STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING _____ B. WING _____	C 02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 2/26/2023 through 2/28/2023.** 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 2/26/2023 through 2/28/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 112 certified bed facility was 91 at the time of the survey. The survey sample consisted of 23 current resident reviews and 6 closed record reviews. Six complaints were investigated during the survey and are as follows: VA00057609 allegations were unsubstantiated without deficiencies cited. VA00055866 allegations were unsubstantiated without deficencies cited. VA00056056 allegations were unsubstantiated without deficencies cited. VA00056470 allegations were substantiated with deficencies cited. VA00056186 allegations were substantiated with deficencies cited. VA00054978 allegations were substantiated with	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: EXECUTIVE DIRECTOR | (X6) DATE: 4/6/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	**Continued From page 1**	F 000		
	deficencies cited.			
F 554 SS=D	**Resident Self-Admin Meds-Clinically Approp CFR(s):** 483.10(c)(7)	F 554	(F554) Resident Self-Admin Meds, Clinically Appropriate	4/11/2023
	§483.10(c)(7) **The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:** **Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to assess two of twenty-nine residents in the survey sample for self-administration of medications (Residents #20 and #293).** **The findings include:** **1. Resident #20 had prescription Flonase (fluticasone propionate) nasal spray at the bedside and self-administered the spray with no prior assessment of the resident's ability to safely administer the medication.** **Resident #20 was admitted to the facility with diagnoses that included hypothyroidism, duodenal ulcer, restless leg syndrome, depression, anxiety, seasonal allergic rhinitis, anemia, and gastroesophageal reflux disease. The minimum data set (MDS) dated 12/22/22 assessed Resident #20 as cognitively intact.** **On 2/26/23 at** 3:40 **p.m., a box containing a bottle of Flonase** 50 **mcg (micrograms) nasal spray was on top of the resident's bedside table. With the resident's permission, the Flonase was inspected. The Flonase was labeled from the pharmacy with**		1. Resident #293 no longer resides in facility. Resident #20 Flonase was immediately removed from resident's room. 2. The Director of Nursing (DON)/designee completed a med pass observation to ensure residents aren't self-administering medications without an assessment. Follow up was completed based on findings. 3. DON/designee re-educated the licensed nursing staff on the facility's Self-Administration of Medication at Bedside policy. 4. DON/ Designee to conduct quality improvement (QI) monitoring of F554 to ensure residents are not self-administering medications without an assessment. QI monitoring conducted via random medication pass observations weekly x4 weeks. Findings to be reported to the Quality Assessment Performance Improvement (QAPI) committee and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Completion: April 11, 2023	

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F 554	Continued From page 2 Resident's #20's name and issue date of 10/29/22. Resident #20 was interviewed at this time about the Flonase. Resident #20 stated she did not use the spray at each bedtime as listed on the label. Resident #20 stated, " I use it when I need it. I use it myself." Resident #20 stated she kept the spray on the bedside table so she could reach it when needed. Resident #20's clinical record documented no current physician's order for Flonase 50 mcg nasal spray. There was no physician's order for the resident to self-administer any medication. The clinical record documented no resident assessment by the interdisciplinary team of the resident's ability to safely self-administer the medication. The resident's plan of care (revised 12/21/22) included no problems, goals and/or interventions regarding self-administration of medications. On 2/27/23 at 4:45 p.m., registered nurse (RN #4) caring for Resident #20 was interviewed about the Flonase at the bedside. RN #4 reviewed the physician orders and stated there was no current order for the medication. RN #4 stated, "She [Resident #20] used to have an order for it [Flonase]." RN #4 stated that she did not know if the resident had been assessed to self-administer. On 2/27/23 at 4:55 p.m., the licensed practical nurse unit manager (LPN #5) was interviewed about Resident #20's bedside Flonase. LPN #5 stated she was not aware the resident had medication in the room. Accompanied by LPN #5, Resident #20's Flonase was observed on the resident's bedside table. LPN #5 stated the medication was labeled from their pharmacy.	F 554		

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F 554	Continued From page 3 LPN #5 stated the resident had no current order for the medication and there was no documented assessment for the resident to self-administer the medication. LPN #5 stated residents were supposed to be assessed by the interdisciplinary team and the self-administration deemed safe/appropriate prior to placing the medicine at the bedside. On 2/28/23 at 1:40 p.m., the director of nursing (DON) was interviewed about Resident #20's bedside Flonase. The DON stated the medication should not have been at the bedside until after the interdisciplinary team assessed the resident. The DON stated if approved, a physician's order would be obtained and the care plan updated. The facility's policy titled Self-Administration of Medication at Bedside (revised 8/22/17) documented, "The resident may request to keep medications at bedside for self-administration in accordance with Resident Rights. Criteria must be met to determine if a resident is both mentally and physically capable of self-administering medication and to keep accurate documentation of these actions...Verify physician's order in the resident's chart for self-administration...Complete Self-Administration of Medications Evaluation...Interdisciplinary Team will review the evaluation...Complete the Care Plan for approved self-administered drugs...The MAR [medication administration record] must identify meds [medications] that are self-administered..." This finding was reviewed with the administrator, director of nursing and regional nurse consultants on 2/27/23 at 5:30 p.m.	F 554		

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F 554	Continued From page 4 2. The facility staff failed to ensure Resident #293 was assessed for self administration of medications. LPN (Licensed Practical Nurse) #1 allowed Resident #293 to self administer insulin to herself without an assessment and/or a physician's order to do so. Findings include: Resident #293 was admitted to the facility on 07/22/22 and discharged from the facility on 08/29/22. Diagnoses for Resident #293 included, but were not limited to: CHF (congestive heart failure), high blood pressure, renal insufficiency, DM (diabetes mellitus), seizure disorder, anxiety disorder, depression, acute osteomyelitis of the left foot with toe amputation, and chronic pain syndrome. Resident #293's most recent MDS (minimum data set) was an admission assessment dated 07/28/22. This MDS assessed the resident with a cognitive score of 13, indicating the resident was intact for daily decision making skills. Resident #293 was also assessed as requiring extensive assistance of at least one or two staff members for mobility, toileting, and bathing. This MDS assessed that Resident #293 had received insulin injections in the previous 6 (six) day look back period. A closed record review was conducted on Resident #293. The resident's progress notes were reviewed from admission to discharge. A nursing progress note dated 07/24/22 and timed 11:23 AM documented, "...states her medications are not right and correct them...signature of LPN (Licensed Practical	F 554		

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F 554	Continued From page 5 Nurse) #1." A nursing note dated 07/24/22 and timed 12:57 PM documented, "...resident said all of her meds were not right told her that I would put her in the book and she could talk to the Dr. in the morning instead of 5 units before meals she [resident #293] states that is wrong it is supposed to be 35 units this writer is not comfortable and she [resident #293] gave her self (sic) the insulin...signature of LPN #1." No other progress notes were written for Resident #293 on 07/24/22 after the above note at 12:57 PM. Resident #293's physician orders were reviewed and documented an order for, but not limited to: "...Insulin Lispro Subcutaneous Pen Injector 200 unit/ml (units/milliliter) Inject 5 [five] units before meals for dm [diabetes mellitus] (Start date: 07/23/22)..." Resident #293's July 2022 MARs (medication administration records) were reviewed. The MARs documented the above Lispro pen injector insulin order of 5 units before meals and had times of administration at 6:30 AM, 11:30 AM, and 4:30 PM. In the 11:30 AM slot on 07/24/22, LPN #1 documented initials along with the number '9' (9=Other/See Nurse Notes). In the 4:30 PM slot on 07/24/22, LPN #1 documented initials and the number '9' again (9=Other/See Nurse Notes). There was no nursing note associated with this entry. Resident #293's clinical records were reviewed for an assessment of Resident #293's ability to self administer medications. No assessment was	F 554		

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F 554	Continued From page 6 found. The physician's orders were again reviewed. There were no physician's orders for the resident to self administer any type of medications. On 02/27/23 at approximately 2:30 PM, the DON (director of nursing) was asked for assistance in locating a self administration of medication assessment for Resident #293. At approximately 3:45 PM, the DON stated that there was no assessment found for Resident #293. On 02/27/23 at approximately 4:15 PM, the DON, administrator, AIT (administrator in training), and corporate nurses were made aware of the above information in a meeting with the survey team. The DON was asked if the physician should have been called and the medicine held until there was clarification from the physician, the facility staff agreed. The DON was asked if insulin is a usual medication for a resident to self administer at the facility, the DON stated that it was not. A physician's progress note dated 07/25/22 (the day after the resident administered her own insulin) documented, "...Today she was complaining that her medication list is not accurate...not on the correct dose...Type 2 diabetes mellitus with hyperglycemia reviewed her medications and adjusted her insulin dosing..." The physician's orders were again reviewed and revealed an insulin order for: "...07/25/22 order date...07/26/22 start date: Insulin Lispro	F 554		

