STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495420	A. BUILDING _____ B. WING _____	C 09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBEMARLE HEALTH & REHABILITATION CENTER	1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 9/6/2022 through 9/8/2022. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/6/2022 through 9/8/2022. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey. Complaint VA00051761 was substantiated with deficient practice. Complaint VA00055413 was unsubstantiated. Complaint VA00055838 was substantiated with deficient practice. The census in this 120 certified bed facility was 107 at the time of the survey. The survey sample consisted of twenty-two (22) current resident reviews and three (3) closed record reviews.	F 000		
F 550	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		10/11/22

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

Electronically Signed | 09/23/2022

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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview, and review of facility documents, the facility failed for one of 25 residents in the survey sample (Resident # 109) to provide a dignified dining experience. Staff were observed	F 550	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility sets forth the following plan of correction to	

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F 550	Continued From page 2 feeding Resident # 109 while standing next to him. The finding were: Resident # 109 was admitted with diagnoses that included Parkinson's Disease, history of COVID-19, macular degeneration, blindness left eye, benign prostatic hyperplasia, Vitamin-D deficiency, dysphagia, chronic prostatitis, psychotic disorder with hallucinations, difficulty in walking, and generalized muscle weakness. According to the most recent Minimum Data Set, a Quarterly Review, with an Assessment Reference Date of 8/29/2022, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with severely impaired daily decision making skills. At 12:30 p.m. on 9/7/2022, Resident # 109 was observed seated at a table in the Unit Four dining area. The resident was being fed by a Certified Nursing Assistant, later identified as CNA # 2, who was standing next to the resident as she fed him. CNA # 2 fed the resident several spoons of mashed potatoes, and cut off several bites of a sandwich and offered them to the resident using a spoon. Resident # 109 reached for a short glass of juice and was able to pull it towards him, but was unable to lift it to drink. CNA # 2 held the glass and placed a straw in the resident's mouth so he could drink. CNA # 2 then offered the resident several spoons of chocolate pudding. After offering the pudding, CNA # 2 brought Resident # 109 a cup of coffee. The resident put	F 550	remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F550 Resident Rights 1. CNA #2 was educated during the survey on how to properly feed a resident and maintain dignity. 2. Current residents that require feeding have the potential to be affected. 3. The DON or designee will educate the nursing staff on the proper way to feed a resident to maintain dignified dining experience. 4. The DON or designee will audit residents during mealtimes weekly to ensure they are being fed thru a dignified dining experience. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis 6. Date of Compliance 10/11/22	

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F 550	Continued From page 3	F 550		

his right index finger through the cup handle, but was unable to hold the cup without assistance from CNA # 2. CNA # 2 then held the cup as she guided it to the resident's lips so he could take a sip of coffee.

After taking a sip of coffee, CNA # 2 walked away from the resident, leaving him holding the cup only by his index finger in the cup handle. The resident was unable to hold the cup and it tipped, spilling coffee on his lap. When CNA # 2 returned to the resident, she took the cup of coffee, placed it on the table and then walked away. CNA # 2 made no effort to check the resident or clean up the spilled coffee.

After CNA # 2 left the resident's side, she was asked if Resident # 109 needed to be fed. CNA # 2 said, "There has been a big change in him since he had COVID. We have to help him now." Resident # 109, who had been on 10 day isolation for COVID-19, was returned to his usual room on Unit Four on 9/6/2022.

In response to a request for the facility's policy and procedure on feeding residents, the facility provided the following:

"Feeding the Person:
Comfort: The person will eat better if not rushed. Sit to show the person that you have time for him or her. Standing communicates that you are in a hurry.
Procedure: Place the chair where you can sit comfortably. Sit facing the person."

(Ref. Mosby's Textbook for Long Term Care Nursing Assistants, Eighth Edition, Copyright 2020, Chapter 20, Page 299 - 302.)

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F 550	Continued From page 4 The findings were discussed during a meeting at 4:00 p.m. on 9/7/2022 that included the Administrator, Director of Nursing, and the survey team.	F 550		
F 578	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility	F 578		10/11/22

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F 578	Continued From page 5 may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility document review, the facility staff failed to document a DNR (DO NOT RESUSCITATE) status in the clinical record for one of 25 residents, Resident #93. Findings were: Resident #93 was admitted with the following diagnoses including but not limited to: COPD (chronic obstructive pulmonary disease), respiratory failure, abdominal aortic aneurysm, and hypertension. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 08/17/2022 assessed Resident #93 as cognitively intact with a summary score of "15". Resident #93 was interviewed on 09/06/2022 at approximately 2:00 p.m. regarding life at the facility. In the course of the conversation she was asked if she had any advance directives in place. She stated that she had chosen to be a DNR. The clinical record was reviewed on 09/07/2022 at approximately 2:45 p.m. There were no physician orders for resuscitation status observed	F 578	F578 Code Status 1. Residents #93 DNR was entered into the medical record during survey on 9/7/2022. 2. Current residents are at risk. Current residents charts were audited to ensure correct code status what entered into the medical record. 3. Current Nursing staff and Discharge planning will be educated by the DON/designee on ensuring correct code status entered into each resident s medical record. 4. The DON or designee will audit new resident admission charts for the correct code status during clincal meeting 5x/weekly. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis 6. Date of Compliance 10/11/22	

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F 578	Continued From page 6	F 578		

in the clinical record. There were no directions regarding advance directives on the care plan.

On 09/07/2022 at approximately 9:15 a.m., RN (registered nurse) #1 was asked about Resident #93's code status. She looked in the electronic record and stated, "I don't see anything about it in here, so if there is nothing here, I would code her."

LPN (licensed practical nurse) #5 was interviewed at approximately 9:30 a.m. and asked the same question. She looked in the clinical record and stated, "I don't see anything here, but I am thinking she is a DNR...there is one more place I can look." She went to the nurse's station and stated, "This is the Golden Rod Book...we keep the DNR information here." She looked in the book and stated, "Here it is." She pulled out a piece of paper, "Durable Do Not Resuscitate Order" with Resident #93's name on it. The form was dated 11/10/2021. It was signed by the resident and a physician. LPN #5 stated, "I thought I remembered seeing this...I'll make sure the order gets in the clinical record and the care plan is updated." She was asked what would have happened since there was no order on the record, if Resident #93 were to "code". She stated, "I always look in all the places, including here."

The above information was discussed during an end of the day meeting on 09/07/2022 with the DON (director of nursing), the administrator, and the corporate nurse consultant.

