24 PM, Human Resource Director (HR) on	{F 835}		

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{F 835}	Continued From page 907 09/30/2021 at 10:48 AM and Maintenance Assistant #1 on 09/30/2021 at 2:56 PM revealed they participated in verbal quizzes regarding abuse, when to report, wandering and wandering interventions. 67). Review of Resident #355 on 09/10/2021 revealed the resident had an admission wandering risk assessment completed on 09/10/2021. Resident #355 was discharged on 09/25/2021 and re-admitted to the facility on 09/28/2021. A review of re-admission for Resident #355 revealed the resident had an admission wandering risk assessment completed on 09/28/2021. The resident was not identified to be at risk for wandering. Interview with MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed that MDS staff will schedule wandering risk assessments to ensure completion. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM and DON #2 on 09/30/2021 at 3:20 PM revealed all-new admissions would be reviewed in the morning clinical meeting to ensure appropriate assessments, including the wandering risk assessment, had been completed. Further interviews revealed that residents identified as at risk for wandering would be discussed during this meeting and appropriate interventions implemented. 68). Review of interviews performed for residents with a BIMS score of 8 or greater revealed no identified concerns. Continued review revealed interviews were initiated on 08/13/2021 with ten (10) resident interviews completed for four (4) weeks then five (5) residents for eight (8) weeks. Interview with ISSD on 09/30/2021 at 2:23 PM, and MDS Nurse #1 on 09/30/2021 at 1:39 PM revealed they were assisting in completing audits	{F 835}		

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{F 835}	Continued From page 908 with residents with no concerns identified. Review of audits initiated on 08/13/2021 for review of random weekly skin assessments for residents with a BIMS score of less than eight (8) to ensure there are no injuries of unknown origin revealed no identified concerns. Interview with Regional Nurse Consultant on 09/30/2021 at 3:40 PM, and DON #2 on 09/30/2021 at 3:20 PM revealed they were completing audits as indicated with no identified concerns. Observation of skin assessment on 09/30/2021 of Resident #45 at 9:23 AM and on 09/30/2021 at 10:20 AM of Resident # 27 revealed no concerns with injuries of unknown origin. 69). Interview with the Registered Dietician on 09/30/2021 at 3:53 PM revealed she started audits on 08/25/2021 of resident diet orders from electronic medical records against orders entered in the diet/tray card software to ensure accuracy. Review of Resident #308's tray card on 09/29/2021 at 12:04 PM, Resident #39's tray card on 09/29/2021 at 12:06 PM, and Resident #334 tray card on 09/29/2021 at 12:30 PM revealed diets were served as ordered by the physician. A review of audits revealed audits were conducted weekly for four (4) weeks. 70). Review of completed audits revealed random meals were audited twice daily for one (1) week beginning 08/23/2021. Starting 08/30/2021, random meals were observed two (2) times per week for two (2) weeks and then weekly from 09/13/2021 for one (1) month. Interview with Former Activities Director/Dietary Manager #3 on 09/30/2021 at 1:30 PM, Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM, and 09/30/2021 at 1:52 PM revealed audits were performed as indicated. Further interviews	{F 835}		

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{F 835}	Continued From page 909 revealed that meals were served as scheduled, including breakfast at 7:00 AM, lunch at 12:00 PM, and dinner at 5:00 PM. Observation on 09/28/2021 at 5:03 PM revealed the evening meal had been served on the third floor. Observation on 09/29/2021 lunch meal revealed meals arrived at the third floor at approximately 12:16 PM, the fourth floor at 12:16 PM and 12:24 PM, and the fifth floor at 12:34 PM and 12:49 PM. 71). Review of Resident #308's tray card on 09/29/2021 at 12:04 PM, Resident #39's tray card on 09/29/2021 at 12:06 PM, and Resident #334's tray card on 09/29/2021 at 12:30 PM revealed the meals honored resident preferences, including likes and dislikes. Interview with the Dietary Manager on 09/30/2021 at 1:30 PM revealed she would be responsible for obtaining food and beverage preferences within seventy-two hours of admission and entering the preferences into the system. A review of audits revealed snack intakes were audited daily for one (1) week from 09/15/2021 to 09/21/2021. Further review of the audits revealed snacks were audited weekly beginning on 09/22/2021. Interview with the Regional Certified Dietary Manager on 09/28/2021 at 2:26 PM and 09/30/2021 at 1:52 PM revealed she audited snack intake and had not identified any concerns. 72). Interview with the Human Resource Director (HR) on 09/30/2021 at 10:48 AM revealed she completed audits for daily staff screening against time clock punches. She revealed no identified concerns. Observation of entry doors on 09/28/2021, 09/29/2021, and 09/30/2021 revealed no concerns. 73). Interview with the Regional Nurse Consultant	{F 835}		

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{F 835}	Continued From page 910 on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, DON #2 on 09/30/2021 at 3:20 PM, and Interim Infection Control Nurse on 09/30/2021 at 3:10 PM revealed audits were being conducted with observations of handwashing, isolation signage and zones, donning/doffing PPE, mask compliance. Any variance or identified concerns will be addressed immediately. A review of the audits revealed they were conducted beginning 09/17/2021 on random shifts and units. 74). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she was responsible in addition to other members to review all residents on narcotics with the pharmacy to ensure that an active script is on file beginning 09/23/2021. A review of audits revealed no identified concerns. RN #1 on 09/29/2021 at 11:55 AM and 09/30/2021 at 12:58 PM, LPN (LPN) #6 on 09/30/2021 at 12:44 PM, LPN (LPN) #7 on 09/29/2021 at 3:00 PM and 09/30/2021 at 1:54 PM, LPN #10 on 09/30/2021 at 12:50 PM, LPN #11 on 09/30/2021 at 10:31 AM revealed no concerns with obtaining scripts for medications and/or receiving medications timely. Observation of medication pass on 09/29/2021 at 4:35 PM on the third floor and 09/30/2021 at 8:09 AM revealed no identified concerns with missing medications. In addition, observation of the narcotic count on the fifth floor on 09/30/2021 at 12:50 PM revealed no identified concerns. 75). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM revealed she was responsible for completing random medication pass observations beginning 09/25/2021. She stated she had not identified any concerns with residents not having medications or narcotic	{F 835}		