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F 554	Continued From page 7 **injection...inject** 35 **units...two times a day...before breakfast and lunch AND inject** 40 **units...in evening...at dinner..."** **On** 02/27/23 **at approximately 3:15 PM, the DON, administrator, AIT (administrator in training), and corporate nurse were made aware of concerns that Resident #293 administered her own insulin without an assessment and/or a physician's order.** **No further information and/or documentation was presented prior to the exit conference on 02/28/23.**	F 554		
F 580 SS=D	**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 §483.15(c)(1)(ii).**	F 580	(F580) Notify of Changes (Injury/Decline/Room, Etc.) 1. Resident #289 no longer resides on our facility. 2. The Social Service Director (SSD)/ Designee completed a quality review of discharges in the last two weeks to ensure the responsible party (RP) notification was done prior to discharge. Follow up was completed based on findings. 3. The Executive Director (ED)/ Designee reeducated the Social Services staff on notifying the RP prior to resident discharges. 4. ED/Designee to conduct QI monitoring of F580 to ensure the RP is notified of resident discharge. QI monitoring conducted via medical records review twice weekly x2 weeks and then weekly x4 weeks. Findings to be reported to the QAPI committee and updated as indicated.	4/11/2023

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F 580	Continued From page 8 (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 staff interview and clinical record review, the facility staff failed to notify the responsible party (RP) for one of 29 residents (Resident #289). This was a closed record review. The findings include: Resident #289's RP was not notified of Resident #289's discharge.	F 580	Quality monitoring schedule modified based on findings. 5. Date of Completion: April 11, 2023	

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F 580	Continued From page 9 Diagnoses for Resident #289 included: Alzheimer's, edema, dementia, depression, and delirium. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/15/22. Resident #289 was assessed with a cognitive score of 6 indicating severely cognitively impaired. On 2/28/23, a review of Resident #289's clinical revealed (via the current MDS) that Resident #289 was discharged to another facility. Review of the nursing progress notes did not evidence a note had been written indicating the discharge or any notification to the RP that a discharge was taking place. On 2/28/23 at 10:15 AM, the regional nurse consultant (Administrative Staff, AS #4) was asked to review Resident #289's clinical record for RP notification of discharge and any other information regarding Resident #289's discharge. AS #4 said she would check with medical records to see what could be found. On 2/28/23 at 10:25 AM, the social worker (other staff, OS #1) was interviewed. OS #1 said that she helped with the planning of resident discharges and helped prepare resident's for discharge. OS #1 was asked to review Resident #289's clinical record for discharge notification to Resident #289's RP. On 2/28/23 at 11:55 AM, the medical record person (other staff, OS #10) verbalized that there was no documentation found regarding notification to the RP of Resident #289's discharge.	F 580		

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F 580	Continued From page 10 On 2/28/23 at 3:10 PM, OS #1 showed documentation of Resident #289's discharge instruction form (verbalizing her assistant had filled the form out) and went on to say that she (OS #1) felt that she had notified the RP but could not find any documentation regarding notification of discharge to the RP. On 2/28/23 at 3:15 PM, the above information was presented to the administrator and director of nursing. No other information was presented prior to exit on 2/28/23.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii)The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584	(F584) Failed to ensure clean and homelike environment 1. Resident #2 no longer resides in the facility. 2. ED, AIT, Maintenance and Housekeeping Supervisor completed room resident room rounds to ensure cleanliness and ensure furniture in good working condition. Follow up was completed based on findings. 3. The Administrator in training (AIT)/ Designee reeducated the housekeeping and maintenance staff on the importance of ensuring that resident rooms are clean and tidy, creating a homelike environment. 4. The ED/ designee to conduct QI monitoring of F584 to ensure a clean and homelike environment. QI monitoring conducted via observations of 5 random resident rooms twice weekly x2 weeks and then weekly x4 weeks. Findings to be reported to the QAPI committee and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Completion: April 11, 2023	4/11/2023

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F 584	Continued From page 11 **services necessary to maintain a sanitary, orderly, and comfortable interior;** §483.10(i)(3) **Clean bed and bath linens that are in good condition;** §483.10(i)(4) **Private closet space in each resident room, as specified in** §483.90 **(e)(2)(iv);** **§483.10(i)(5) Adequate and comfortable lighting levels in all areas;** **§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of** 71 **to 81°F; and** §483.10(i)(7) **For the maintenance of comfortable sound levels.** **This REQUIREMENT is not met as evidenced by:** **Based on observation, family interview, staff interview, and clinical record review, the facility staff failed to provide a clean, homelike environment for one of twenty-nine residents in the survey sample (Resident #2).** **The findings include:** **Resident #2's room was observed with food, spills, and trash on the floor, as well as a broken bedside table.** **Resident #2 was admitted to the facility with diagnoses that included cerebral infarction, hernia, congestive heart failure, protein-calorie malnutrition, atherosclerotic heart disease, and hypothyroidism. The minimum data set (MDS) dated 2/8/23 assessed Resident#2 as cognitively**	F 584		

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F 584	Continued From page 12 intact. On 2/27/23 at 7:56 a.m., Resident #2 was observed in bed with her eyes closed. There were two pieces of partially eaten bread and an empty medicine cup laying on the floor between the bed and the heating unit. There was a medication caplet on the floor to the right of the heating unit. There were multiple spills on the floor beside the Resident #2's bed and under the over-bed table. The over-bed table had liquid spills on the surface. Several pieces of paper trash were in the floor around the bed. The bedside table near the center of the room was in disrepair. The door on the lower portion of the table was hanging open at an angle. The door would not latch when attempts were made to close the door. The hand sanitizer dispenser on the wall near the room entrance was empty. Resident #2's room was observed again on 2/27/23 at 9:30 a.m. and on 11:30 a.m. in the same condition with trash, spills, debris, and food items on the floor/in the room. On 2/27/23 at 10:21 a.m., Resident #2's family member was interviewed about the resident's quality care/life in the facility. The family member stated that she visited the resident frequently and was concerned about the housekeeping and room appearance during visits. The family member stated she frequently found sticky substances on the over-bed table, in addition to spills and trash on the floor during visits. The family member stated that housekeeping "needs improvement" and she was not happy with the cleanliness of Resident #2's room. On 2/28/23 at 8:15 a.m., the housekeeping supervisor (other staff #9) was interviewed about	F 584		

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F 584	Continued From page 13 the condition of Resident #2's room. OS #9 stated that there was one housekeeper assigned to each unit and rooms were supposed to be cleaned daily and as needed. OS #9 stated that housekeepers worked only during the day shift and were supposed to "do rounds" on their unit each shift and prioritize cleaning. OS #9 stated that Resident #2's room was probably not cleaned until the afternoon (2/27/23) and food/spills should not have been left on the floor. OS #9 stated that spilled liquids and food items should be cleaned promptly following meals. OS #9 stated that the broken bedside table should have been reported to maintenance for repair. This finding was reviewed with the administrator, director of nursing and regional nurse consultants on 2/27/23 at 5:30 p.m.	F 584		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure One of 29 residents was free from misappropriation of property, Resident #57. Resident #57's medication was "borrowed" by a staff member to be administered to another	F 602	(F602) Free from Misappropriation/Exploitation 1. Resident #294 suffered no apparent harm. Registered Nurse (RN) #3 and Licensed Practical Nurse (LPN) #3 were suspended immediately pending investigation 2. The DON/designee conducted a facility narcotic count and narcotic sign out sheet review. No further issues noted. 3. The DON/ designee reeducated the licensed nurses on the policy and procedures for medication administration and the 5 rights of medication administration.	4/11/2023