The facility policy, ""Do Not Resuscitate" was reviewed. The policy contained the following: "CPR (cardiopulmonary resuscitation) will not be

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F 578	Continued From page 7 initiated when there is a valid Do Not Resuscitate (DNR) order located on the patient's permanent record." A meeting was held with the DON, the administrator, and the corporate nurse consultant at approximately 10:30 a.m. on 09/08/2022. The DNR policy was shown to the corporate nurse consultant. She was asked if she saw anything about care planning the DNR, or putting the order on the record." She stated, "I don't see that either, but it should be care planned and the order should be in the record." No further information was obtained prior to the exit conference on 09/08/2022.	F 578		
F 580	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580		10/11/22

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F 580	Continued From page 8 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on complaint investigation, clinical record review, and staff interview, the facility failed for resident of 25 residents in the survey sample (Resident # 112), to notify the resident's family of a change in condition. Resident # 112 suffered a change in mental status that was not communicated to the resident's family. The findings were:	F 580	F580 Notification of Change 1. Resident #112 in no longer a resident in the facility. 2. Current residents have the potential to be affected. 3. The DON or Designee will educate current licensed nursing staff on Change of Condition to include notification of the responsible party with documentation in	

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F 580	Continued From page 9 Resident # 112 was admitted with diagnoses that included Multiple Sclerosis, non-pressure chronic ulcer of left lower leg, arteriosclerosis, peripheral vascular disease, restless leg syndrome, protein-calorie malnutrition, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, iron deficiency anemia, acute ischemic heart disease, hypertension, anxiety disorder, history of malignant neoplasm of bronchus and lung, absence of (part) lung, and generalized muscle weakness. According to a Medicare 5-Day Minimum Data Set with an Assessment Reference Date of 3/11/2021, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact with a Summary Score of 15 out of 15. Review of the Progress Notes in Resident # 112's closed Electronic Health Record revealed the following entries: 4/28/2021 - 7:56 p.m. - Skilled Note "Resident has been confused today and keeps talking as if she thinks staff will harm her. She is suspicious of mediations and possible poisoning. No complaints of pain but is very difficult to redirect and get to cooperate with medication administration. Urine will be collected and will monitor closely." 4/28/2021 - 8:38 p.m. - Skilled Note "...Res (Resident) has been stating to staff that staff is trying to kill her. Resident threw remote to TV and cup of full water at charge nurse. Res refuses to give staff urine for UA C&S (Urinalysis Culture and Sensitivity)...Resident yelling out loud help. Resident doesn't want staff to kill her. Res	F 580	the medical record. 4. The DON or designee will audit change of condition notifications five times a week to ensure all changes of condition were reported to the responsible party. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis 6. Date of Compliance 10/11/22	

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F 580	Continued From page 10	F 580		

offered fluids and she threw her drink on the floor. MD will be made aware of change in mental status. Res refused vital signs."

4/29/2021 - 3:08 p.m. - Medical Note "...has been having behaviors and throwing objects at staff. Told me she saw a TV show about her being a play girl which no one had business putting on TV!!"

4/29/2021 - 9:34 p.m. - Skilled Note "...Resident became confused and disoriented starting at around 9:00 p.m. Resident's son called expressing concern about his mother 3 times. Resident has called him and was very confused, she also called 911. Resident is stating that staff is trying to kill her, there are dead bodies in the basement and will not let us assist her to change into a gown and go to bed. Phoned Dr. (name) and we will keep an eye on her as this will be the third night in a row she has exhibited this behavior. Relayed message to Dr. (name) that son (name) would like to speak with him."

4/30/2021 - 11:12 p.m. - Skilled Note "Night shift aide was doing rounds and found resident lying on floor...This nurse asked resident if we could help her up off the floor, Resident stated, 'Ya'll are going to kill me anyway, so just get it over with.'..."

At 3:00 p.m. on 9/7/2022, the Medical Director was interviewed regarding Resident # 112 and any conversations he may have had with the resident's son. The Medical Director reviewed Resident # 112's EHR, but was unable to remember whether or not he spoke with the resident's son.

There was no documentation in Resident # 112's

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F 580	Continued From page 11 EHR that the family was was notified of her sudden change in mental status. The findings were discussed during a meeting at 10:30 a.m. on 9/8/2022 that included the Administrator, Director of Nursing, and the survey team.	F 580		
F 645	COMPLAINT DEFICIENCY PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility;	F 645		10/11/22

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and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.

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F 645	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed for one of 25 residents in the survey sample, to ensure the resident had a completed Preadmission Screening and Resident Review (PASARR). Resident # 109 did not have a PASARR completed at admission. The findings include: Resident # 109 was admitted with diagnoses that included Parkinson's Disease, history of COVID-19, macular degeneration, blindness left eye, benign prostatic hyperplasia, Vitamin-D deficiency, dysphagia, chronic prostatitis, psychotic disorder with hallucinations, difficulty in walking, and generalized muscle weakness. According to the most recent Minimum Data Set, a Quarterly Review, with an Assessment Reference Date of 8/29/2022, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with severely impaired daily decision making skills. A review of Resident # 109's Electronic Health Record (EHR) revealed the resident did not have a PASARR completed at admission. Resident # 109 was admitted on 8/22/2018. The Discharge Planner was identified at the person responsible for obtaining the PASARR for a resident. At approximately 10:45 a.m. on 9/7/2022, the Discharge Planner was interviewed regarding a PASARR for Resident # 109. The Discharge Planner, who said she was not in that position when the resident was admitted,	F 645	F645 PASARR 1. The PASARR for resident 109 was updated during the survey on 9/7/22. 2. Current residents in the facility have the potential to be affected. An audit of current residents was preformed to ensure a PASARR is present in the medical record. 3. The Regional Director of Clinical Services/designee will educate the Discharge planner on PASARR requirements for long-term care upon admission to a nursing facility. 4. The Administrator or designee will audit new admission weekly for the presence of a PASARR upon admission to the facility. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis 6. Date of Compliance 10/11/22	

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F 645	Continued From page 14 reviewed the resident's EHR and stated, "There is no PASARR." The findings were discussed during a meeting at 4:00 p.m. on 9/7/2022 that included the Administrator, Director of Nursing, and the survey team.	F 645		
F 655	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	F 655		10/11/22

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F 655	Continued From page 15 this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to develop a baseline care plan for one of 25 residents in the survey sample. Resident #107 did not have a baseline care plan for a PICC (peripherally inserted central catheter) line. The Findings Include: Diagnoses for Resident #107 included: Acute respiratory failure, pneumonia, MRSA (methicillin resistant staphylococcus aureus), and diabetes. The most current MDS (minimum data set) was a 5 day assessment with an ARD (assessment reference date) of 7/26/22. Resident #107's cognitive score was a 12 indicating moderately cognitively intact. Resident #107 was admitted to the facility on 8/28/22 On 9/06/22 at 3:45 PM an interview with Resident #107 was attempted. During the interview Resident #107 was asked about the PICC line observed in the right upper arm. Resident #107	F 655	F655 Baseline Care Plan 1. Resident # 107 was updated during the survey on 9/7/22. 2. Current new admission to the facility have the potential to be affected. 3. The Regional Director of Clinical Services/designee will educate the nursing leadership team on baseline care plan requirements. The DON or designee will educate current licensed nursing staff of initiation of the baseline care plan. 4. The DON or designee will audit new admission charts 5x/ weekly during clinical meeting for the presence of a baseline care plan. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis 6. Date of Compliance 10/11/22	

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F 655	Continued From page 16 verbalized she did not know what it was for. On 9/6/22 Resident #107 physician orders were reviewed and documented an order for the PICC line for antibiotic treatments. Resident #107's baseline care plan was reviewed and did not evidence a care plan was put in place for the PICC line. On 09/07/22 at 8:51 AM the director of nursing (DON) was interviewed regarding the care plan. The DON reviewed the care plan and said the baseline care plan becomes part of the resident's regular care plan after 14 days and a care plan should have been created for a PICC line upon admission. On 09/07/22 at 4:04 PM the above information was presented to the administrator, DON and nurse consultant. No other information was presented prior to exit conference on 9/8/22.	F 655		
F 656	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		10/11/22