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{F 835}	Continued From page 911 counts. A review of audits revealed the facility utilized the Centers for Medicare Services Critical Element Pathway for Medication Administration to conduct the medication pass observation of twenty-five medications. A review of audits revealed a minimum of twenty-five medications were observed daily from 09/25/2021 with no identified concerns. Further review of medication observations revealed that medication administration was observed on random shifts, including 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. 76). Interview with the Regional Nurse Consultant on 09/30/2021 at 3:40 PM. The DON on 09/30/2021 at 3:20 PM revealed medication delivery tickets were being reviewed in clinical meetings Monday through Friday against ordered medications. A review of the audit revealed no identified concerns. 77). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, Regional Nurse Consultant on 09/30/2021 at 3:40 PM, RDON on 09/30/2021 at 4:17 PM, and the DON on 09/30/2021 at 3:20 PM revealed staffing was being audited daily beginning 09/11/2021, to ensure adequate staffing was maintained. A review of the audits revealed no identified concerns. 78). Interview with the Interim Administrator on 09/30/2021 at 5:05 PM, and the Dietary Manager on 09/30/2021 at 1:30 PM revealed staffing was being monitored daily to ensure adequate staffing. A review of the audits revealed no identified concerns. 79). Interview with the Vice President of	{F 835}		

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{F 835}	Continued From page 912 Operations on 09/30/2021 at 4:10 PM and Interim Administrator on 09/30/2021 at 5:05 PM revealed daily audits had been conducted daily from 09/11/2021. A review of the audits revealed no identified concerns. 80). Interview with the Senior Marketing Liaison on 09/30/2021 at 10:55 AM revealed he completed observations on different shifts to identify any change in resident condition. Further interviews revealed if a change in condition was identified, staff would complete a stop and watch. An audit review revealed no concerns with the change of conditions not being addressed by facility staff. 81). Review of interviews performed on 09/25/2021 for residents with a BIMS score of 8 or greater revealed no identified concerns. A review of the questionnaire completed during interviews revealed residents were asked: Is everyone treating you well? Do you feel safe here? Do you have any concerns? Interview with the Medical Records Staff on 09/29/2021 at 8:34 AM revealed she completed the interviews with residents on 09/25/2021, and she stated she identified no concerns.	{F 835}		
{F 837} SS=E	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the	{F 837}		12/30/21

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{F 837}	Continued From page 913 administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: The Governing Body failed to ensure facility policies were developed and implemented regarding management and operation of the facility. The Governing Body failed to ensure compliance with 42 CFR 483.80 Infection Control during survey visits on 07/14/2020, 09/24/2020, 11/13/2020, and 12/10/2020. Immediate Jeopardy (IJ) was identified on 11/20/2020 and determined to exist on 11/17/2020, at 42 CFR 483.80 Infection Control, F-880 at a S/S of an "L" due to the facility's failure to prevent the spread of COVID-19. Immediate Jeopardy (IJ) was identified 11/25/2020 and determined to exist on 11/09/2020, in the area of 42 CFR 483.12 Freedom from Abuse, F-600 related to failure to protect Resident #21 from abuse. The facility submitted a Plan of Correction and achieved compliance effective 01/20/2021. However, the Governing Body failed to ensure the facility had an active Quality Assurance Performance Improvement program to ensure compliance was maintained. Immediate Jeopardy was identified again on 08/11/2021, at 42 CFR 483.80 Infection Control (F880) and at 42	{F 837}	F 837 Governing Body Criteria 1: An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021 on (F580, F600, F655, F656, F684, F686, F692, F755, F880). However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified for (F725, F835, F837, F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. An acceptable allegation of compliance was received on 09/25/2021, which alleged removal of the Immediate Jeopardy on 9/26/2021. The State Survey Agency determined the Immediate Jeopardy was removed as alleged during a revisit conducted on 09/28-30/2021, which lowered the scope and severity to D for all tags, while the facility monitors the effectiveness of systemic changes and quality assurance activities.	

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(F 837)	Continued From page 914 CFR 483.12 Freedom from Abuse, F-600. The facility failed to isolate residents who were positive for COVID-19 to prevent spread to other residents. Two (2) residents died due to COVID-19. Further, the facility failed to protect resident #86 (who was Resident #21 on the 12/12/2020 survey) from further abuse. The Governing Body further failed to ensure there were enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating. The Governing Body's failure to ensure policies were developed and implemented regarding management and operation of the facility to ensure compliance and to ensure residents were free from abuse has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist on 03/06/2021, at 42 CFR 483.10 Resident Rights (F580), 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686) (F692), 42 CFR 483.45 Pharmacy Services (F755) and 42 CFR 483.80 Infection Control (F880). The facility was notified of Immediate Jeopardy on 08/11/2021. An acceptable Allegation of Compliance (AOC) was received on 09/03/2021, which alleged removal of the Immediate Jeopardy on 09/02/2021. However, the AOC could not be verified based on observations, staff interviews, and review of facility documentation. Additional Immediate Jeopardy was identified at 42 CFR	(F 837)	Criteria 2: On 9 /15/2021 a conference call was held with Med-Net Concepts the Vice President of Operations, Director of Clinical Operations, Regional Nurse Consultants to review the following: 1) the outcomes of the survey, 2) expectations and roles of the Governing Body as outlined in the Rules and Regulations, 3) determined a plan for the following communication/monitoring tools: Infection Control (COVID 19 Isolation), enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning QAPI committee. The governing body replaced Administrator with an Interim Administrator on 9/13/21. A permanent administrator was placed on 10-01-2021 and he was presented the education prior to assuming the role of administrator. Criteria 3: The Regional Director of Operations and VP of Operations met with the Administrator, the DON, and the Medical Directors on 9/16/21 regarding the duties of the Governing Body including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body. Also reviewed the QAPI/QAA processes, the need to participate regularly in QAPI process, the need to identify Root Cause	

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{F 837}	Continued From page 915 483.35 Nursing Services (F725), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867). The facility was notified of the Immediate Jeopardy on 09/10/2021. The Immediate Jeopardy is ongoing. A second acceptable allegation of compliance was received on 09/25/2021, which alleged removal of the Immediate Jeopardy on 09/26/2021. The State Survey Agency determined the Immediate Jeopardy was removed as alleged during a revisit conducted on 09/28-30/2021, which lowered the scope and severity to "D" 42 CFR 483.10 Resident Rights (F580), 483.12 Comprehensive Person-Centered Care Plans (F655) (F656), 42 CFR 483.25 Quality of Care (F684) (F686), 42 CFR 483.35 Nursing Services (F725), and 42 CFR 483.45 Pharmacy Services (F755); and to "E" at 42 CFR 483.12 Freedom from Abuse (F600), 42 CFR 483.25 Quality of Care (F692), 42 CFR 483.70 Administration (F835) (F837), 42 CFR 483.75 Quality Assurance and Performance Improvement (F867), and 42 CFR 483.80 Infection Control (F880), while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Interview by email with the Regional Nurse Consultant on 08/18/2021 at 2:20 PM, revealed the facility did not have a specific policy for the Governing Body. She stated the Chief Nursing Officer, Regional Vice President, and the Regional Nurse Consultant provided oversight at the facility.	{F 837}	(we will use the 5 whys) and auditing systems per the QAPI Calendar. Effective 12/3/21the Governing Body approved to have a member of the Governing Body team on site every day until the Immediate Jeopardy is removed. Members consist of Vice President of Operations, Regional Vice President of Operations, and regional nurse consultants. Members of the governing body will review weekly the grievance log and the interviews with residents to ensure they feel safe to ensure any new grievances are addressed. Criteria 4: Beginning on 09-13-2021, the interim administrator started monitoring daily, weekly, and monthly audits for F580, F600, F655, F656, F684, F686, F692, F755, F880, F725, F835, F837, and F867. The Administrator will monitor all audits on a weekly and/or until substantial compliance is met and monthly thereafter as recommended by the QAPI committee. Any findings that were not within regulations and addressed immediate and/or not reported immediately will result in disciplinary action in accordance with facility policy and procedures that can result in termination. All findings and progress will be presented to QAPI Committee consisting of at a minimum of: Administrator, Medical Director, Director of Nursing, Dietary Manager, Social Service Director, and two other staff members to update progress and/or findings to determine recommendations or feedback to continue current plan in place.	