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F 602	Continued From page 14 resident. Findings were: A medication pass and pour observation was conducted with RN (registered nurse) #3 at approximately 8:45 a.m.. RN #3 was observed preparing and administering medications to Resident # 294. At the conclusion of the medication pass, the medicines were reconciled against the physician orders. Resident #294 had four medications scheduled for the 9:00 a.m. medication pass that were not observed as given, but were each signed off on the MAR (medication administration record) as administered. The four medications were: Gabapentin 100 mg, Ferrous Sulfate 325 mg, Acidophilus Capsule, and Bacid. RN #3 was interviewed at approximately 10:30 a.m., regarding the described omitted medications for Resident #294. RN #3 stated, "I had her [Resident #294] confused with someone else, I will get them." At 10:45 a.m., RN #3 came to the conference room and stated that she was ready to give the omitted meds to Resident #294. Observed on the medication cart was a med cup with three pills. RN#3 stated, "That resident [#294] does not have any Gabapentin here...I had to borrow it from another resident...I had to do the same thing yesterday...I had to sign them both out today....I wanted to take more for later but [name of LPN #3] said no, that is too much to waste." When asked what she meant when she said she "borrowed" it, RN#3 stated, "If there is another resident on the same medication, we can borrow	F 602	4. The DON/ designee to conduct QI monitoring of F602 to ensure residents are free of misappropriation of property. QI monitoring conducted via random medication pass observations three times weekly x2 weeks, twice weekly x2 weeks and then weekly x2 weeks. Findings to be reported to the QAPI committee and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Completion: April 11, 2023	

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F 602	Continued From page 15 it...another nurse signs it off with me as wasted." When asked if that was within the facility policy, RN#3 stated, "Yes." At approximately 1050 a.m., the med cart where Gabapentin was borrowed from was observed. LPN #3 was interviewed about the Gabapentin that was borrowed by RN #3. The narcotic sheet belonging to Resident #57 was observed. Per the narcotic sheet 30, 100 mg tablets of Gabapentin were received at the facility on 02/17/2023, with orders to administer 1 cap three times per day. The first dose from that sheet was administered on 02/23/2023 at 3:00 p.m. All doses were listed in date range order including the dose for 8:00 a.m., on 02/27/2023. Two doses were signed out after that by RN #3 with the dates of administration being 02/25/2023 and 02/26/2023. Two more doses were signed out and marked through as errors. The Gabapentin count remaining on the card was correct at "16". LPN #3 was asked who had counted the narcotics the previous evening and at change of shift, as well as whether the count was correct. LPN #3 stated that she had done the counts and they were correct. When asked how the count was correct if RN #3 had "borrowed" a Gabapentin the day before and not signed it out until that morning, LPN #3 stated, "My count was right...I'm going to be honest, she took both of them today and wanted to take more, but I told her no." When asked where the second Gabapentin obtained that morning was, LPN #3 stated, "I don't know." When asked if nurses normally "share meds/borrow meds" between residents, LPN#3 stated, "No, we are supposed to call the pharmacy and get them from [Name of dispensary]." The DON came to the unit at that	F 602		

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F 602	Continued From page 16 time and stated that she was looking in to this, as RN #3 had come to her and told her about borrowing of the meds. When asked if it was within facility policy to "borrow" medications from another resident, the DON stated, "No, and I told her that. I told her she has to get the medications from the pharmacy." Resident #294's MAR (medication administration record) was reviewed at 11:15 a.m. RN #3 had documented that she had given Resident #294 her Gabapentin at 9:00 a.m. and 5:00 p.m. on 02/25/2023 and 02/26/2023. RN #3 was interviewed and asked if she had given the medication on those days and at those times. She stated, "I don't know if I gave it or not, I am getting her and another resident confused." When asked about the second Gabapentin she "borrowed" from Resident #57 earlier in the day, RN#3 pulled open the top drawer of the med cart. A medication cup was observed with a pill inside. RN#3 stated, "This is for later...I was going to take more but [name of LPN #3] said no, she couldn't let me have that much." When asked about her earlier statement that she had borrowed Gabapentin the previous evening, RN#3 was asked who she had borrowed it from. RN #3 stated, "I don't remember what I did, I don't think I gave it to her, I 'm getting them all mixed up." The DON came to the conference room at 1230 and stated, "I found the extra Gabapentin on the cart...I am throwing it away...We are going to count all the med carts now." While counting the medication cart on Unit 4 (where Resident #57's medications were kept), LPN #3 was asked about the practice of "borrowing" medications and how often it was done. LPN #3 stated, "Not very	F 602		

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F 602	Continued From page 17 often...we are supposed to go through the pharmacy...She [RN #3] was in such a dither about the Gabapentin...she kept saying she needed it right now...I just gave it to her and signed with her that it was wasted." All narcotics were counted with no errors noted. During the count each narcotic sheet was observed. There were no entries on the narcotic sheets (other than Resident #57) that medications had been "wasted". Per the facility policy, "Medication-oral Administration...medications ordered for a particular resident may not be administered to another resident, unless permitted by State law and facility policy, and approved by the Director of Nursing..." Also, per the facility policy "Abuse, neglect, Exploitation & Misappropriation...Misappropriation of resident properly is the deliberate misplacement, exploitation, or wrongful, temporary, permanent use of a resident's belongings or money without the resident's consent. Employee Mispronunciation includes but is not limited to: ...Diversion of resident's medication(s), including, but not limited to, controlled substances for staff use or personal gain..." The above information was discussed during an end of the day meeting on 02/27/2023 with the DON and the administrator. No further information was obtained prior to the exit conference on 02/28/2023.	F 602		
F 635 SS=E	Admission Physician Orders for Immediate Care	F 635		

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F 635	**Continued From page 18** **18 CFR(s):** 483.20(a) §483.20(a) **Admission orders** **At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.** **This REQUIREMENT is not met as evidenced by:** **Based on clinical record review and staff interview, the facility staff failed to ensure immediate care orders upon admission for Resident #293 regarding diet.** **Findings include:** **Resident #293 was admitted to the facility on 07/22/22 and discharged from the facility on 08/29/22. Diagnoses for Resident #293 included, but were not limited to: CHF (congestive heart failure), high blood pressure, renal insufficiency, DM (diabetes mellitus), seizure disorder, anxiety disorder, depression, acute osteomyelitis of the left foot with toe amputation, and chronic pain syndrome.** **Resident #293's most recent MDS (minimum data set) was an admission assessment dated 07/28/22. This MDS assessed Resident #293 with a cognitive score of 13, indicating the resident was intact for daily decision making skills. Resident #293 was also assessed as requiring extensive assistance of at least one or two staff members for mobility, toileting, and bathing. Resident #293triggered in the CAAS (care area assessment summary) section of this MDS for care planning of nutrition.** **A physician's progress note dated 07/25/22**	F 635	(F635) Admission Physician Orders for Immediate Care 1. Resident #293 no longer resides in the facility. 2. The Registered Dietitian (RD)/ designee conducted a review to ensure that residents currently residing in the facility have a diet order. Follow up completed based on findings. 3. The DON/designee reeducated licensed nurses that admission orders should include a diet. Follow up completed based on findings. 4. The DON/designee to conduct QI monitoring of F635 to ensure immediate care orders upon admission include a diet. QI monitoring conducted via random medical records review of new resident admissions twice weekly x3 weeks and then weekly x3 weeks. Findings to be reported to the QAPI committee and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Completion: April 11, 2023	4/11/2023

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F 635	Continued From page 19 documented, "...Allergy list: ...tomato products...clams..." Resident #293's physician's orders were reviewed from admission to discharge. There were no diet orders found for Resident #293. Resident #293's care plan was reviewed. The care plan documented, "...dietary consult as needed...Provide, serve diet as ordered...RD to evaluate and make diet change recommendations..." On 02/27/23 at approximately 4:15 PM, the DON, administrator, AIT (administrator in training), and corporate nurse were made aware of the above information in a meeting with the survey team. No further information and/or documentation was presented prior to the exit conference on 02/28/23 to evidence that Resident #293 had a physician ordered diet.	F 635		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure professional standards of nursing were followed during medication administration on one of three	F 658	(F658) Professional Standards: CP Standard of Practice in Med Pass 1. Residents #297, #40 and #293 no longer reside in the facility. Resident #294 suffered no apparent harm. Registered Nurse (RN) #3 and Licensed Practical Nurse (LPN) #3 were suspended immediately pending investigation 2. The DON/designee conducted a med pass observation to ensure professional standards of nursing were followed. Follow up completed based on findings.	4/11/2023