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F 656	Continued From page 17 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for two of twenty-five residents in the survey sample. Resident #102 had no care plan developed regarding diabetic management, anticoagulant use and epilepsy. Residents #22 had no individualized care plan for recreational activities.	F 656	F656 Comprehensive Care Plan 1. Resident #102 was discharged prior to her care plan being updated. 2. Current resident have the potential for their care plan to not be updated to reflect current status. 3. The Regional Director of Clinical Reimbursement/designee will educate the current nursing leadership team and the	

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F 656	Continued From page 18 The findings include: 1. Resident #102 was admitted to the facility with diagnoses that included osteomyelitis, epilepsy, cellulitis, diabetes, MRSA (methicillin resistant staphylococcus aureus) infection, depression, hypertension, heart failure, history of cerebral infarction, and acute deep vein embolism/thrombosis of lower extremity. The minimum data set (MDS) dated 8/22/22 assessed Resident #102 as cognitively intact. On 9/7/22 at 8:00 a.m., Resident #102 was interviewed about quality of care in the facility. Resident #102 stated she received blood sugar checks and insulin daily. The resident stated she was also prescribed a blood thinner and took medication for management of seizures. Resident #102's clinical record documented a physician's order dated 8/16/22 for blood sugar checks before meals, 4 units of Lispro insulin after each meal, sliding scale insulin with meals, 8 units of Lantus insulin at bedtime and Metformin 850 mg (milligrams) twice per day for diabetic management. The resident had a current physician's order dated 9/2/22 for the anticoagulant Eliquis 5 mg twice per day for prevention of deep vein thrombosis. The resident also had a physician's order dated 8/16/22 for levetiracetam 750 mg twice per day for prevention of seizures. The resident's medication administration record documented the blood sugar checks and medications were administered as ordered. Resident #102's plan of care (revised 8/31/22) included no problems, goals and/or interventions regarding insulin administration, diabetic	F 656	MDS Coordinators on how to identify items that should be present in a comprehensive care plan. 4. The DON or designee will audit 5 care plans weekly to ensure the care plan is appropriate and matches the residents current state and condition. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis 6. Date of Compliance 10/11/22	

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management, anticoagulant use or seizure prevention.

On 9/7/22 at 11:35 a.m., the licensed practical nurse (LPN #1) acting unit manager was interviewed about Resident #102's plan of care. LPN #1 reviewed the care plan and stated diabetic management, anticoagulant use and seizure prevention should have been included in the plan. LPN #1 stated the unit managers were responsible for care plan development and updates.

This finding was reviewed with the administrator, director of nursing and regional director of clinical services during a meeting on 9/7/22 at 4:00 p.m.

2. Resident #22 was admitted to the facility with diagnoses that included myocardial infarction, end stage renal disease, seizures, heart failure, asthma, atherosclerotic heart disease, depression, peripheral vascular disease, obstructive sleep apnea, personality disorder, bipolar disorder, obesity and deep vein thrombosis. The minimum data set (MDS) dated 6/22/22 assessed Resident #22 as cognitively intact.

On 9/6/22 at 2:45 p.m., Resident #22 was interviewed about quality of care/life in the facility. When asked about activities, Resident #22 stated she liked bingo but had experienced difficulty seeing the cards because of cataracts. Resident #22 stated she also participated in outings, went outside for fresh air and group activities.

The MDS assessment dated 6/22/22 assessed Resident #22's recreational preferences as music, pets/animals, news, groups, fresh

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F 656	Continued From page 20 air/outside, religious services and listed that participating in her favorite activities as very important. Resident #22's plan of care (revised 7/18/22) included no individualized problems and/or interventions regarding recreational activities. The plan documented the resident was self-directed and independent with activities with goal of the resident participating in 3 to 5 activities weekly. Interventions documented were, "Honor patient's preferences...Provide an opportunity for decision making, self-expression, creative expression." The plan made no mention of the resident's assessed preferences or interventions to promote the resident's participation. The plan made no mention of visual difficulties with bingo. On 9/7/22 at 2:42 p.m., the activities director (other staff #4) was interviewed about Resident #22's recreation care plan. The activities director stated Resident #22 participated in outings, liked bingo, music activities and socializing with other residents outside. The activities director stated she was aware the resident had visual difficulties when playing bingo. The activities directors stated she was responsible for the care plan section regarding recreational activities. The activities director stated Resident #22's care plan was listed the way she was taught and she had not been instructed to include specifics about residents' assessed preferences. This finding was reviewed with the administrator, director of nursing and regional director of clinical services during a meeting on 9/7/22 at 4:00 p.m.	F 656		
F 657	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		10/11/22

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F 657	Continued From page 21 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and during the course of a complaint investigation, the facility staff failed to review and revise the CCP (comprehensive care plan) for one of 25 residents in the survey sample. Resident #111's CCP was not reviewed and revised for adequate fall interventions and/or supervision for the prevention of falls.	F 657	F657 Care Plan Timing and Revision 1. Resident #111 is no longer a resident and care plan unable to be updated. 2. Current residents in the facility have the potential to be affected. 3. An audit of falls for the last 30 days was preformed to ensure intervention had been Placed on the care plan.	

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F 657	Continued From page 22 Findings include: Resident #111's CCP was not reviewed and revised for adequate fall interventions and/or supervision for the prevention of falls. Resident #111's diagnoses included, but were not limited to: ataxia [impaired coordination] following a non-traumatic intracerebral hemorrhage, myelodysplastic syndrome, pancytopenia, headache, anemia, cognitive communication deficit, abnormalities of gait and mobility, lack of coordination, dysphagia, mild protein calorie malnutrition, high blood pressure, atrial fibrillation, vertigo (dizziness) and fracture of right femur. The most recent full MDS (minimum data set) was an admission assessment dated 07/12/22. This MDS assessed the resident with a cognitive score of 11, indicating moderate impairment in daily decision making skills. The resident was assessed as requiring extensive assistance from two staff for transfers, bed mobility, dressing, eating and toileting. The resident was assessed as requiring total assistance from two staff for bathing. The resident was coded as incontinent of bowel and bladder. A complaint investigation was conducted on Resident #111 on 09/06/22 through 09/08/22. An allegation within the complaint alleged that the resident had multiple falls at the facility, with the last fall resulting in a fractured hip. Resident #111's clinical records were reviewed and revealed the following. An admission assessment dated 07/06/2022 and timed 2:50 PM documented, "...on arrival:	F 657	4. The Regional Director of Clinical Services/designee will in service the nursing leadership team and the MDS team on when to update a care plan appropriately. 5. The DON/designee will audit care plans for residents with falls weekly to ensure fall interventions have been placed on the care plan 6. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis 7. Date of Compliance 10/11/22	

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cognitively intact...Does the resident exhibit any signs of or complain...of pain? no
Admission Narrative note: Resident admitted from [initial of hospital] following ICH [intracerebral hemorrhage] and CVA [stroke]. No surgical intervention pursued. Vitals are stable and c/o of headache persistently. Able to make all needs known...will evaluate. History noted for pancytopenia, HTN, afib, CVA. Family in to visit. Monitor closely..."

The resident's nursing progress notes were reviewed and documented the resident had a fall on 07/13/22.

The resident's CCP was reviewed and the care plan included the following interventions:

"...place bed in lowest position while resident is in bed Created on: 07/07/2022, ensure the resident wears shoes when ambulating Created on: 07/07/2022, place common items within reach of the resident Created on: 07/07/2022, remind the resident to use their call light to ask for assistance with ADLS Created on: 07/07/2022, reorientation to the room to assist the resident to familiarize Created on: 07/07/22, therapy referral Created on: 07/07/2022..."