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{F 837}	Continued From page 916 Review of Statements of Deficiencies (SOD) for survey visits on 07/14/2020, 09/24/2020, 11/13/2020, and 12/10/2020, revealed the facility was found to be out of compliance with 42 CFR 483.80 Infection Control regulations for the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Review of the SOD initial comments for an abbreviated survey completed by the State Agency on 12/12/2020, revealed Immediate Jeopardy (IJ) was identified on 11/20/2020 and determined to exist on 11/17/2020, at 42 CFR 483.80 Infection Control, F-880 at a S/S of an "L", 42 CFR 483.21 Care Plan Timing and Revision, F-657 at a S/S of an "L", and 42 CFR 483.70 Administration, F-835 at a S/S of an "L". The facility was notified of the IJ on 11/20/2020. According to the 12/12/2020 Statement of Deficiencies, observation and interviews revealed the facility failed to fully and consistently implement their COVID-19 Action Plan (AP), Infection Control (IC) policies and the Health Department's (HD) recommendations; failed to place IC/isolation signage on residents' door that were under precautions; failed to ensure adequate personal protective equipment (PPE)/supplies were available for use; and failed to ensure staff wore the PPE according to guidelines and policies. Facility staff from housekeeping, laundry, central supply and nursing were observed not following IC practices to prevent cross contamination between units set up for COVID-19 positive residents and units with residents testing negative. Additionally, there was no evidence Administration consistently	{F 837}	The Administrator will forward all QAPI Meeting minutes to the members of the Governing Body including the Vice President of Operations, Regional Vice President of Operations, and regional nurse consultant for review of all audits results. QAPI committee meetings have been monthly and as of 12/11/21 the QAPI meetings are weekly until DVO approves any changes. A governing body representative was onsite daily since 9-10-21 and remained through the removal of the immediate jeopardy; and attended the facility QAPI meetings. Site visits will be weekly and/or until substantial compliance. The Governing Body will meet quarterly to review findings from systematic audits. Compliance Date 12/30/2021	

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{F 837}	Continued From page 917 monitored employee infection control practices to prevent the spread of COVID-19. Due to the facility's failure to follow their COVID-19 AP, IC Policies, CMS/CDC guidelines, and the HD recommendations, residents were unnecessarily exposed to COVID-19. On 10/13/2020, the facility identified one (1) staff member as positive for COVID-19 and four (4) residents to be positive for COVID-19 on 10/17/2020 and 10/28/2020. On 10/22/2020, ten (10) additional residents were identified to be positive for COVID-19. From 10/24/2020 through 11/13/2020 sixty-eight (68) tested positive for COVID-19 and there was a total of ten (10) resident deaths. Six additional residents tested positive of on 11/20/2020. Review of facility COVID-19 testing revealed on 07/22/2021, the facility conducted routine testing of staff and residents and all were negative. On 07/24/2021, two staff members tested positive for COVID-19 at an outpatient clinic/hospital. Although, the facility was aware the staff tested positive, interviews with staff revealed there was no attempt by the facility to determine what residents were exposed to the infected staff in an effort to isolate the residents to prevent further spread of the virus. In addition, the facility failed to immediately test residents for COVID-19 per the facility policy after the known exposure. Further review of facility testing, revealed residents were not tested until 07/28/2021, four (4) days after the staff members were positive. During the 07/28/2021 resident testing, Resident #314 and Resident #311 tested positive for COVID-19. However, observation and interviews revealed the facility did not isolate the residents to prevent the spread of COVID-19 infection to others. Interviews with staff revealed they were unable to isolate Resident #311 due to wandering	{F 837}		

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{F 837}	Continued From page 918 behavior; subsequently, the resident continued to wander the hallways without a mask. Observation and interviews revealed the facility made no attempts to isolate the residents until 08/05/2021, eight days after the residents tested positive, when a plastic zip barrier was placed over the resident's doorway. Further, continued review of facility testing revealed staff were routinely tested for COVID-19 on 07/30/2021. However, SRNA #13 stated she was not tested prior to starting her scheduled shift on 07/30/2021 from 6:00 PM through 6:00 AM on 07/31/2021. During her shift, at approximately 12:00 AM on 07/31/2021, she stated she started feeling sick while caring for residents. She stated she reported her symptoms to the nurse who conducted a rapid COVID-19 test, which was positive. From 07/28/2021 through 08/05/2021, an additional three (3) residents tested positive for COVID-19. Prior to the barrier being placed on 08/05/2021, Resident #325, who resided across the hall from COVID-19 positive residents, was observed walking in the hallways and sitting in a chair in the hallway adjacent to COVID-19 positive rooms. Resident #325 was not wearing a mask. On 08/08/2021, Resident #325 tested positive for COVID-19. On 08/09/2021, Resident #325 developed respiratory distress and was transferred to the emergency room and hospitalized. Resident #325 was readmitted from the hospital to the facility on 08/12/2021, and on 08/19/2021, Resident #325 developed respiratory distress, had a decline in condition and was sent back to the hospital and expired on 08/26/2021.	{F 837}		