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F 658	Continued From page 20 units (Unit 2) and one of 29 residents, Resident #293. Findings were: 1. A medication pass and pour observation was conducted with RN (registered nurse) #3 at approximately 8:45 a.m.. RN #3 was observed preparing medications for three residents, Resident # 294, Resident #397, and Resident #40. RN #3 prepared medications for Resident #294. RN#3 obtained a Lovenox injection from the cart, a lidocaine patch, and a 12.5 mg tablet of Carvedilol 12.5 mg. When the medications were given to the resident, Resident #294 stated, "Only one pill today?" RN #3 responded, "Yes, that is the pill for your heart." Medications for Resident #297 were prepared and included Farxiga, Aspirin, Magnesium Oxide, Atorvastatin, Fluoxetene, Glimepiride, Vitamin D, Ferrous Sulfate, Metformin, and Pantroprazole. While in the room with Resident #297, RN #3 inquired about any pain she may be experiencing. Resident #297 complained of a headache, RN #3 left the room to go get pain medication for the resident, leaving the medicine cup full of pills in the room. RN#3 went to the medication cart, entered an order (from the standing order sheet) into the computer system, and obtained Tylenol for the resident. RN#3 stated, "The order is for two 325 mg tabs of Tylenol, I'm just going to give her this 650 mg tablet." When RN #3 returned to the room, Resident #297's pill cup was empty. RN #3 also prepared medications for Resident #40. RN #3 obtained a stock medication bottle of	F 658	3. The DON/ designee reeducated the licensed nurses on the policy and procedures for medication administration and the 5 rights of medication administration. 4. The DON/ Designee to conduct QI monitoring of F658 to ensure professional standards of nursing were followed during medication administration. QI monitoring conducted via random med pass observations three times a week x2 weeks, twice a week x2 weeks and then weekly x2 weeks. Findings to be reported to the QAPI committee and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Completion: April 11, 2023	

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F 658	Continued From page 21	F 658		

Folic Acid from the medication cart. She was asked what strength the medication was so it could be written down. RN#3 stated, "400 mcg". RN#3 then looked at the orders and stated, "I am going to be honest; she is ordered to get 1 mg...I don't have that...I am sure we have been giving her the 400 mcg, I think that's what I am going to give her today." RN#3 then placed a 400 mcg pill in the cup. RN#3 then stated, "No, I'm not going to do that...I will order if from the pharmacy...it is once a day I will give it later if it gets here." RN#3 also pulled a 450 mg tablet of Cranberry and placed it in the medication cup. When the medications were taken to Resident #40, she stated, "I'm not taking that Cranberry...it makes me pee." Resident #40 removed the Cranberry pill from the cup and handed it to RN #3.

At the conclusion of the medication pass, the medicines were reconciled against the physician orders. Resident #294 had four medications scheduled for the 9:00 a.m. medication pass that were not observed as given, but were each signed off on the MAR (medication administration record) as administered. The four medications were: Gabapentin 100 mg, Ferrous Sulfate 325 mg, Acidophilus Capsule, and Bacid.

Resident #40's orders were reviewed. She was ordered to receive 500 mg of Cranberry. 450 mg had been pulled for administration by RN #3. The Cranberry was also signed out as given, when Resident #40 had refused to take it.

RN #3 was interviewed, at approximately 10:30 a.m., regarding the discrepancies described above. RN#3 stated, "I had her (Resident #294) confused with someone else, I will get them." Also discussed were the medications left in the

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F 658	Continued From page 22 room with Resident #297 while she obtained Tylenol. RN#3 stated, "My bad, I thought she had taken them." When asked if Resident #297 was assessed and approved for self-administration of medication, RN#3 stated, "No." Lastly, the discrepancy with the Cranberry dosage for Resident #40 was discussed. RN#3 stated, "Oh God, but she didn't take it." When asked why she had signed the medication off as administered, RN#3 stated, "I screwed that up". At 10:45 a.m., RN #3 came to the conference room and stated that she was ready to give the omitted meds to Resident #294. Observed on the medication cart was a med cup with three pills. RN#3 stated, "That resident does not have any Gabapentin here...I had to borrow it from another resident...I had to do the same thing yesterday...I had to sign them both out today....I wanted to take more for later but (name of LPN #3) said no, that is too much to waste." When asked what she meant when she said she "borrowed" it, RN#3 stated, "If there is another resident on the same medication, we can borrow it...another nurse signs it off with me as wasted." She was asked if that was within the facility policy. RN #3 stated, "Yes." When asked where was the fourth omitted medication, "Bacid". RN #3 looked in the stock drawer and in Resident #294's medications. RN#3 stated, "I don't see that...it is the same as the Acidophilus Lactobacillus. So I'll just give her two of those." RN#3 added the second Acidophilus to the medication cup and took them to Resident #294 for administration. RN #3 was asked if there was a "stat box" for meds in the facility or a "dispensary" from the pharmacy where she could go to get needed medications if they were not on the medication	F 658		

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F 658	Continued From page 23 cart. RN#3 stated, "Yes, we have a [Name of dispensary]." When asked if she had access to the dispensary, RN#3 stated, "[Name of DON] had to set me up...that was before." When asked to explain what "before meant", RN#3 stated, "Before today." When asked again if she had access, RN#3 stated, "Yes, but this is faster to borrow them...sometimes it takes pharmacy so long." At approximately 1050 a.m., the med cart where Gabapentin was borrowed from was observed. LPN #3 was interviewed about the Gabapentin that was borrowed by RN #3. The narcotic sheet belonging to Resident #57 was observed. Per the narcotic sheet, 30 100 mg tablets of Gabapentin were received at the facility on 02/17/2023, with orders to administer 1 cap three times per day. The first dose from that sheet was administered on 02/23/2023 at 3:00 p.m. All doses were listed in date range order, including the dose for 8:00 a.m., on 02/27/2023. Two doses were signed out after that by RN #3, with the dates of administration being 02/25/2023 and 02/26/2023. Two more doses were signed out and marked through as errors. The Gabapentin count remaining on the card was correct at "16". LPN #3 was asked who had counted the narcotics the previous evening and at change of shift, as well as whether the count had been correct. LPN #3 stated that she had done the counts and that they had been correct. When asked how the count was correct, if RN #3 had "borrowed" a Gabapentin the day before and not signed it out until that morning. LPN #3 stated, "My count was right...I 'm going to be honest, she [RN#3] took both of them today and wanted to take more but I told her no." When asked where	F 658		

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F 658	Continued From page 24 was the second Gabapentin tab that was obtained that morning, RN#3 stated, "I don't know." When asked if nurses normally "share meds/borrow meds" between residents, LPN #3 stated, "No, we are supposed to call the pharmacy and get them from [Name of dispensary]." The DON came to the unit at that time and stated that she was looking in to this, adding that RN #3 had come to her and told her about borrowing the meds. When asked if it was within facility policy to "borrow" medications from another resident, the DON stated, "No, and I told her that. I told her she has to get the medications from the pharmacy." Resident #294's MAR (medication administration record) was reviewed at 11:15 a.m. RN #3 had documented that she had given Resident #294 her Gabapentin at 9:00 a.m. and 5:00 p.m. on 02/25/2023 and 02/26/2023. RN #3 was interviewed and asked if she had given the medication on those days and at those times. RN#3 stated, "I don't know if I gave it or not; I am getting her and another resident confused." When asked about the second Gabapentin tab that she "borrowed" from Resident #57 earlier in the day, RN#3 pulled open the top drawer of the med cart. A medication cup was observed with a pill inside. RN#3 stated, "This is for later...I was going to take more but [LPN#3] said no, that she couldn't let me have that much." When asked about her earlier statement that she had borrowed Gabapentin the previous evening, RN#3 was asked who she had borrowed the medication from. RN#3 stated, "I don't remember what I did, I don't think I gave it to her, I'm getting them all mixed up." The DON came to the conference room at 1230	F 658		

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F 658	Continued From page 25 and stated, "I found the extra Gabapentin on the cart...I am throwing it away...We are going to count all the med carts now." Per the facility policy, "Medication-oral Administration....Review the MAR or EMAR should there be any uncertainties verify the MAR/EMAR with the Physician's Orders...Document the administration and acceptance or decline of all medications administered..." Also the facility policy, "Administering Medications" contained the following: "Medications are administered in accordance with prescribe orders...if a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose...medications ordered for a particular resident may not be administered to another resident, unless permitted by State law and facility policy, and approved by the Director of Nursing...Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely." The above information was discussed during an end of the day meeting on 02/27/2023 with the DON and the administrator. No further information was obtained prior to the exit conference on 02/28/2023. 2. The facility staff failed to follow professional standards of practice for medication	F 658		