On 07/14/22 the CCP documented, "...ACTUAL FALL: [Name of Resident #111] is at risk for injury from fall/falls. Resident had a fall. Created on: 07/14/2022, The resident will resume usual activities without further incident through the review date. Continue interventions...Created on: 07/14/2022..."

The resident CCP was then updated with an intervention on 07/28/22 to include: "...bed alarm

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to bed created on: 07/28/2022..."

The resident had another fall on 07/30/22. An SBAR Summary note dated 07/30/22 documented, "...The Change In Condition/s reported on this Evaluation are/were: Falls...Code Status: DNR...Recommendations: n/a...New Testing Orders...n/a...New Intervention Orders: Other - n/a..."

A progress note dated 7/30/2022 and timed 5:51 PM documented, "...Health Status Note...Resident found sitting beside his bed, range of motion indicates no injury, assisted up off floor by 2 staff. Resident was belligerent when writer explained to him that he should always ring for assistance if he wants to get out of bed or back to bed. Stated I wanted to get up. Wife...informed. MD made aware."

No other interventions and/or supervision was added for the prevention of falls.

On 08/04/2022 at 7:21 PM, a progress note documented, "...Fall Note...Skin tear on right shin. No other injuries noted at this time...What interventions were in place at the time of the fall? Chair alarm, What are the risk factors that could have contributed to the fall?: Confusion and gait imbalance, What new interventions were implemented in response to the fall?: Education regarding call bell usage, Was the Provider/resident and RP notified at the time of the fall?: Yes..." There was no evidence of a chair alarm intervention in the physician's orders and/or on the resident's care plan (only in the note above).

The resident's CCP was again reviewed. An

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intervention was added on 08/05/22, "...Keep resident in high traffic area for safety Created on: 08/05/22..."

It was documented again on 08/06/22 that the resident had another fall. The note documented, "08/06/2022 6:33 PM...Observations...BP 133/76... bowel Status: incontinent...Pain: no...Non Pharmacological interventions provided: [blank] Pharmacological interventions provided: [blank]...Continues skilled nursing care due to intracerebral hemorrhage. A&Ox2. Takes medication whole with no issues noted. 2 person assist with ADLs. Incontinent to bowel and bladder. Skin is intact. Resident fell this evening. States he slipped out of the bed. No injuries noted. Will continue to monitor for any changes. Vitals are within normal limits."

There were no new interventions and/or supervision added to the resident's CCP.

On 08/07/22 the resident had another fall, this fall resulted in Resident #111 sustaining a right hip fracture.

On 08/07/22 2:19 PM, a progress note documented, "...health Status Note... Resident had a fall after lunch in his room. CNA [certified nursing assistant] found resident at the foot of the bed laying on his left side. Resident states he was trying to get up to go to the bathroom. After examining resident, he presented with right side hip pain that was radiating down his leg. Skin tear was noted to right elbow. Vitals were stable. Resident states he also hit his head. Notified weekend supervisor [also known as RN #2] and stated nurse was sending him to [name of hospital] ER due to possible fracture. Notified

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DON. Unable to get MD on the phone. Call and let emergency contact know and they were going to meet resident at the hospital."

On 09/08/22 at 10:19 AM, the survey team met with the administrator, DON, and corporate nurse regarding the repeated falls Resident #111 was having and the lack of adequate supervision and/or interventions for the prevention of falls. The staff were made aware that the resident's CCP did not reflect adequate supervision and/or interventions. A fall policy was requested. The facility staff stated they would look for any additional information regarding this resident.

The facility fall policy was presented and documented, "...Falls Management Program...considers all patients to be at risk for falls and provides and environment as safe as practicable...a fall risk assessment will be completed upon admission, readmission, quarterly, and significant change of condition...incorporate identified interventions into the Comprehensive care plan...discuss risks and interventions...Investigate the fall, and record findings surrounding the fall...A licensed nurse will review, revise and implement interventions to the care plan based...each fall will be reviewed for causative factors utilizing the post fall assessment, device assessment and incident report...the unit manager verifies care plan revisions, patient monitoring, appropriate referrals..."

On 09/08/22 at approximately 11:10 AM, the DON, administrator and corporate nurse returned. The administrator stated that they had additional information to present. The DON stated that they (facility) had interventions in

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F 657	Continued From page 27 place, but they weren't on the resident's care plan and that they discussed the falls in their meetings. The DON presented a meeting information sheet. The information documented, "...7/13/22 [name of resident] fall ? head injury resident to ED for evaluation/continue interventions...08/4/22 [name of resident] fall skin tear on right shin area resident will be place in a highly trafficked area when up to assist with fall prevention...08/06/22 [name of resident] fall none [injury] resident will be monitored for adverse effects of medications to assist with fall prevention...08/07/22 [name of resident] fall right hip pain resident sent to ER for evaluation..." No information was presented for the fall on 07/30/22. The facility staff were made aware that the only new interventions that were implemented was on 07/27/22, which was the bed alarm and on 08/05/22 it was added for the resident to be put in a high traffic area. The remaining interventions were in already in place and had not been effective for Resident #111. The DON, administrator and corporate nurse were also made aware that each fall the resident had was in the resident's room, not in a high traffic area. No further information and/or documentation was presented prior to the exit conference to evidence that the facility staff reviewed and revised the CCP to include adequate supervision and/or interventions for the prevention of falls for Resident #111. This was a complaint deficiency.	F 657		
F 689	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		10/11/22

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F 689	Continued From page 28 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and during the course of a complaint investigation, the facility staff failed to ensure adequate supervision and/or interventions for the prevention of falls for one of 25 residents (Resident #111), which resulted in actual harm and failed to ensure one of 25 residents (Resident #7) was safe when consuming hot liquids. Findings include: 1.) Resident #111's diagnoses included, but were not limited to: ataxia [impaired coordination] following a non-traumatic intracerebral hemorrhage, myelodysplastic syndrome, pancytopenia, headache, anemia, cognitive communication deficit, abnormalities of gait and mobility, lack of coordination, dysphagia, mild protein calorie malnutrition, high blood pressure, atrial fibrillation, vertigo [dizziness/off balance feeling] and fracture of right femur. The most recent full MDS (minimum data set) was an admission assessment dated 07/12/22. This MDS assessed the resident with a cognitive score of 11, indicating moderate impairment in daily decision making skills. The resident was	F 689	F689 Accidents and Incidents 1. Resident # 111 is no longer a resident in the facility. Resident #71□s hot liquid evaluation was updated during survey on 9/8/22. 2. Current Residents have the potential to be affected. An audit of current residents hot liquid evaluation was completed to ensure safety while consuming hot liquids. An audit of falls intervention implementation for falls for the last 30 days. 3. The DON or Designee will educate current nursing staff on safety while consuming hot liquids and ensuring interventions identified are in place while consuming hot liquids. The DON or designee will educate current nursing staff of the need to ensure intervention are placed to prevent falls after each fall and to ensure that current interventions are in place to ensure resident safety at all times. 4. The DON or designee will observe 10 residents during consumption hot liquids for those identified to be a risk weekly to ensure current interventions are in place and the resident is safe. The DON or	