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{F 837}	Continued From page 919 One (1) additional resident (Resident #327) tested positive for COVID-19 on 08/07/2021 and was hospitalized on 08/14/2021, and expired on 08/15/2021 at the hospital. Resident #82 and Resident #329 had also been hospitalized due to COVID-19. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist at 42 CFR 483.80 Infection Control (F880). The facility was notified of the Immediate Jeopardy on 08/11/2021. Further review of the 12/12/2020 SOD revealed additional IJ and Substandard Quality of Care (SQC) was identified on 11/25/2020 and determined to exist on 11/06/2020, in the areas of 42 CFR 483.25 Quality of Care, F-689, Free from Accident Hazards/Supervision at a S/S of a "J", 42 CFR 483.21 Comprehensive Resident Centered Care Plans, F-656, Develop/Implement Comprehensive Care Plan, at a S/S of a "J", and 42 CFR 483.70, Administration F-835, at a S/S of a "L". The facility was notified of the IJ on 11/25/2020. Additional IJ and Substandard Quality of Care (SQC) was also identified on 11/25/2020 and determined to exist on 11/09/2020, in the areas of 42 CFR 483.12 Freedom from Abuse, F-600, Free from Abuse at a S/S of a "J", F-607, Develop and Implement Abuse Policy at a S/S of a "J", F-608, Reporting Reasonable Suspicion of a Crime at a S/S of a "J", F-609, Reporting Alleged Violations at a S/S of a "J", F-610, Investigation of Abuse at a S/S of a "J", and 42 CFR 483.70, Administration, F-835 at a S/S of an "L". The facility was notified of the IJ on 11/25/2020.	{F 837}		

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{F 837}	Continued From page 920 Continued review of the 12/12/2020 SOD, revealed additional deficient practice was identified at 42 CFR 483.10 Resident Rights, F-550, Resident Rights, at a S/S of a "D" and F-580, Notification of Change, at a S/S of a "G"; 42 CFR 483.25, Quality of Care, F-697, Pain Management, at a S/S of a "G"; and 42 CFR 483.60, Food and Nutrition Services, F-804, Nutritive Value/Palatable/Preferred Temperature, at a S/S of a "D". Total census 92. According to the 12/12/2021 SOD, the facility failed to protect Resident #21 (Resident #86 in the 09/10/2021 survey) from abuse and failed to implement the facility's policy related to reporting, protecting and investigating allegations of abuse. On 11/09/2020, the facility transferred Resident #21 to the hospital for an evaluation related to behaviors. However, review of the Emergency Room (ER) records dated 11/09/2020, revealed the resident was assaulted by a staff member at the facility. The resident was diagnosed with a right wrist sprain. During interview with Resident #21, he/she stated that a week or two ago, Registered Nurse (RN) #5 brutalized him/her; grabbed and twisted his/her arm; and hit him/her with a phone on his/her hand and arm. Observation at the time of the interview revealed bruising to the resident's right hand/thumb/wrist and forearm. SRNA #19 and SRNA #20 stated that on 11/09/2020, they found Resident #21 on the first floor of the facility crying and scared. The SRNAs stated the resident reported to them that RN #5 had broken his/her hand, twisted his/her arm, and hit him/her with the phone. SRNA #19 and SRNA #21 stated the resident's right thumb was twisted and swollen. Further staff interviews with the SRNAs revealed that on 11/09/2020, they observed RN #5 being aggressive towards	{F 837}		

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{F 837}	Continued From page 921 Resident #21, threatening the resident with a "shot", and yelling at the resident. However, SRNA #19 and SRNA #20 failed to follow the facility's policy related to abuse and failed to report this to anyone. RN #5 continued to work the remainder of the shift and worked again on 11/10/2020. Interview with the Administrator on 11/17/2020 revealed he was not aware of Resident #21's allegation of abuse. He stated this was the first time he was hearing of the allegation. However, interview with Interim Director of Nursing (DON) on 11/17/2020 revealed she received a text message from RN #5 on 11/09/2020 stating Resident #21 was sent out to the hospital for behaviors. She further stated she did not review the resident's record upon return from the hospital, and had she done so, she would have seen the ER report with the allegation of assault. Review of Resident #86's (Resident #21 from the 12/12/2021 survey) medical record revealed on 07/13/2021 at 11:15 AM, the resident called the State Police because Resident #82 was coming in his/her room and was exposing him/herself. However, review of the record revealed RN #1 informed the Police that "95% of our residents had Dementia and some do wander". Per the record, the RN informed the Police a resident had not been exposing him/herself to Resident #86 or others. The RN also documented she informed the Police Resident #86 "has been known to exaggerate." Further review of Resident #86's medical record and an incident report dated 07/15/2021 revealed at approximately 5:50 PM Resident #82 had wandered into Resident #86's room again and "picked up" the resident's shoes. According to	{F 837}		

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{F 837}	Continued From page 922 the incident report, Resident #86 pressed his/her personal alarm provided by the facility (exact date unknown) and threw water on Resident #82. Documentation also indicated a stop sign had been implemented to prevent residents from wandering into his/her room; however, the resident "frequently takes it down." The incident report indicated the investigation determined Resident #82 was abused by Resident #86 because he/she threw water on him/her when he/she entered the resident's room and steps taken to prevent further abuse was that the facility would encourage Resident #86 to keep his/her stop sign up when he/she was in her room. An interview with Resident #86, on 07/27/2021 at approximately 1:00 PM, revealed he/she felt like the facility was not trying to help him/her, and the resident did not know what else to do. The resident stated Resident #82 entered his/her room, "beat me up" and then "asked me how I liked it". Per the resident, Resident #82 had exposed him/herself to the resident numerous times since Resident #82's admission to the facility. The resident stated he/she reported the incidents to facility staff; however, stated, "No one here is helping me". Resident #86 stated he/she had even contacted the Police, but again, no actions had been taken to protect the resident. The resident also stated he/she was "moved down here" (to the opposite end of the hall) to keep Resident #82 away from him/her; however, Resident #82 continued to come in/out of his/her room. Resident #86 stated on 07/15/2021, he/she was lying in bed and Resident #82 entered his/her room again. Resident #82 exposed him/herself to the resident, picked up the resident's shoe and Resident #86 on the left, upper arm. The resident stated he/she threw	{F 837}		

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{F 837}	Continued From page 923 water on the resident to get him/her out of his/her room, and reported; however, no actions had been taken to protect the resident from further abuse from Resident #82. Immediate Jeopardy was identified, on 08/11/2021, and was determined to exist again at 42 CFR 483.12 Freedom from Abuse (F600). The facility was notified of the Immediate Jeopardy on 08/11/2021. Interview with the Regional Vice President (RVP) on 08/30/2021, at 3:30 PM revealed he had been the RVP at the facility for 90 days, and was a member of the Governing Body. He stated a Governing Body meeting had not been held since he became the RVP. He stated he did not know who the RVP was previously. He stated he was not sure how the facility monitored to ensure care and services were provided to residents, except through clinical meetings and Quality Assurance/Performance Improvement (QAPI) meetings. However, he stated since he had been the RVP, he had not been involved in any QAPI or clinical meetings. He stated he was not aware there were not enough staff at the facility to turn and reposition residents every two (2) hours. He stated he hoped with SRNAs and nursing, they could get all the tasks done that needed to be done. The RVP stated the facility was always looking for staff, but had been "aggressively" looking recently. Further interview with the RVP revealed it was not brought to his attention that the facility needed more money for food, nor that residents were not getting snacks. He stated if it had been brought to the Administrator's attention and it had not been addressed, he should have been notified.	{F 837}		