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F 658	Continued From page 26 administration for Resident #293. LPN (Licensed Practical Nurse) #1 allowed Resident #293 to self administer insulin to herself without an assessment and/or a physician's order to self administer medications. Findings include: Resident #293 was admitted to the facility on 07/22/22 and discharged from the facility on 08/29/22. Diagnoses for Resident #293 included, but were not limited to: CHF (congestive heart failure), high blood pressure, renal insufficiency, DM (diabetes mellitus), seizure disorder, anxiety disorder, depression, acute osteomyelitis of the foot with toe amputation, and chronic pain syndrome. Resident #293's most recent MDS (minimum data set) was an admission assessment dated 07/28/22. This MDS assessed the resident with a cognitive score of 13, indicating the resident was intact for daily decision making skills. Resident #293 was also assessed as requiring extensive assistance of at least one or two staff members for mobility, toileting, and bathing. This MDS assessed that Resident #293 had received insulin injections in the previous 6 (six) days. A closed record review was conducted on Resident #293. Resident #293's progress notes were reviewed from admission to discharge. A nursing progress note dated 07/24/22 and timed 11:23 AM documented, "...states her medications are not right and correct them...signature of LPN (Licensed Practical Nurse) #1."	F 658		

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F 658	Continued From page 27 A nursing note dated 07/24/22 and timed 12:57 PM documented, "...resident said all of her meds were not right told her that I would put her in the book and she could talk to the Dr. in the morning instead of 5 units before meals she [resident #293] states that is wrong it is supposed to be 35 units this writer is not comfortable and she [resident #293] gave her self (sic) the insulin...signature of LPN #1." No other progress notes were written for Resident #293 on 07/24/22 after the above note at 12:57 PM. The Resident #293's physician orders were reviewed and documented an order for, but not limited to: "...Insulin Lispro Subcutaneous Pen Injector 200 unit/ml (units/milliliter) Inject 5 [five] units before meals for dm [diabetes mellitus] (Start date: 07/23/22)..." Resident #293's July 2022 MARs (medication administration records) were reviewed. The MARs documented the above Lispro pen injector insulin order of 5 units before meals and had times of administration as 6:30 AM, 11:30 AM, and 4:30 PM. In the 11:30 AM slot on 07/24/22, LPN #1's initials were documented, along with the number '9' (9=Other/See Nurse Notes). In the 4:30 PM slot on 07/24/22, LPN #1's initials were documented, along with the number '9' (9=Other/See Nurse Notes). Resident #293's clinical records were reviewed for a resident self administration of medication assessment. No self administration assessment was found.	F 658		

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F 658	Continued From page 28 On 02/27/23 at approximately 2:30 PM, the DON (director of nursing) was asked for assistance in locating a self administration of medication assessment for Resident #293. At approximately 3:45 PM, the DON stated that there was no self administration assessment for Resident #293. On 02/27/23 at approximately 4:15 PM, the DON, administrator, AIT (administrator in training), and corporate nurse were made aware of the above information in a meeting with the survey team. The DON was asked if the physician should have been called and the medicine held until there was clarification from the physician, the facility staff agreed. The DON was asked if insulin is a usual medication for a resident to self administer at the facility, the DON stated that it was not. A physician's progress note dated 07/25/22 documented, "...Today she was complaining that her medication list is not accurate...not on the correct dose...Type 2 diabetes mellitus with hyperglycemia reviewed her medications and adjusted her insulin dosing..." Resident #293's physician's orders were again reviewed and revealed an order for: "...07/25/22 order date...07/26/22 start date: Insulin Lispro injection...inject 35 units...two times a day...before breakfast and lunch AND inject 40 units...in evening...at dinner..." On 02/27/23 at approximately 11:00 AM, the DON stated that Resident #293 should not have administered her own insulin, that the LPN should have held the medication, and called for clarification, but stated the LPN had been	F 658		

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F 658	Continued From page 29 educated on 07/25/22. On 02/27/23 at approximately 3:15 PM, the DON, administrator, AIT (administrator in training), and corporate nurse were again made aware of the above information in a meeting with the survey team. No further information and/or documentation was presented prior to the exit conference on 02/28/23.	F 658		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where	F 661	(F661) Failure to complete a discharge summary 1. Resident #2 no longer resides in our facility. 2. The Social Service Director (SSD)/ Designee completed a quality review of discharges in the last two weeks to ensure discharge summary was completed. Follow up was completed based on findings. 3. The DON/ designee reeducated the licensed nurses and the social services staff on ensuring discharge summary is completed on resident discharge. 4. ED/Designee to conduct QI monitoring of F661 to ensure discharge summary was completed. QI monitoring conducted via medical records review twice weekly x2 weeks and then weekly x4 weeks. Findings to be reported to the QAPI committee and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Completion: April 11, 2023	4/11/2023

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F 661	Continued From page 30 the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, the facility staff failed to ensure a discharge summary was completed for one of 29 residents. This was closed record review. The findings include: The facility did not complete a discharge summary for Resident #289. Diagnoses for Resident #289 included: Alzheimer's, edema, dementia, depression, and delirium. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/15/22. Resident #289 was assessed with a cognitive score of 6 indicating severely cognitively impaired. On 2/28/23 Resident #289's clinical record was reviewed and documented (via the current MDS) dated 3/4/22, that Resident #289 was discharged to another facility. Review of the nursing progress notes and physician progress notes did not evidence a discharge summary had been completed. On 2/28/23 at 10:15 AM, the regional nurse consultant (Administrative Staff, AS #4) was asked to review Resident #289's medical record for a discharge summary. AS #4 said that she would check with medical records to see what could be found.	F 661		

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F 661	Continued From page 31 On 2/28/23 at 10:25 AM, the social worker (other staff, OS #1) was interviewed. OS #1 said that she helped with the planning of resident discharges and helped prepare resident's for discharge. OS #1 was asked to review Resident #289's clinical record for a discharge summary. On 2/28/23 at 11:55 AM, the medical record person (other staff, OS #10) verbalized that no documentation had been found that a discharge summary had been completed. On 2/28/23 at 3:10 PM, OS #1 showed documentation of Resident #289's discharge instruction form (verbalizing that her assistant had filled the form out) and went onto say that she could not find where a discharge summary had been completed. On 2/28/23 at 3:15 PM the above information was presented to the administrator and director of nursing. No other information was presented prior to exit on 2/28/23.	F 661		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, and clinical record review, the facility staff failed to provide Activities of Daily Living (ADL's) for two of	F 677	(F677) Failure to provide ADL Care 1. Resident #40 and Resident #293 no longer reside in the facility. 2. The DON/designee conducted a quality review of Activities of Daily Living (ADL) documentation for the last week to ensure that ADL care completed. Follow up completed based on findings.	4/11/2023

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F 677	Continued From page 32 29 residents (Residents #40 and Resident #293). The Findings Include: 1. Facility staff failed to provide a scheduled shower for Resident #40. Diagnoses for Resident #40 included; Adult failure to thrive, diabetes, major depression, and stage three pressure ulcer. The most current MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 1/12/2023. Resident #40 was assessed with a cognitive score of 13 indicating cognitively intact. During the interview with Resident #40 conducted on 2/26/23 at 4:10 PM, Resident #40 verbalized that the staff had not given her a shower on Friday (2/24/23) as scheduled, and went on to say that one of the nursing staff said there wasn't enough towels or washcloths. On 2/27/23 Resident #40's clinical record was reviewed. Section "G, Functional Status" indicated Resident #40 needed extensive assistance with one person to assist for bathing. Resident #40's shower record was also reviewed and did not evidence that Resident #40 received a shower on 2/24/23. The shower record did document Resident #40 last received a shower on 2/22/23. Review of Resident #40's shower schedule evidenced showers to be completed every Tuesday and Friday. On 2/28/23 9:01 AM, certified nursing assistant (CNA #2) was interviewed. CNA #2 reviewed the	F 677	3. The DON/ designee reeducated the nursing staff on the facility's ADL policy. 4. The DON/ designee to conduct QI monitoring of F677 to ensure ADL care is provided. QI monitoring conducted via medical records review of 5 random residents twice weekly x2 weeks and then weekly x4 weeks. Findings to be reported to the QAPI committee and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Completion: April 11, 2023	