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F 689	Continued From page 29 assessed as requiring extensive assistance of two staff for transfers, bed mobility, dressing, eating and toileting. The resident was assessed as requiring total assistance of two staff for bathing. The resident was coded as incontinent of bowel and bladder A complaint investigation was conducted on Resident #111 on 09/06/22 through 09/08/22. An allegation within the complaint alleged that the resident had multiple falls at the facility, with the last fall (on 08/07/22) resulting in Resident #111 sustaining a right fractured hip. Resident #111's clinical records were reviewed and revealed the following: An admission assessment dated 07/06/2022 and timed 2:50 PM documented, "...on arrival: cognitively intact...Does the resident exhibit any signs of or complain of...pain? no Admission Narrative note: Resident admitted from [name of hospital] following brain bleed and stroke. No surgical intervention pursued. Vitals are stable and c/o of headache persistently. Able to make all needs known. PT and OT will evaluate. History noted for pancytopenia, HTN, afib, CVA. Family in to visit. Monitor closely..." Nursing notes were then reviewed and revealed that the resident had a fall on the following days: On 7/12/2022 at 6:27 PM, a skilled nursing note documented, "...Nursing Focus: Continues skilled nursing care due to intracerebral hemorrhage. A&O (alert and oriented) x 2. Takes medication whole...2 person assist with ADLs. Incontinent to bowel and bladder....No other complaints at this time..."	F 689	designee will audit all falls that occur to ensure that intervention are placed after a resident has a fall. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis 6. Date of Compliance 10/11/22	

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On 7/13/2022 at 6:00 PM, a nursing noted documented, "...Alert Note...Patient found on the floor at 1500 [3:00 PM], fell from w/c [wheelchair], head was resting under the chair, patient indicated that he did hit head. 911 called... patient transported...Daughter...aware...VS [vital signs] stable post fall."

A fall risk assessment dated 07/13/22 documented that the resident was on an antihypertensive and anti-seizure medication, the resident was chair bound, incontinent and had improper body position. The assessment did not address the areas of unsafe behavior or mobility (those areas were blank). This assessment did not indicate by a score and/or other means that the resident was at risk for fall or was at high risk for falls.

A fall investigation dated 07/13/22 and timed 3:00 PM was reviewed and documented that the resident was, on an anti-seizure medication, was not alert and oriented, was confused and disoriented, was restless and was in the resident's room at the time of the fall, did not call for help and that the call light was not in reach and that the resident was not wearing proper shoes and that the resident had cognitive impairment.

The fall on 07/13/22 was unwitnessed and occurred in the resident's room. There were no specific details in the investigation regarding the circumstances around the fall and there were no interviews from staff.

The resident's CCP (comprehensive care plan) was then reviewed and documented, "...ensure

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the resident wears shoes when ambulating created on: 07/07/2022, place bed in lowest position while resident is in bed created on: 07/07/2022, place common items within reach of the resident created on: 07/07/2022, remind the resident to use their call light to ask for assistance with ADLS created on: 07/07/2022, reorientation to the room to assist the resident to familiarize created on: 07/07/22, therapy referral created on: 07/07/2022...ACTUAL FALL: [Name of Resident #111] is at risk for injury from fall/falls. Resident had a fall. Created on: 07/14/2022, The resident will resume usual activities without further incident through the review date. Continue interventions on the at-risk plan Created on: 07/14/2022..."

On 07/27/22 at 4:50 PM, a skilled nursing note documented, "...weakness. He is alert and oriented to self, cognitive status varies...no complaints of pain...Continues to be a two assist for transfers and ADL's..."

The resident's physician's orders were reviewed. A bed alarm was ordered on 07/27/22. The resident's July 2022 MARs (medication administration records) were reviewed. The MARs documented the bed alarm order on the MAR and it was signed off that this intervention was in place for the resident from 07/27/22 through 07/31/22.

The resident's CCP was updated and documented, "...bed alarm to bed created on: 07/28/2022..."

On 7/30/2022 at 5:48 PM an SBAR [situation-background-assessment-recommendation] Summary note documented, "...The Change

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In Condition/s reported on this Evaluation are/were: Falls...Code Status: DNR...Recommendations: n/a...New Testing Orders...n/a...New Intervention Orders: Other - n/a..."

On 7/30/2022 at 5:51 PM a progress note documented, "...Health Status Note...Resident found sitting beside his bed, range of motion indicates no injury, assisted up off floor by 2 staff. Resident was belligerent when writer explained to him that he should always ring for assistance if he wants to get out of bed or back to bed. Stated I wanted to get up. Wife...informed. MD made aware."

The fall on 07/30/22 was an unwitnessed fall. There was no fall investigation and/or fall risk assessment for the fall on 07/30/22. There was no information regarding the bed alarm, if it was in place and/or sounding.

On 08/04/2022 at 7:21 PM, a progress note documented, "...Fall Note...Skin tear on right shin. No other injuries noted at this time...What interventions were in place at the time of the fall?: Chair alarm, What are the risk factors that could have contributed to the fall?: Confusion and gait imbalance, What new interventions were implemented in response to the fall?: Education regarding call bell usage, Was the Provider/resident and RP notified at the time of the fall?: Yes..."

A late entry note documented, "...Post Fall Documentation Late Entry: Situation: Date and time the fall occurred: 08/04/2022 4:00 PM...Background: Circumstances of the fall: unknown... Assessment (RN)/Appearance (LPN):

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Current status of the resident's injuries or reports of pain from the fall: no c/o pain...Recommendations: Interventions currently in place to prevent additional falls: Bed alarm and bed in lowest position...Resident's response to new interventions: no response.."

A fall investigation dated 08/04/22 and timed 7:15 PM documented the resident was on an antihypertensive, was not alert and oriented, was confused and disoriented, was restless, the fall was in resident's room, did not call for help, call bell in reach and was wearing appropriate footwear and contributing factors was cognitive impairment. There was no specific information regarding the circumstances of the fall in this investigation or any interviews from staff. There was no information regarding the bed alarm, if it was in place and/or sounding.

A fall risk assessment dated 08/04/22 documented that the resident was on an antihypertensive medication, tried to stand, transfer, or walk alone unsafely, propels or walks alone in unsafe places, uses assistive devices inconsistently, and that the resident was incontinent. The fall risk assessment did not address the resident's gait and balance [that section was blank] and the assessment did not provide a score or a means to quantify the resident's risk for falls.

The fall on 08/04/22 was unwitnessed and occurred in the resident's room.

A practitioner note dated 8/4/2022 and timed 1:00 AM documented, "...Encounter...
Date of Service: 08/04/2022 Visit Type: New Evaluation...This patient is a pleasant 88-year-old

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Caucasian male currently in the skilled nursing setting following a recent hospitalization...Nursing staff reports this patient has been having episodes of increased irritability and agitation and poor safety awareness. The patient's PCP recently started this patient on Depakote 125 mg twice daily dosing for improved mood stabilizing properties. The patient is also on Remeron 15 mg nightly for insomnia and depression. The patient appears to be tolerating these medications without any adverse side effects. When the patient is seen today he is noted to be lying down in bed and is in no obvious pain or discomfort. The patient is notably only oriented to person and somewhat to place... This provider assessed the patient's pain on a 0-10 pain scale and the patient reports a pain level of 0...The patient does report minimal anxiety and depressive symptoms due to being in the skilled nursing setting ...Care Plan Recommendations: Continue the medications at current dosages as the patient is stable at this dose and dose reduction would likely cause a deterioration of the patient's psychiatric illnesses/symptoms...Monitor patient for mood changes or behaviors: i.e. agitation/aggressiveness, irritability, sleep disturbances, appetite disturbances, significant change in energy level, paranoia, hallucinations, erratic behaviors, change in LOC, mood lability, anxiety, SI/HI, or potential side effects to current psychiatric medications. If any noted please notify TeamHealth..."