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{F 837}	Continued From page 924 The RVP further stated it "would have been ideal" if he had known about the Infection Control deviancies from December 2020; however, no one told him anything about any ongoing QAPI monitoring from the December 2020 survey. He stated he had heard the facility had been cited for Immediate Jeopardy in the past, but he did not know the specifics. **The facility alleged the following was implemented to remove Immediate Jeopardy effective 09/26/2021: 1). Braden Scale Assessments were completed on all residents by facility nurses on 08/28/2021 and comprehensive full body skin assessments were completed on all residents on 09/11/2021. The facility utilized the Braden Scale Assessment and comprehensive full body skin assessment to review and update care plans of residents who had pressure injuries by 09/17/2021. 2). The wound care physician evaluated Resident #65 on 08/25/2021. Staff assessed and measured all pressure injuries, and staff evaluated all current treatments and reported them to the Medical Director/Physician #1 by 09/17/2021. 3). Beginning 09/17/2021, upon admission a skin assessment and Braden Scale assessment will be completed, and the baseline care plan will be developed within 48 hours to include any pressure ulcer or potential for pressure ulcer. A comprehensive care plan will be developed within 21 days of admission to include pressure ulcers or potential pressure ulcers and include interventions to prevent pressure ulcer development or worsening of pressure ulcers.	{F 837}		

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{F 837}	Continued From page 925 4). Residents #45, #65, #308, #309, #311, #314 and #320 were bathed including a shower, nail care and moisturizing lotion applied post shower, and assisted with dressing in clean appropriate clothing. Clean linens were placed on the residents' beds on 09/11/2021. The residents were evaluated by social services on 09/15/2021. 5). All residents were offered a shower and interviewed to obtain shower/hygiene preferences by the Director of Nursing (DON) or designee. New bath/shower schedules were implemented by nursing staff to accommodate resident preference. Resident preferences for hygiene were obtained and incorporated into resident care plans and State Registered Nurse Aide (SRNA) care plans by the Regional Nurse Consultant were completed on 09/13/2021. 6). On 08/28/2021, the Registered Dietitian (RD) began reviewing all residents' diets and made recommendations for meal changes or supplements to promote healing and to address any weight loss issues. 7). All residents with the diagnoses of Diabetes and Chronic Obstructive Pulmonary Disorder (COPD), Asthma and Pneumonia were assessed by licensed nurse and/or Respiratory Therapist with no concerns were identified completed 08/13/2021. 8). The Regional Nurse reviewed all residents with orders for glucose monitoring by 07/30/2021 and orders were amended to include mandatory entry of glucose values on the Medication Administration Record (MAR).	{F 837}		

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{F 837}	Continued From page 926 9). The Regional Certified Dietary Manager (CDM) observed the meal service for breakfast, lunch and dinner on 09/11/2021, all three meals were delivered on time. 10). Direct Care staffing was increased through recruitment efforts with additional staffing provided through agency and travel contracts. Direct care nursing staff schedules for the next day will be reviewed daily by the Director of Nursing and the Administrator to ensure staffing levels are adequate to meet the acuity of the residents. The staff will be validated as present on the unit at the start of each shift by the Director of Nursing, Nursing Supervisor, Administrator or designee. Direct care nursing staff call offs will be replaced by calling other qualified staff to see if they can fill the opening, and/or calling agencies to see if they have qualified staff to fill the opening. If direct care staff cannot be replaced the Director of Nursing, Assistant Director of Nursing, or member of the nursing management team will fill the shift. If appropriate staffing levels cannot be met, the center will prioritize resident care that can be achieved during emergency staffing, prioritize required task including administration of medication, no showers- sponge baths, care provided to incontinent residents, turn residents that cannot turn self, meals served timely, and assist residents with meal if needed. 11). The facility has increased dietary staffing through recruitment efforts and appropriate staffing levels have been achieved to ensure meals are prepared and delivered timely. 12). On 08/11/2021, all residents including #64, #86 and #322, were reassessed for psychosocial	{F 837}		

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{F 837}	Continued From page 927 and physical forms of abuse with Brief Interview for Mental Status (BIMS) score of eight (8) or above and skin integrity reviews for residents with BIMS less than eight (8) were completed by Licensed Nurse. Residents with a diagnosis of Dementia had their Care Plan reviewed and revised, as necessary by the Minimum Data Set (MDS) Coordinator on 09/07/2021. No new residents were identified as indicating any psychosocial and/or physical harm. 13). The Regional Nurse Consultant completed a wandering risk assessment on all residents by 08/16/2021. All residents who were identified as at risk for wandering had care plans reviewed and updated by the MDS Coordinator. A list of all identified active wander risk residents were placed at each nursing station with a list of potential interventions for nursing to reference. 14). Residents #39, #65, #81, #90, #330 and #332 were weighed by 09/17/2021. The Registered Dietician (RD) completed a comprehensive nutrition assessment and RD recommendations were reviewed for recommendations by the Director of Nursing (DON) or designee on 09/17/2021. Further, the DON or designee, spoke with the attending Medical Doctor (MD) and validated the diet orders and recommendations. Recommendations were entered into the electronic medical record and on the tray card. The Registered Dietician and Director of Nursing (DON), reviewed diet orders in electronic medical record to ensure both the record and tray card reflected accurate information on 09/17/2021. 15). Beginning 09/15/2021, staff began offering snacks to all residents daily in the morning and	{F 837}		

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{F 837}	Continued From page 928 afternoon by the restorative nurse aide, activity aides, or designee. Snacks ordered by a physician will be documented by the restorative aide, dietary aides and/or licensed nursing staff. 16). The facility evaluated the COVID-19 unit on 08/11/2021, located on the 5th floor of the facility for compliance with CDC guidelines and implemented yellow and red zones. The DON identified two (2) residents who had been exposed to positive residents and a yellow zone was designated with erection of a plastic zip wall barrier and those two (2) residents were moved to this zone on 08/11/2021. 17). The facility had three (3) residents who were in the red zone on 08/11/2021(Residents #327, #328 and #329). Residents #327, #328 and #329 have completed quarantine per facility policy and physician orders. Residents #311 and #314 completed quarantine per COVID-19 policy and physician's order. Residents #311 and #314 were no longer in isolation. 18). All staff eligible for testing were tested for COVID-19 on 09/16/2021. The facility did not identify any new cases based on the employee testing on 09/16/2021. All residents eligible were tested for COVID-19 on 09/17/2021. The facility did not identify any new positive cases. 19). The facility was conducting ongoing surveillance testing as recommended for COVID-19. Positive COVID-19 residents will be placed in isolation zone (red zone) and placed in droplet precautions with use of personal protective equipment. The facility will provide physician notification, family notification and care plan revisions. The DON or designee will review	{F 837}		