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F 677	Continued From page 33 shower records and verbalized that she was assigned to Resident #40 on 2/24/23, but could not remember why Resident #40 did not receive a shower and did not remember if she offered Resident #40 a shower. When asked about shortages of linen supplies, CNA #2 verbalized that does happen and sometimes that will prevent a resident from getting a shower. On 2/28/23 at 9:05 AM, laundry aide (Other Staff, OS #14) was interviewed regarding shortages of linens. OS #14 verbalized, up until a few days ago, he was the only laundry aide, and only worked 6 hours a day, making it hard to keep up with all the laundry. OS #14 said that some CNA's will come to the laundry room, take a stack of towels and washcloths, and hide them, which left other CNA's short of linens. On 2/28/23 at 3:09 PM the above finding was presented to the administrator and director of nursing during a surveyor/facility staff meeting. No other information was presented prior to exit conference on 2/28/23. 2. The facility staff failed to assist Resident #293 with toileting. Findings include: Resident #293 was admitted to the facility on 07/22/22 and discharged from the facility on 08/29/22. Diagnoses for Resident #293 included, but were not limited to: CHF (congestive heart	F 677		

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F 677	Continued From page 34	F 677		

failure), high blood pressure, renal insufficiency, DM (diabetes mellitus), seizure disorder, anxiety disorder, depression, acute osteomyelitis of the left foot with toe amputation, and chronic pain syndrome.

The resident's most recent MDS (minimum data set) was an admission assessment dated 07/28/22. This MDS assessed the resident with a cognitive score of 13, indicating the resident was intact for daily decision making skills. The resident was also assessed as requiring extensive assistance of at least one or two staff members for bed mobility, transfers and toileting. This MDS assessed the resident in Section H. Bladder and Bowel H0300. Urinary Incontinence, as 'Occasionally incontinent' and H0400. Bowel Continence as 'Always continent'.

A closed record review was conducted on Resident #293. The resident's progress notes were reviewed from admission to discharge.

A nursing progress note dated 08/29/22 (the date of the resident's discharge) and timed 5:32 AM documented, "...Went to unit four this am to pass meds. This patient asked me to take her to the restroom. I told this patient that I would but when she was ready to get off I didn't know if I would be able to get her off right away. She said so you are refusing to take me I stated no (sic)...Patient proceeded to argue with me. Told this patient to let me check her blood sugar and I would take her and be back as soon as I could. She stated no they can take my BS [blood sugar] later I am going to the restroom. Told her again I would take her and she again stated no. Patient wheeled her self (sic) to unit two and sat at the nurse's station...signature of LPN (Licensed

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F 677	Continued From page 35 Practical Nurse) #6." On 02/28/23 at approximately 12:30 PM, the DON was made aware of the above information. The DON stated the LPN (identified as LPN #6) had worked night shift the night prior and she could get a number for a phone interview. On 02/28/23 at 3:00 PM, LPN #6 was interviewed by phone and was asked about the nursing note written on 08/28/22 regarding Resident #293. The LPN stated that the she was busy "passing pills" and did not have time to take the resident to the bathroom. The LPN then stated that she could have taken the resident, but stated that the resident was one that liked you to stay with her until she finished and that she (LPN #6) simply did not have time. The LPN was asked why she was pressed for time. The LPN stated that it was not due to staffing. The LPN was asked if a CNA (certified nursing assistant) could have taken the resident, the LPN stated, "they were probably doing their last rounds (2 CNA's) and were just busy too." The LPN stated that she did not ask a CNA to assist the resident. The LPN again stated that she told the resident she could take her, but didn't know when she would be able to return to get her off the toilet. On 02/28/23 at approximately 3:15 PM, the DON (director of nursing), administrator, AIT (administrator in training), and corporate nurses were made aware of the above information in a meeting with the survey team. The facility staff were asked what should have happened with LPN #6 and Resident #293. The DON and administrator stated at the same time, "Take her to the bathroom." The other facility staff all agreed the LPN should have taken the resident to	F 677		

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F 677	Continued From page 36 **the bathroom.** **No further information and/or documentation was presented prior to the exit conference on 02/28/23.**	F 677		
F 759 SS=E	**Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)** §483.45(f) **Medication Errors.** **The facility must ensure that its-** **§483.45(f)(1) Medication error rates are not 5 percent or greater;** **This REQUIREMENT is not met as evidenced by:** **Based on medication pass and pour observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a medication error rate of less than five percent. A total of thirty-three medication opportunities were observed with seven errors. This resulted in a medication error rate of 21.21%.** **Findings were:** **1. A medication pass and pour observation was conducted with RN (registered nurse) #3 at approximately 8:45 a.m.. RN #3 prepared medications for Resident #294. She obtained a Lovenox injection from the cart, a lidocaine patch, and a 12.5 mg tablet of Carvedilol 12.5 mg. When the medications were given to the resident, Resident #294 stated, "Only one pill today?" RN #3 responded, "Yes, that is the pill for your heart."** **Medications for Resident #297 were prepared and included Farxiga, Aspirin, Magnesium Oxide, Atorvastatin, Fluoxetene, Glimepiride, Vitamin D,**	F 759	(F759) Med Pass error rate greater than 5% 1. Resident #294 suffered no apparent harm. Resident #40 & #297 no longer reside in the facility. Resident #28 suffered no apparent harm, MD was notified on 2.28.2023, and MD changed order for Ferrous Sulfate. 2. The DON/designee conduct a med pass observation to ensure medication error rate less than 5%. Follow up completed based on findings. 3. The DON/designee reeducated the licensed nurses on ensuring that they're following the 5 Rights of Medication Administration and on following proper procedure. 4. The DON/ designee to conduct QI monitoring of F759 to ensure medication error rate less than 5%. QI monitoring conducted via med pass observation three times a week x2 weeks, twice a week x2 weeks and then weekly x2 weeks. Findings to be reported to the QAPI committee and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of completion: April 11, 2023.	4/11/2023

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F 759	Continued From page 37 Ferrous Sulfate, Metformin, and Pantroprazole. While in the room with Resident #297, RN #3 inquired about any pain that she may be experiencing. Resident #297 complained of a headache, RN #3 left the room to go get pain medication for the resident, leaving the medicine cup full of pills in the room. RN#3 went to the medication cart, entered an order (from the standing order sheet) into the computer system, and obtained Tylenol for the resident. RN#3 stated, "The order is for two 325 mg tabs of Tylenol, I'm just going to give her this 650 mg tablet." When RN #3 returned to the room, Resident #297's pill cup was empty. RN #3 also prepared medications for Resident #40. RN #3 obtained a stock medication bottle of Folic Acid from the medication cart. When asked what strength the medication was so it could be written down, RN#3 stated, "400 mcg". RN#3 then looked at the orders and stated, "I am going to be honest; she is ordered to get 1 mg...I don't have that...I am sure we have been giving her the 400 mcg, I think that's what I am going to give her today." RN#3 then placed a 400 mcg pill in the cup. RN#3 then stated, "No, I'm not going to do that...I will order if from the pharmacy...it is once a day I will give it later if it gets here." RN#3 also pulled a 450 mg tablet of Cranberry and placed it in the medication cup. When the medications were taken to Resident #40, she stated, "I'm not taking that Cranberry...it makes me pee." Resident #40 removed the Cranberry pill from the cup and handed it to RN #3. At the conclusion of the medication pass, the medicines were reconciled against the physician orders. Resident #294 had four medications scheduled for the 9:00 a.m. medication pass that	F 759		