The resident's CCP was again reviewed. An intervention was added on 08/05/22, "...Keep resident in high traffic area for safety Created on: 08/05/22..."

On 08/06/2022 at 6:33 PM a skilled note

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documented, "...Observations...BP 133/76...bowel Status: incontinent...Pain: no...Non Pharmacological interventions provided: [blank] Pharmacological interventions provided: [blank]...Continues skilled nursing care due to intracerebral hemorrhage. A&O x 2...2 person assist with ADLs...Resident fell this evening. States he slipped out of the bed. No injuries noted. Will continue to monitor for any changes. Vitals are within normal limits."

A fall investigation dated 08/06/22 and timed 6:24 PM documented that the resident was on an antihypertensive, was alert and oriented, was not confused/disoriented, was calm, the fall occurred in the resident's room, he did call for help, call light was in reach and was wearing the proper footwear and contributing factors were listed as fatigue/weakness. There was no specific information regarding the circumstances of the fall or any interviews from staff. There was no information regarding the bed alarm, if it was in place and/or sounding.

The fall on 08/06/22 was unwitnessed and occurred in the resident's room.

On 08/07/22 2:19 PM, a progress note documented, "...health Status Note... Resident had a fall after lunch in his room. CNA [certified nursing assistant] found resident at the foot of the bed laying on his left side. Resident states he was trying to get up to go to the bathroom. After examining resident, he presented with right side hip pain that was radiating down his leg. Skin tear was noted to right elbow. Vitals were stable. Resident states he also hit his head. Notified weekend supervisor [also known as LPN #1] and stated nurse was sending him to [name of

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hospital] ER due to possible fracture. Notified DON. Unable to get MD on the phone. Call and let emergency contact know and they were going to meet resident at the hospital."

The fall on 08/07/22 that resulted in the resident sustaining a right hip fracture was unwitnessed and occurred in the resident room. There was no investigation completed on this fall. There was no documentation regarding the resident's bed alarm, whether it was in place and/or functioning. There were no interviews from staff regarding this fall.

Resident #111 had the fall with injury on 08/07/22. The resident was sent to the hospital and admitted and returned to the facility on 08/10/22.

The resident's hospital discharge summary dated 08/10/22 documented, "...primary discharge diagnosis: Acute intertrochanteric fracture of the proximal RIGHT femur, closed, presumed pathologic due to osteoporosis...confusion, presumed not new since stroke...chronic pancytopenia, likely myelodysplastic syndrome variant...He was admitted on 08/07/22 after a fall out of bed. He was found to have an acute right hip fracture...hospital list: fall, closed right hip fracture..."

On 09/07/22 at 3:50 PM, LPN#1 [also known as the weekend supervisor] was interviewed regarding Resident #111's fall on 08/07/22 [Sunday]. LPN #1 stated that she remembered the resident and that he would get up and try to self transfer and fell and broke his hip. The LPN stated he would attempt to self transfer and we (staff) continually reminded him not to get up and to use the call bell. The LPN stated that the

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resident was confused and that this was an unwitnessed fall. The LPN was asked if an investigation was done on this resident for this fall. The LPN stated, "As far as I know we did." The LPN then looked in the resident's record and stated that she did not see an investigation for that fall for Resident #111. No further information was provided by LPN #1.

On 09/08/22 at 8:48 AM, RN #3 [also known as the corporate nurse] presented information regarding Resident #111. The RN stated that they had an investigation for the resident's falls for 07/13/22, 08/04/22, and 08/06/22 and also did fall risk assessments [documented above], but they did not have an investigation for the unwitnessed falls on 07/30/22 or on 08/07/22 when the resident sustained a femur fracture. The RN stated that the resident was sent out to the hospital on those days.

The fall investigations and fall risk assessments were reviewed and RN #3 was made aware that the fall risk assessment did not score the resident for fall risks. The RN stated that she was aware of that and that they (facility) were working on a scoring system to better assess fall risk residents. The RN was made aware that the fall investigations were vague and did not provide any real details surrounding the resident's falls and did not have any staff interviews and/or statements that may provide additional information surrounding the falls. The RN was made aware of the serious concerns regarding the resident repeat falls and the resident's fall on 08/07/22, which resulted in harm.

On 09/08/22 09:06 AM, LPN (Licensed Practical Nurse) #7 was interviewed regarding Resident

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#111. LPN #7 stated that the resident used to be in room 228 and that she normally worked that area and worked with that resident. The LPN stated, "Since the resident first came to us, he was..., I wouldn't use the word non-compliant, but he was hard to get to do stuff, he didn't want to eat or drink, he'd raise the bed up and down and he was a big fall risk. We had to keep encouraging him to use the call bell, he would keep attempting to get up. We had an extended bed for him [he was tall] and he had a bed alarm...I think he had a bed alarm, he didn't have a chair alarm."

LPN #7 further stated, "When he came back from the hospital he was on hospice and they [hospice] ordered fall mats and had them delivered and we put them down, I remember because they were pink. I think he was in the chair some and we'd bring him out in the hall, but that was rare. He was a big sleeper and spent a lot of time in his room and in bed. For the most part while I was here he wanted to stay in the bed and sleep. The day he fell the last time [08/07/22], I did not hear an alarm that day, I'm not sure if it was on or not, but I had heard that in the past and remembered the sound it was really loud and annoying, but I didn't hear it that day. One of the girls working was a TNA (temp nurse aid) she is no longer working here and a CNA I don't recall her name. He (Resident #111) was my patient and I was doing med pass when that happened. Of course, it was an unwitnessed fall and from what I understand the CNA took the [lunch] tray in and left and then went to get his roommates tray and came back and he (Resident #111) was on the floor. He was not a big drinker and didn't eat much and we would have to encourage him."

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LPN #7 was asked who updates the care plans. The LPN stated that she thought it would be the unit managers or MDS, but she had not done that. The LPN stated that the Unit Manager was LPN #1 when the resident's last fall occurred, I believe it was a Saturday or Sunday and LPN #1 was the supervisor. LPN #7 stated that she went to the resident's room immediately, checked the resident out, checked his vitals, and stated, 'for me to even touch his leg he was screaming in pain.' LPN #7 stated that she went and got LPN #1 and they both went to the resident and both agreed that he needed to be sent out.

LPN #7 stated that the resident's wife was there just before the resident fell and stated that his wife did tell the TNA that he had attempted to get up before she left. LPN #7 stated that she did not hear the resident's wife say that, but that is what the TNA told her and reported to her after the fall occurred. LPN #7 stated that 911 was called and when EMS [emergency medical services] got here, he [resident] was in so much pain that they had to medicate him and stated that she believed they gave him IV [intravenous] fentanyl to get him on the gurney because he was in so much pain. LPN #7 stated, "He never did use the call bell to my knowledge." The LPN stated that she worked with him frequently and the resident seemed to decline pretty fast and the resident was typically quite most of the time. LPN #7 stated that she did not recall the resident being combative with care or anything like that. LPN #7 stated that was the first time he fell on her shift. LPN #7 stated, "I had a feeling that was going to happen with him anyways."