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{F 837}	Continued From page 929	{F 837}		

newly positive COVID-19 residents to ensure isolation precautions have been initiated. In addition, any resident exposed will be placed in droplet precaution in isolation zone (yellow). The facility will provide physician notification, family notification and care plan revisions. The facility employee testing protocol will be twice weekly on designated days effective 08/16/2021. The facility requires all staff must be tested on designated days. If the employee is not tested, the facility will not allow the employee to work without a current negative COVID-19 test. During testing, the employee will be tested prior to entering the facility by the Infection Prevention Nurse or designee. All testing dates and times will be posted to the employee page, time clock and common areas.

20). The facility screens all residents once a shift for signs and/or symptoms of COVID-19 and documented on the Medication Administration Record (MAR). The facility implemented monitoring for signs and/or symptoms on all residents on 09/17/2021.

21). Resident #9, Resident #321, Resident #324, Resident #326 and Resident #351, medications were reviewed for usage and appropriate administration times by the physician on 09/23/2021.

22). The facility stated all residents will receive their medication as ordered beginning 09/23/2021 and implemented pharmacy and physician notification if any medication was unavailable. The facility will abide by new orders from the physician regarding the unavailable medication.

23). The facility formulated an agreement on

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{F 837}	Continued From page 930 09/23/2021, with the facility's pharmacy to provide the facility with a three (3) day supply of medications that requires the facility's approval for cost authorization while pending cost review. 24). New admissions and re-admissions entering the facility after normal business hours and on weekends will have discharge orders submitted, entered into the electronic medical record and submitted to pharmacy through pharmacy integration. The facility implemented the use of fax transmittal as a backup to the electronic pharmacy integration by entering the order in the electronic medical record to receive medications. If the facility does not receive medications in a timely manner the pharmacy will be notified, and the facility will utilize the emergency medication kit. If an emergency arises and medication is unavailable, the physician will be notified for substitution and/or new orders. 25). The Regional Nurse Consultant, Director of Nursing, and licensed nursing staff completed an audit of all residents' ordered medications and verified all medications were available in the facility by 09/25/2021. 26). The facility conducted a Quality Assurance Performance Improvement (QAPI) meeting on 08/12/2021. The facility reviewed education, facility process, and audited implementation to ensure compliance with the AOC and all audits. The Administrator oversees the QAPI committee. The QAPI committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy, Maintenance, Dietary and Environmental Services.	{F 837}		

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{F 837}	Continued From page 931 27). The facility appointed an Interim Administrator on 09/13/2021 to replace the current Administrator. The facility's Interim Administrator will receive daily oversight and guidance from the Regional Vice President or Regional Director of Operations and Regional Clinical Nurse for 30 days. Upon completion of the thirty-day oversight, the Regional Administrative Team will audit the Administrator to determine if continued daily oversight is needed. The administration has direct oversight and responsibility to direct, discipline, and communicate areas of concern and process improvement. 28). The Administrator, Medical Director, and QAPI Committee reviewed procedures for a contact person for call-ins, answering call lights, Activities of Daily Living (ADL) Care, serving, and timeliness of meal trays incontinence care and turning and repositioning on 09/15/2021. 29). The Vice President of Operations, Director of Clinical Operations and Regional Nurse Consultants conducted a conference call on 09/15/2021 with a contract company for a consultation to review the following: (1) the outcomes of the survey; (2) expectations and roles of the Governing Body as outlined in the Rules and Regulations; (3) determined a plan for the following communication/monitoring tools: Infection Control (COVID 19 Isolation), enough staff at the facility to monitor/assess residents, turn and reposition residents, provide incontinent care, prepare and distribute meals, and assist residents with eating, caring for pressure wounds, effective Pharmacy Services, dealing with abuse and neglect effectively, sufficient staff, providing appropriate ADLS, and providing a functioning	{F 837}		

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{F 837}	Continued From page 932 QAPI committee. 30). The Administrator and Regional Nurse Consultant reviewed and revised the QAPI Plan beginning 09/16/2021 and presented the reviews and/or revisions to the QAPI Committee during the 09/16/2021 meeting. The facility developed a standardized plan to ensure all topics were reviewed as needed at the QAPI meetings. The agenda included reviewing pressure ulcers, Foley catheters, enteral feeding tubes, contractures, physical restraints, medication usage, risk management, infection control, hospital readmission rate, rehabilitation management, social services, concerns of grievance, activities, resident council, and family council concerns, grievances, admissions, discharges, census, staff development, vacant positions, employee orientation, dietary variances, tray audit report, weight loss, work injuries, terminations, employees on family medical leave, a leave of absence, new hires, medical record compliance review, pharmacy reports, restorative nursing, business office, and admission actions. The QAPI Committee and Medical Director approved the standardized agenda on 09/16/2021 to include, but not limited to, the topics presented during the meeting. 31). The Regional Director of Operations and Vice President of Operations met with the Administrator, the DON, and the Medical Director on 09/16/2021 regarding the duties of the Governing Body, including setting policy and procedures to be implemented in the facility and communicating information to other members of the Governing Body. During the meeting, the QAPI processes, the need to participate regularly in the QAPI process, the need to identify root	{F 837}		

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{F 837}	Continued From page 933 causes with the utilization of the five (5) why approaches and, auditing systems per the QAPI Calendar. The Administrator will notify the medical Director of future QAPI Committee meetings. 32). The Administrator will collect all monitoring reports before each QAPI Committee meeting beginning 09/15/2021 for review to ensure compliance with the deficiencies cited during the 09/10/2021 survey. QAPI Meetings were held on 09/16/2021 to discuss abatement and develop interventions to remove the jeopardy. The facility implemented QAPI meetings weekly, times four (4) weeks, as needed, and monthly. The Administrator will forward all QAPI Meeting minutes to the Governing Body members, including the Vice President of Operations, Regional Vice President of Operations, and the Regional Nurse Consultant, to review the audit results. The QAPI committee will review the audits at the QAPI meetings. Committee for review. The Administrator oversees the QAPI Committee. The QAPI Committee consists of the Director of Nursing, Administrator, Medical Director, Social Services Director, Activities, Clinical, Therapy, Maintenance, Dietary and Environmental Services. 33). The Governing Body will provide the facility's Administrator with resources and education materials for QAPI, including but not limited to the QAPI Tool Kit, QAPI at a Glance, and a resource guide to effectively implement the QAPI plan beginning 09/16/2021. The Governing Body will meet quarterly for the upcoming year and reevaluate for frequency after one (1) year. 34). The Administrator will increase the frequency	{F 837}		