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F 759	Continued From page 38 were not observed as given, but were each signed off on the MAR (medication administration record) as administered. The four medications not given were: Gabapentin 100 mg, Ferrous Sulfate 325 mg, Acidophillus Capsule, and Bacid. Resident #40's orders were reviewed. She was ordered to receive 500 mg of Cranberry. 450 mg had been pulled for administration by RN #3. The Cranberry was also signed out as given, when Resident #40 had refused to take it. RN #3 was interviewed at approximately 10:30 a.m., regarding the discrepancies described above. RN#3 stated, " I had her [Resident #294] confused with someone else, I will get them." Also discussed were the medications left in the room with Resident #297 while she obtained Tylenol. RN#3 stated, "My bad, I thought she had taken them." When asked if Resident #297 was assessed and approved for self-administration of medication, RN#3 stated, "No." Lastly the discrepancy with the Cranberry dosage for Resident #40 was discussed, RN#3 stated, "Oh God, but she didn't take it." When asked why she had signed the medication off as administered, RN#3 stated, "I screwed that up". At 10:45 a.m., RN #3 came to the conference room and stated that she was ready to give the omitted meds to Resident #294. Observed on the medication cart was a med cup with three pills. RN#3 stated, "That resident does not have any Gabapentin here...I had to borrow it from another resident...I had to do the same thing yesterday." When asked what she meant when she said she "borrowed" it, RN#3 stated, "If there is another resident on the same medication, we can borrow it...another nurse signs it off with me as wasted."	F 759		

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F 759	Continued From page 39 When asked if that was within the facility policy, RN#3 stated, "Yes." When asked where was the fourth omitted medication, "Bacid". RN#3 looked in the stock drawer and in Resident #294's medications. RN#3 stated, "I don't see that...it is the same as the Acidophillus Lactobacillus so I'll just give her two of those." RN#3 then added the second Acidophillus to the medication cup and took them to Resident #294 for administration. Per the facility policy, "Medication-oral Administration....Review the MAR or EMAR should there be any uncertainties verify the MAR/EMAR with the Physician's Orders...Document the administration and acceptance or decline of all medications administered..." Also the facility policy, "Administering Medications" contained the following: "Medications are administered in accordance with prescribe orders...if a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose...medications ordered for a particular resident may not be administered to another resident, unless permitted by State law and facility policy, and approved by the Director of Nursing...Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely." The above findings were discussed during an end of the day meeting on 02/27/2023 with the DON and the administrator. No further information was obtained prior to the	F 759		

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F 759	Continued From page 40 exit conference on 02/28/2023. 2. During a medication pass observation, Resident #28 was not administered the iron tablet as ordered by the physician. On 2/26/23 at 5:48 p.m., a medication pass observation was conducted with registered nurse (RN) #5 administering medications to Resident #28. Among the medications administered to Resident #28 was an iron tablet 325 mg. Resident #28's clinical record documented a physician's order dated 7/19/22 for ferrous sulfate (iron) oral delayed release tablet 324 mg two times per day with meals for treatment of anemia. On 2/27/23 at 10:10 a.m., licensed practical nurse (LPN) #5 assigned to care for Resident #28, was interviewed about the iron tablet administered during the medication pass observation on 2/26/23. LPN #5 reviewed Resident #28's clinical record and stated that the physician's order was for the delayed release ferrous sulfate 325 mg, not the standard release tablets. LPN #5 stated that the iron tablets were "in-house" stocked items. LPN #5 reviewed the medication cart and stated that no slow-release ferrous sulfate tablets were in the cart. This finding was reviewed with the administrator, director of nursing, and regional nurse consultants on 2/27/23 at 5:30 p.m.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals	F 761		

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F 761	Continued From page 41 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to properly store liquid narcotics in two of three refrigerators, Unit 2 and Unit 3. Findings were: On 02/27/2023 at approximately 12:30 p.m., the refrigerators on all three units were observed with the DON (director of nursing). The locked	F 761	(F761) Label/Store Drugs & Biologicals 1. No residents were identified with this alleged deficient practice. Lock boxes were ordered from the Pharmacy, and Maintenance affixed the boxes in the medication refrigerators on 2/27/2023. 2. Refrigerators on the other units were checked and had lock boxes already affixed. 3. The DON/designee reeducated the licensed nurses on proper storage of refrigerated narcotic medication. 4. The DON/ designee to conduct QI monitoring of F761 to ensure properly store liquid narcotics. QI monitoring conducted via observations twice weekly x1 week, and then weekly x5 weeks. Findings to be reported to the QAPI committee and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Completion: April 11, 2023	4/11/2023

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F 761	Continued From page 42 **refrigerator on Unit 2 had two bottles of liquid Ativan stored directly on the shelf of the refrigerator. There was no permanently affixed locked box observed in the refrigerator. The DON stated that they had attempted to add the permanently affixed locked boxes without success.** **The locked refrigerator on Unit 3 was observed. A locked "tackle box" was removed from the refrigerator. Inside were two bottles of liquid Ativan.** **On 02/27/2023 at approximately 4:30 p.m., the DON came to the conference room and stated, "We have installed the locked boxes today."** **The facility policy, "Storage and Expiration Dating of Medications, Biologicals" contained the following: "Store all drugs...in locked compartments, including the storage of Schedule II-V medications in separately locked, permanently affixed compartments...". Also under the section, "Controlled Substances Storage...Controlled substances stored in the refrigerator must be in a separate container and double locked."** **No further in formation was obtained prior to the exit conference on 02/28/2023.**	F 761		
F 800 SS=E	**Provided Diet Meets Needs of Each Resident CFR(s): 483.60** §483.60 **Food and nutrition services.** **The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the**	F 800	(F800) Provided Diet Meets Needs of Each Resident 1. Resident #293 no longer resides in the facility. 2. The Diet Manager/ designee conducted a quality review of current residents to ensure that dietary preferences were taken into consideration. Follow up completed based on findings.	4/11/2023

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F 800	Continued From page 43 preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on a closed clinical record review, staff interview and facility document review, the facility staff failed to ensure one of 29 residents' (Resident #293) dietary preferences were taken into consideration. Findings include: Resident #293 was admitted to the facility on 07/22/22 and discharged from the facility on 08/29/22. Diagnoses for Resident #293 included, but were not limited to: CHF (congestive heart failure), high blood pressure, renal insufficiency, DM (diabetes mellitus), seizure disorder, anxiety disorder, depression, acute osteomyelitis the left foot with toe amputation, and chronic pain syndrome. Resident #293's most recent MDS (minimum data set) was admission assessment dated 07/28/22. This MDS assessed the resident with a cognitive score of 13, indicating the resident was intact for daily decision making skills. Resident #293 was also assessed as requiring supervision with set up only for meals. An allegation within a complaint regarding Resident #293 documented that the resident was not provided a diabetic diet and/or the resident's food preferences were not honored and that the resident's food allergies (tomato products) were not taken into consideration when meals were provided for the resident. Resident #293's clinical records were reviewed. The admission assessment documented that	F 800	3. The ED/designee reeducated the Dietary Manager on honoring food preferences. 4. The ED/designee to conduct QI monitoring of F800 to ensure dietary preferences were taken into consideration. QI monitoring conducted via observations of 5 random residents twice weekly x2 weeks and then weekly x4 weeks. Findings to be reported to the QAPI committee and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Completion: April 11, 2023	

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F 800	Continued From page 44 Resident #293 had food allergies that included tomatoe, tomatoe products, and clams, but no documetation was found that referred to a diabetic diet or the need for a diabetic diet. Resident #293's physician's orders were reviewed. Resident #293's food allergies were listed at the top of the physician order set. The actual physician's orders included an order, dated 7/24/22, for "dietary liberty for special occasions." No other diet orders were found for Resident #293. Resident #293's initial care plan dated 07/22/22 was reviewed and documented "...maintain weight, adequate fluids, diet and supplements as ordered, report problems, monitor for dehydration." This initial care plan was a generic, check-off type of care plan that was not specific or individualized to this resident. Resident #293's comprehensive care plan was reviewed and documented, "...Diabetes Mellitus...Dietary consult as needed...(date initiated: 08/04/22)...is at risk related to DM...obesity...receives therapeutic diet order (date initiated: 08/04/22)...Provide, serve diet as ordered (08/04/22)..." No specific diet was indicated within the care plan, neither were any food preference or allergies included. A dietary preference assessment dated 08/12/22 (21 days after the resident's admission) was reviewed and documented Resident #293's allergies as fish and tomatoes, but did not included any "likes" or "dislikes." Resident #293's records were reviewed in its entirety, but there was no way to determine what	F 800		