The facility's fall policy was presented, "Falls Management Program...considers all patients to

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be at risk for falls and provides and environment as safe as practicable...a fall risk assessment will be completed upon admission, readmission, quarterly, and significant change of condition...incorporate identified interventions into the Comprehensive care plan...discuss risks and interventions...do not move or reposition until a licensed nurse has completed a physical and mental assessment...assess, intervene, and promptly provide the necessary interventions for any patient experiencing a fall...notify physician, responsible party and EMS...post fall include neurological assessment if the fall was unwitnessed...complete post fall assessment to determine, to the extent possible the cause of a patient fall...Investigate the fall, and record findings surrounding the fall...A licensed nurse will review, revise and implement interventions to the care plan based on: post fall assessment findings, review device assessment, review of fall risk assessment...unit manager will review the incident report and any post fall follow up...each fall will be reviewed for causative factors utilizing the post fall assessment, device assessment and incident report...the unit manager verifies care plan revisions, patient monitoring, appropriate referrals..."

On 09/08/22 at 10:19 AM, the survey team met with the administrator, DON, and corporate nurse. The staff were made aware of serious concerns regarding repeated falls for this resident and specifically the fall 08/07/2, which resulted in fractured hip. The facility staff were made aware of the concerns regarding the lack of supervision and/or interventions for the prevention of falls for this resident, who had been identified as known as being at risk. The facility staff stated that they would look for any additional information.

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F 689	Continued From page 41 On 09/08/22 at approximately 11:10 AM, the DON, administrator and corporate nurse returned and stated that they had additional information. The DON stated that the discharge summary documented that the resident's fracture was pathological and that it could not be proven that this fall (the fall from the bed on 08/07/22) is what caused the resident's fracture. The DON was made aware that the discharge summary documented, that the resident had an Acute intertrochanteric fracture of the proximal RIGHT femur... presumed pathologic due to osteoporosis. The discharge summary also that the resident had a fall out of bed and was found to have an acute right hip fracture and was then admitted to the hospital. The DON was also made aware according to Resident #111's clinical records, Resident #111 did not have a previous diagnosis of osteoporosis or a current diagnosis of osteoporosis. The facility staff were made aware that through the complaint investigation and interviews, the resident was in severe pain after the fall that resulted in the hip fracture and that, according to interviews the resident was screaming out in pain when the nursing staff attempted to touch and assess the resident's leg. It was also reported that the EMS had to medicate the resident to be able to get the resident on the gurney due to the severity of the pain he was experiencing. The DON, administrator and corporate nurse were also made aware that the resident's care plan was not updated with new fall interventions and/or supervision and that there was no investigation completed by the facility of this unwitnessed fall.	F 689		

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The DON stated that they had interventions in place, but they weren't on the resident's care plan and they (staff) discussed the falls in their meetings and presented documentation to the survey team. The information documented, "...7/13/22 [name of resident] fall ? head injury resident to ED for evaluation/continue interventions.[no new interventions added]..08/4/22 [name of resident] fall skin tear on right shin area resident will be place in a highly trafficked area when up to assist with fall prevention [this intervention was added to the care plan]...08/06/22 [name of resident] fall none [injury] resident will be monitored for adverse effects of medications to assist with fall prevention [this intervention was added to the care plan on 08/08/22 after the fall with injury]...08/07/22 [name of resident] fall right hip pain resident sent to ER for evaluation..." No information was presented for the fall on 07/30/22.

The facility staff were made aware that these interventions were the same interventions already in place and that the only new intervention for actual fall prevention was putting the resident in a high traffic area which was implemented on 08/05/22. The facility staff were also made aware that the all of the resident's falls occurred in the resident's room (not in a high traffic area) and all of the resident's falls were in unwitnessed.

No further information and/or documentation was presented prior to the exit conference on 09/08/22 at 11:45 AM to evidence that adequate supervision and/or interventions were implemented for Resident #111 for the prevention of falls, which subsequently resulted in injury. Resident #111 had a total of five falls between

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07/06/22 and 08/07/22. The resident sustained a right hip fracture as result of the last fall on 08/07/22 (the resident's last fall).

This is a complaint deficiency.

2. Resident #71 was admitted to the facility with the following diagnoses, including but not limited to: Left femur fracture, dementia, protein-calorie malnutrition, and hypertension.

A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 08/04/2022 assessed Resident #71 as having problems with both long and short term memory, as well as severely impaired with daily decision making skills.

On 09/06/2022 at approximately 12:30 p.m., the lunch time meal was observed, Resident #71 was sitting up in her wheelchair, her lunch tray was on a table in front of her. She was attempting to feed herself. Her napkin was crumpled in the middle of her plate, her cold drink was spilled onto the tray, the plate, the table, her clothes, and the floor. She was asked if she needed any help. She stated, "I spilled it."

A nurse in the hallway was asked to come to the room. She spoke with Resident #71 and went to get her another tray and drink.

On 09/07/2022 at approximately 8:30 a.m., Resident #71 was observed sitting in her bed. Her breakfast was on the bedside table in front of her. The front of her gown was wet. She had her coffee cup in her hand and was attempting to get it to her mouth. The coffee spilled down the front

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of her gown. CNA (certified nursing assistant) #1 was in the adjacent room. She was called to Resident #71's bedside and told about the spilled coffee. She removed the cup from Resident #71's hand. She was asked if the coffee cup was hot to touch, she nodded her head. She was asked if Resident #71 was hurt. She left the room and spoke with RN (registered nurse) #1. RN #1 came to the room. She and CNA #1 removed Resident #71's gown. Her chest was not red and she denied pain.

The MDS (ARD 08/04/2022) was reviewed at approximately 8:45 a.m. Under section G, "Functional Status", Resident #71 was assessed as a 1/2 for eating, meaning "Supervision-oversight, encouragement, or cueing/One person physical assist". The care plan was reviewed. The Focus area "ADL (activities of daily living)..." contained the following intervention regarding eating: "(Resident name) is able to feed herself after set up. she needs encouragement to complete meals."

CNA #1 was interviewed at approximately 9:00 a.m. regarding Resident #71. CNA #1 stated that Resident #71's dementia had gotten worse over the last couple of weeks. She stated, "She's been spilling more, her hand motions are more jerky." She was asked if the facility had cups with lids. She stated, "The lids we have right now don't really fit the cups." She was asked if the facility had cups with spouts to prevent spills She spoke with LPN (licensed practical nurse) #5 who stated, "We have those cups, we'll get her one to use....(Name of Resident #71) just came out of isolation for COVID, before that she was up and around the unit. She hasn't gotten her strength back...she also needs to be up in the chair when

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F 689	Continued From page 45 she's eating not sitting up in the bed, that will help...I will update the care plan." During the lunchtime meal on 09/07/2022 Resident #71 was observed with a plastic cup, with handles on each side, and a spout on the lid. There were no spills observed. The above information was discussed during an end of the day meeting on 09/07/2022. The administrative team was asked if there was an assessment done regarding hot liquid safety. The corporate nurse consultant stated, "The company has one, but I don't know if it has been implemented here. I will look." On 09/08/2022 a hot liquid assessment for Resident #71 was presented. It was dated 06/14/2022. The resident was not assessed as being at risk for drinking hot liquids. The corporate nurse consultant was asked if there was a policy on when the hot liquid assessment should be done. During a meeting on 09/08/2022 at approximately 10:30 a.m., the corporate nurse consultant stated that there was no policy regarding the hot liquid assessment, but it should be done quarterly, annually, and if there was a change. No further information was obtained prior to the exit conference on 09/08/2022.	F 689		
F 756	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		10/11/22

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F 756	Continued From page 46 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to respond to a pharmacy recommendation for one of twenty-five residents in the survey sample.	F 756	F756 Med Recs 1. Resident #57 remains on Bactrim as a prophylaxis and the Azithromycin has been discontinued.	