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{F 837}	Continued From page 934 of QAPI Committee meetings to weekly for four (4) weeks and, as needed effective 09/16/2021, to ensure the quality of care is monitored and complies with the standard of care and compliance with State and Federal requirements is demonstrated. 35). All nursing staff were educated by the Director of Nursing, MDS Coordinator, or designee on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician by 09/17/2021. 36). On 09/13/2021, the Regional Certified Dietary Manager (CDM) educated the Dietary Manager on the provision of timely nutritional assessment to ensure diet order accuracy, on diet order accuracy, and on when to enter diet orders into the electronic medical record. The CDM educated the Dietary Manager to enter resident diet orders into the tray care system. If the nurse enters the order, the nurse will send a written communication to the dietary staff, including diet and texture. In the morning clinical meetings, staff will review diet orders from the previous day to ensure accuracy. 37). Therapy provided education to all nursing staff on turning and positioning range of motion, and transfer of resident from bed to chair and chair to bed beginning on 08/19/2021 and completed on 09/17/2021. The facility employed and assigned additional staff through recruitment and agency contracts to ensure adequate staff to turn and reposition all residents who cannot reposition themselves. 38). The Regional Director of Nursing educated	{F 837}		

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{F 837}	Continued From page 935 all nursing staff on pressure ulcer prevention, including turning and repositioning, adequate hydration and nutrition, positioning devices, how to complete and document a head-to-toe skin assessment, and how to notify the registered dietician, physician, and RP of a new skin impairment by 09/17/2021. The facility nursing staff will call or email the Registered Dietitian, Physician, and Resident Representative of any new skin changes. 39). The DON or designee educated all staff on timely call light response. In addition, direct care staff, including nurses and certified nursing assistants, were provided education on providing timely hygiene per the resident's plan of care, timely toileting, dressing residents in their choice of clean clothing, and timely delivery of meal trays. The DON or designee will educate any facility staff not working during education upon returning to work. 40). On 08/31/2021, The Regional Director of Nursing educated all licensed nursing staff, the Registered Dietician, the Social Service Director, and the MDS Nurses on entering new care plans into the electronic medical record, including goals and interventions. In addition, the Regional Director of Nursing educated staff to update the existing care plan in the electronic medical record with new goals and interventions for any new skin impairments identified during their shift. 41). The facility's Respiratory Therapist educated Licensed nurses on identifying and assessing residents with a change in respiratory status on 08/12/2021. In addition, on 08/12/2021, the DON and/or designee educated all licensed nurses on identifying signs/symptoms of	{F 837}		

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{F 837}	Continued From page 936 hyperglycemia/hypoglycemia, the facility's diabetic protocol, documenting a resident's change in condition, documentation of blood sugar in the medical record, notification of the physician and following physician orders. The facility licensed nursing staff will not be allowed to work until they have received this education. The DON educated all clinical staff on documentation of glucose levels on 08/19/2021 and 08/20/2021 during mandatory in-services. 42). Beginning 08/12/2021, the DON educated licensed nurses on completing a baseline Care Plan with interventions and goals relevant to diabetes and a respiratory diagnosis within 48 hours of admission, reviewing and providing a copy to the resident and/or the responsible party. Licensed nursing staff not working during education was notified of ongoing education and will not be allowed to work until they have received this education. 43). Beginning 08/12/2021, the DON educated all staff on the facility's "call off" procedure. The call-off procedure for the facility included: in the event a person needs to call out of work for dayshift, they are to notify their immediate supervisor two hours before the start of the shift. If staff needs to call off on the night shift, they are to notify their immediate supervisor four hours before the start of their shift. If the facility does not have appropriate staffing levels, the immediate supervisor and/or designee will call other qualified staff to replace the person calling off. If emergency staffing is required, the Administrator and/or designee will call for assistance from staffing companies. Staff not working will be in-serviced upon return to work.	{F 837}		

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{F 837}	Continued From page 937 44). All staff were provided re-education by the Administrator and/or designee on 08/12/2021 on the process of identifying, preventing, and reporting abuse, as well as identifying and implementing immediate interventions for wandering residents. 45). All nursing staff were educated by the Director of Nursing, MDS Coordinator, or designee on proper weighing techniques, obtaining, documenting, and reporting weight changes to the Registered Dietician by 09/17/2021. On 09/13/2021, the CDM educated the Dietary Manager on diet order accuracy and timely nutritional assessment to ensure diet order accuracy. When staff enters diet orders into the electronic medical record, the nurse entering the order will send the written communication to the dietary staff. The Dietary Manager will enter the order into the tray care system. The facility will review diet orders from the previous day in the clinical meeting to ensure accuracy. 46). The Regional CDM educated the Dietary Manager on 09/13/2021 on facility policy regarding meal service times and the use of recipes including recipes for those requiring fortified diets to ensure all meals meet the nutritional needs of residents in accordance with established national guidelines to reflect religious, cultural and ethnic needs of the population. 47). As of 09/15/2021, the Regional CDM completed education with the dietary manager on obtaining food preferences, the facility's tray card system, ordering food based on menus, stocking snack/hydration carts, snacks, and hydrations procedures, appropriate scoop sizes, and/or portion sizes.	{F 837}		

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{F 837}	Continued From page 938 48). The Director of Nursing or Regional Director of Nursing educated nurses and the Dietary Manager on the process for entering, activating, and/or implementing the registered dietician's recommendations for dietary orders on 09/17/2021. 49). All staff were provided re-education by the DON and/or designee by 09/17/2021 on the COVID-19 policy/guidelines, handwashing, donning/doffing Personal Protective Equipment (PPE), yellow and red zones. In addition, the DON/designee educated, licensed staff on monitoring residents for Covid-19 symptoms beginning. 08/12/2021, the DON/designee educated all staff, including contract staff, who were not working. During the QAPI meeting on 08/12/2021, the Covid-19 policy, the handwashing policy, donning and doffing PPE, red and yellow zones, and monitoring residents for signs/symptoms of the Covid-19 were reviewed. 50). Staff were provided re-education on 08/20/2021 by the DON, Regional DON, or Regional Nurse Consultant to enter COVID-19 symptom monitoring orders on all new admissions into the resident's record. 51). All licensed nursing staff have been educated on the five (5) rights of medication administration, including right medication, right patient, right dose, right time, and right route. The Regional DON/DON/designee educated all licensed nursing staff working on 09/23/2021 on the process to follow when a medication was not available for administration as ordered. The education included calling the pharmacy to obtain	{F 837}		

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	185256	A. BUILDING _____ B. WING _____	R 09/30/2021

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{F 837}	Continued From page 939 the medication, obtaining the anticipated medication delivery time, notify the MD if an ordered medication will either be omitted or given outside of the ordered medication time. The education also included following new orders given by the MD, documenting the conversation, and new orders from the MD in the electronic medical record. All other licensed nursing staff will be provided training as scheduled for shifts. 52). On 09/25/2021, the DON /Regional Nurse Consultant educated all licensed nursing staff, including new hires and/or agency staff, on the use of the emergency medication kit, the system in place for ensuring medications are in-house, or notifying the physician for new orders for new or re-admitting residents, including on weekend and after-hours. 53). The Interim Administrator educated all staff on his contact information and role as the Abuse Coordinator from 09/13/2021 through 09/17/2021. In addition, education on staffing schedules and who to notify if unable to work their scheduled shift. 54). The facility will audit weekly resident head-to-toe skin assessments daily, Monday through Friday, for three (3) months effective 09/17/2021 to ensure they have been completed weekly on each resident. In addition, the facility will notify the physician, Registered Dietician, and Responsible Party of any new skin impairment and those new interventions have been put in place to prevent decline. 55). Central supply audited all lab supplies for the expiration date on 08/28/2021. Audits will be conducted weekly for all lab supplies for four (4)	{F 837}		

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{F 837}	Continued From page 940 weeks effective 09/17/2021 and then monthly for three (3) months. 56). The Director of Nursing, Assistant Director of Nursing (ADON), or Nursing Supervisor will audit resident progress notes for daily four (4) weeks effective 09/13/2021, then weekly for one (1) month. Staff will review Progress notes for Saturday and Sunday on Monday. The Nursing Supervisor conducted audits to ensure any new areas of skin impairment identified had a care plan implemented to include new interventions. 57). Beginning on 09/11/2021, the facility's leadership staff and/or designee began visual rounding of residents assessing hygiene, toileting, incontinence, and resident repositioning. All residents will be visually rounding on once each shift daily for two (2) weeks, fifty percent of the residents each shift for four (4) weeks, and twenty-five percent of residents each shift for four (4) weeks. The facility has two (2) shifts, 6:00 AM to 6:00 PM and 6:00 PM to 6:00 AM. 58). On 09/11/2021, the facility's leadership staff began visual monitoring and timing of call light response times, including the length of time call lights are answered, across all shifts. Leadership staff will conduct ten (10) call light observations each shift for two (2) weeks and then five (5) call light observations each shift for eight (8) weeks. 59). On 08/13/2021, the DON and/or Designee began monitoring respiratory assessments and Situation Background Assessment and Recommendation (SBAR) communications for acute change in respiratory status Monday through Friday in the clinical morning meeting. The facility reviewed any acute change in	{F 837}		

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{F 837}	Continued From page 941 respiratory status for Physician notification and implementation of any physician order. Care Plans were reviewed and updated as needed. Audits will be daily for one (1) week, then five (5) times a week for four (4) weeks. 60). The MDS Nurse, DON, and/or Designee began audits on 09/15/2021 of baseline care plan completion for all new admissions and re-admissions to ensure staff completed the baseline Care Plan within 48 hours of admission. 61). All residents admitted within the last thirty days with a diagnosis of Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Asthma, or current Pneumonia had their baseline Care Plan reviewed and updated as needed by the MDS Nurse(s) and/or designee. New interventions will be added to the care plan in the morning meeting by the DON, ADON, and/or nursing designee. 62). Beginning on 08/19/2021, the MDS Nurse, DON, and/or Designee will monitor new admissions and re-admissions to audit baseline care plans for completion, accuracy, and review with the resident and/or responsible party. Any variance or identified concern was addressed immediately. Audits will be conducted Monday through Friday for all admissions/re-admissions to the facility for four (4) weeks, fifty percent of admissions for a week for two (2) weeks, and then ten percent of admissions weekly for four (4) weeks. 63). On 09/11/2021, the Dietary Manager and/or designee began auditing how long it took to pass meal trays to residents after arriving at the unit. All three (3) meals will be observed on all three	{F 837}		

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{F 837}	Continued From page 942 (3) units daily for two (2) weeks, two (2) meals on all three (3) units daily for two (2) weeks, and one (1) meal on all three (3) units daily for four (4) weeks. 64). On 08/15/2021, the DON and/or Designee began audits of staff's knowledge with a verbal quiz of identification and assessment of residents with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia, the facility's diabetic protocol, documenting a change in a resident's condition, notification of the physician and following physician's orders. Leadership will quiz staff randomly across all shifts; ten (10) staff for one (1) week and five (5) staff a week for four (4) weeks. 65). On 08/13/2021, the DON and/or Designee began monitoring all documented blood sugar results Monday through Friday in the clinical morning meeting. The DON/designee will review any blood sugar results outside of the normal range for MD notification and implementation of any Physician's Orders. Care plans will be reviewed and updated as needed. The DON or designee will complete a visual rounding on diabetic residents across both shifts and all three (3) units to identify any resident with apparent signs and symptoms of hypoglycemia/hyperglycemia to ensure the resident was immediately assessed by licensed staff. Any variance or identified concerns will be addressed immediately. Audits will be daily for one (1) week, then five (5) times a week for four (4) weeks. 66). On 08/13/2021, the Administrator and/or designee implemented an employee questionnaire on abuse and identification of	{F 837}		

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{F 837}	Continued From page 943 residents with wandering behavior to determine the proper reporting of abuse across all shifts and units. The employee questionnaire will be completed for five (5) staff daily for one (1) week, then three (3) times a week for two (2) weeks, and then weekly for four (4) weeks. Any variance or identified concerns will be addressed immediately. 67). Beginning on 08/13/2021, the Director of Nursing and/or designee will review each resident's wandering risk assessment upon admission and quarterly with their Minimum Data Set (MDS) assessment. Any resident identified as wandering will be discussed in the clinical morning meeting to review and initiate new interventions. Any variance or identified concerns will be addressed immediately. New interventions will be care planned in the morning meeting by the Director of Nursing, Assistant Director of Nursing, or nursing designee. 68). Beginning on 08/13/2021, the Social Services Director or designee will perform random interviews of residents with a BIMS score of eight (8) or greater to ensure they feel safe in the facility and have not been subject to or witnessed abuse. The DON or designee will review random weekly skin assessments for residents with a BIMS score of less than eight (8) to ensure no injuries of unknown origin beginning 08/13/2021. Any variance or identified concerns will be addressed immediately. 69). On 08/25/2021, the Registered Dietician conducted audits of resident diet orders from the electronic medical record against orders entered in the diet/tray card software to ensure accuracy.	{F 837}		