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F 756	Continued From page 47 Resident #57's recommendation regarding continued use of antibiotics had no physician response. The findings include: Resident #57 was admitted to the facility with diagnoses that included prostate cancer, anemia, protein-calorie malnutrition, emphysema, heart failure, COPD (chronic obstructive pulmonary disease), depression, anxiety, obstructive uropathy, bladder cancer and chronic pain. The minimum data set (MDS) dated 7/28/22 assessed Resident #57 as cognitively intact. Resident #57's clinical record documented a pharmacy recommendation dated 6/29/22 documenting the following, "This resident is on this Azithromycin and Bactrim DS since 6/20/22 without stop date. Prolonged use of antimicrobial agents can result in superinfection. Please indicate below the duration of therapy or reasons for continual usage..." The response section on the form was blank with no response from the physician indicating a discontinue date or reason to continue the medications. The clinical record documented no response to the recommendation. On 9/7/22 at 2:07 p.m., the director of nursing (DON) was interviewed about a response to the pharmacy recommendation. After reviewing the clinical record, the DON stated she found no response to the recommendation. The DON stated she received recommendations from the pharmacist monthly and sent them to the physicians for a response. The DON stated when physician response was received, she made sure	F 756	2. Current Resident have the potential to be affected. An audit of recommendation from the last 30 days was performed and recommendation acted upon as ordered. 3. The Regional Director of Clinical Services/designee will educate the DON on the Drug Regimen Review process. 4. The DON/designee will audit pharmacy recommendations weekly to ensure recommendations are followed per physician orders. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis 6. Date of Compliance 10/11/22	

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F 756	Continued From page 48 any orders were implemented. Regarding Resident #57's recommendation of 6/29/22, the DON stated the response "just got overlooked." The facility's policy titled Medication Regimen Review (effective 8/2020) documented,"...Resident-specific irregularities and/or clinically significant risks resulting from or associated with medication are documented in the resident's active record and reported to the Director of Nursing, Medical Director, and/or prescriber as appropriate...Recommendations are acted upon and documented by the facility staff and/or the prescriber...The prescriber accepts and acts upon recommendation or rejects provides an explanation for disagreeing..." This finding was reviewed with the administrator, director of nursing and regional director of clinical services during a meeting on 9/7/22 at 4:00 p.m.	F 756		
F 812	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		10/11/22

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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 812	Continued From page 49 §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, staff interview and facility document review, the facility staff failed to serve food in a sanitary manner. Hot food items were served from the steam table on unit 3 below the safe/recommended temperature of 135 degrees (F). Dietary staff entered the unit 3 kitchen during meal service without washing hands. A maintenance employee entered the unit 3 kitchen during food service without a hairnet. The findings include: On 9/6/22 at 12:16 p.m., lunch service from the unit 3 kitchen was observed. The dietary aide (other staff #2) placed trays of hot food on the steam table from a hot box. The dietary aide then left the kitchen stating he had to get a pen to record the food temperatures. The dietary aide returned a few minutes later, entered the kitchen and without prior hand hygiene, put on gloves. The food temperatures of items on the steam table measured by the dietary aide were as follows (in degrees F). shrimp stir-fry - 153 Salisbury steak - 155 steamed rice - 173 broccoli - 171 mixed vegetables - 137 mashed potatoes - 138 shredded/chopped shrimp - 105 pureed vegetable - 126 pasta noodles - 132	F 812	F 812 Food Store/ Prepare/Serve Sanitary 1. The Dietary Staff member was educated during survey on hand washing and safe temperature for serving food items. The maintenance employee was educated during survey about the use of hair net while in the kitchen or kitchenette. 2. Current residents have the potential to be affected. 3. The Dietary Manager/designee will educate the dietary staff on proper hand hygiene during meal service and the safe temperatures for food distribution to a resident and what action should be taken if not in appropriate temperature range. 4. The Administrator or designee will audit three times weekly the food temperatures to ensure they meet the safe serve requirements. The Administrator will perform random audits to ensure hair nets are worn by those in the kitchen and appropriate hand hygiene is being performed during the meal service. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis 6. Date of Compliance 10/11/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495420	A. BUILDING _____ B. WING _____	C 09/08/2022

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F 812	Continued From page 50	F 812		

The dietary aide proceeded to plate and serve food items from the steam table to residents in the dining room and the remaining residents on unit 3 that ate lunch in their rooms. This included the shredded/chopped shrimp, pureed vegetable and pasta that was less than 135 degrees (F). The food items that were below 135 degrees (shredded/chopped shrimp, pureed vegetable, pasta) were not removed from the steam table or reheated prior to serving.

On 9/6/22 at 12:30 p.m., a maintenance employee entered the unit 3 kitchen while food was served from the steam table. The maintenance employee had no hair net and performed no hand hygiene upon entrance to the kitchen. The maintenance employee had a hand-held device pointing it at kitchen equipment. The maintenance employee touched the top of the steam table surface with his bare hand, opened the ice machine and opened the refrigerator, pointing the device. The maintenance employee then left the kitchen.

On 9/6/22 at 12:35 p.m., a facility employee entered the unit 3 kitchen. Without prior hand hygiene, this employee opened the refrigerator, retrieved a plated salad and then left the kitchen.

On 9/6/22 at 12:43 p.m., another dietary aide brought an additional pan of shredded/chopped shrimp and placed it on the steam table. The dietary manager (other staff #1) entered the kitchen at this time and checked the temperature of the additional shredded/chopped shrimp at 130 degrees. This container of shredded/chopped shrimp remained on the steam table and was not reheated.

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F 812	Continued From page 51	F 812		

On 9/6/22 at 12:45 p.m., the dietary manager (other staff #1) and dietary aide (other staff #2) were interviewed about food temperature requirements on the steam table. The dietary manager stated foods were supposed to be 140 degrees or higher when served from the steam table. The dietary manager stated foods under 140 degrees were to be returned to the kitchen and reheated prior to service. The dietary aide stated he thought the steam table would heat the food back up to temperature. The dietary manager stated any staff entering the kitchen should have on a hairnet and hands washed prior to touching any kitchen equipment or food items. The dietary manager stated the dietary aide should have washed his hands prior to putting on gloves after returning to the kitchen.

The facility's policy titled Food: Preparation (October 2019) documented, "It is the center policy that all foods are prepared in accordance with the guidelines of the FDA Food Code...The Dining Services Director insures that all staff practice proper hand washing technique and practice proper glove use...The Dining Services Director or Cook(s) are responsible for food preparation techniques, which minimize the amount of time, that food items are exposed to temperatures greater than 41 [degrees F] and/or less than 135 [degrees F]...The Cook(s) insures that all foods are held at appropriate temperatures, greater than 135 [degrees F]...for hot holding..." The Service Line Check List (undated) used to record food temperatures documented, "...Holding temperature guidelines (F)...hot food > [greater than or equal to] 135 [degrees]..." This form stated reheated foods should reach 165 degrees F for 15 seconds prior

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F 812	Continued From page 52 to service. The facility policy titled Staff Attire (October 2019) documented, "...The Dining Services Director insures that all staff members have their hair off the shoulders, confined in a hair net or cap..." These findings were reviewed with the administrator, director of nursing and regional director of clinical services during a meeting on 9/7/22 at 4:00 p.m.	F 812		