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F 800	Continued From page 45 type of diet Resident #293 actually received or if the resident had been served items to which the resident was allergic. No physician's order could be found to identify a specific diet for Resident #293, for the duration of the stay (admission 07/22/22 through discharge 08/29/22). On 02/28/23 at approximately 9:30 AM, the DON (director of nursing) was asked who completed the dietary preference sheet. The DON stated that the person is no longer employed, but stated that Resident #293 should have had a diet order on admission and was not sure how she didn't. On 02/28/23 at 11:00 AM, the DDM (district dietary manager) was made aware of the above information. The DDM stated that the resident's preference assessment should be completed within 48 hours of admission. A policy was requested regarding dietary preferences and allergies. A policy was presented titled, "Dining and Food Preferences." The policy documented, "...The diet requisition form will notify the dining services department of food allergies upon admission and prior to any meals served...dining services director or designee will interview the resident or resident representative to complete a food preference interview within 48 hours of admission. The purpose of identifying individual preferences for dining location, meal times...food and beverage...will be entered into the medical record...Food allergies, food intolerance, food dislikes, and food and fluid preferences will entered into the resident profile..." The DON, administrator, AIT (administrator in training), and corporate nurses were made aware	F 800		

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F 800	**Continued From page 46** **of these findings in a meeting with the survey team on 02/28/23, at approximately 4:15 PM.** **No further information and/or documentation was presented prior to the exit conference on 02/28/23 to evidence that Resident #293's meal preference and dietary needs were taken into consideration during the resident's stay.**	F 800		
F 806 SS=E	**Resident Allergies, Preferences, Substitutes CFR(s):** 483.60(d)(4)(5) §483.60(d) **Food and drink** **Each resident receives and the facility provides-** §483.60(d)(4) **Food that accommodates resident allergies, intolerances, and preferences;** **§483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;** **This REQUIREMENT is not met as evidenced by:** **Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide alternate menu options of similar nutritive value for three of twenty-nine residents in the survey sample when they chose not to eat food initially served (Residents #20, #25 and #45). Alternate menu options of similar nutritive value were not routinely provided to residents in the facility and not posted and/or communicated in advance for choices prior to the meal.** **The findings included**	**F 806**	(F806) Resident Allergies, Preferences, Substitutes 1. Facility recognizes that dietary staff failed to provide alternate menu options of similar nutritive value. 2. The Dietary Manager/ designee conducted a quality review to ensure alternate menu options of similar nutritive value. Follow up based on findings. 3. The DON/designee reeducated nursing and dietary staff on notifying and giving the resident an option for an alternative meal per their dietary preferences. The Dietary/ Activities staff to post menus with main course and an alternate of similar nutritive value in resident rooms. 4. The ED/AIT/Designee to conduct QI monitoring of F806 to ensure alternate menu options of similar nutritive value. QI monitoring conducted via observations of 5 random residents weekly x6 weeks. Findings to be reported to the QAPI committee and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Completion: April 11, 2023	4/11/2023

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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 806	Continued From page 47 1. Resident # 25 in the survey sample was admitted with diagnoses that included discitis, anemia, diverticulitis, congestive heart failure, hypertension, **gastroesophageal** reflux disease, hyperlipidemia, Vitamin D deficiency, obstructive uropathy, morbid obesity, and generalized muscle weakness. According to the most recent Annual Minimum Data Set, with an Assessment Reference Date of 12/8/2022, the resident #25 was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. At approximately 10:30 a.m. on 2/27/2023, Resident # 25 was interviewed regarding food and food choices offered by the facility. Asked if an alternate meal choice was offered, Resident # 25 said, "There is always soup and a sandwich if you don't like what is being served for lunch or dinner. Sometimes it's tomato soup, or mushroom soup, or chili, or some kind of soup and a sandwich of some kind." Asked if an alternate meal similar to the meal being served was offered, Resident # 25 said, "No." Resident # 25 went on to talk about breakfast. "I would like to have fried eggs. We get tired of scrambled eggs everyday." Resident #25 went on to say that he keeps Carnation Instant Breakfast packets in his room to fix just for a change sometimes. During an end of day meeting at 5:30 p.m. on 2/27/2023, that included the Administrator, Director of Nursing, Dietary Manager, and the survey team, these findings were presented. The question of fried eggs was brought up. Asked if the residents could have fried eggs for breakfast, the Dietary Manager said, "No, they are not on	F 806		

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	495336	A. BUILDING _____ B. WING _____	C 02/28/2023

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F 806	Continued From page 48 the menu." 2. Resident # 45 in the survey sample was admitted with diagnoses that included osteomyelitis of the right ankle and foot, hypertension, diabetes mellitus, hyperlipidemia, depression, chronic obstructive pulmonary disease, right below the knee amputation, generalized muscle weakness, difficulty walking, atrial fibrillation, benign prostatic hyperplasia, morbid obesity, and restless leg syndrome. According to the most recent Minimum Data Set, a Quarterly Review with an Assessment Reference Date of 2/10/2023, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15. Resident # 45 was interviewed also interviewed. Asked about alternate food choices, Resident # 45 said, "We get a bologna sandwich and soup, or a pimento cheese sandwich and soup, or some kind of sandwich and soup if we don't like what is being served." When asked if an alternate meal choice, similar to the type of full meal being served was offered, Resident # 45 said, "No. The only thing we get is a sandwich and some kind of soup. We never get a meal as an alternate." These findings were discussed during an end of day meeting at 5:30 p.m. on 2/27/2023, that included the Administrator, Director of Nursing, Dietary Manager, and the survey team. 3. Resident #20 stated that she was not offered options for alternate food items, when not eating	F 806		

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F 806	Continued From page 49 the meal initially served, adding that she was unaware of any posted menus and food alternates. Resident #20 was admitted to the facility with diagnoses that included hypothyroidism, duodenal ulcer, restless leg syndrome, depression, anxiety, seasonal allergic rhinitis, anemia, and **gastroesophageal reflux disease.** The minimum data set (MDS) dated 12/22/22 assessed Resident #20 as cognitively intact. On 2/26/23 at 3:47 p.m., Resident #20 was interviewed about quality of care and life in the facility. When asked about food, Resident #20 stated that if she did not like or want the food served, the only option was a sandwich. Resident #20 stated that soup used to be offered each day, but was not always available. Resident #20 stated that she was allergic to fish. So that when fish was on the menu, Resident #20 stated that she was served a sandwich instead. Resident #20 stated she never knew what the menus were as she stayed mostly in her room and did not go to the dining room. On 2/27/23 at 11:15 a.m., the facility's menu was observed posted at the entrance to the dining room. The menu documented the following food options for Monday (2/27/23). There were no meal alternates included in the posted menu. Breakfast - French toast, bacon Lunch - Fish on bun, rice pilaf, tomatoes, roll, yellow cake/peanut butter frosting Dinner - Kielbasa sausage, baked beans, vegetable blend, roll, yellow cake with frosting Resident #20's clinical record documented a	F 806		

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F 806	Continued From page 50 physician's order dated 1/20/22 for a regular diet with regular, thin liquids. Resident #20's meal ticket listed "allergic to fish, vegetable soup and sandwich when fish is the meal..." On 2/27/23 at 11:22 a.m., Resident #20 was interviewed about the upcoming lunch menu that included a fish sandwich. Resident #20 stated, "I don't want fish...I'll get a wrapped-up sandwich." Resident #20 stated that she was not aware of any alternates for the fish other than a ham or cheese sandwich. Resident #20 stated, "I don't go out of my room. They don't provide menus." On 2/27/23 at 12:19 p.m., Resident #20 was observed in her room with lunch. Resident #20 was served chicken tenders, rice, tomatoes, a grilled cheese sandwich and tomato soup. Resident #20 stated, "Nobody asked me about the alternate. I just get what they serve me." Resident #20 stated that she was not aware chicken tenders or tomato soup were food options for that day. On 2/27/23 at 1:00 p.m., the dietary manager (other staff #2) was interviewed about menu options and alternates to the entree. Other staff #2 stated, "We don't typically post the alternates." Other staff #2 stated that she did not have a prepared alternate the previous day (2/26/23). Other staff #2 stated the alternates on most days were the foods on the "always available" menu that included sandwiches and soups. Other staff #2 stated the chicken tenders were prepared today because "so many people don't like fish." Other staff #2 stated that alternate entree foods were not routinely prepared, unless serving a meal that many residents did not like such as fish.	F 806		

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F 806	Continued From page 51 On 2/27/23 at 4:30 p.m., the regional dietary manager (other staff #6) was interviewed about menu options/alternates to the main entree. Other Staff #6 stated that food alternates were available and these food items were the options on the "always available" menu. Other Staff #6 stated that alternate food items other than those listed on the "always available" menu were not posted. The facility's "Always Available Menu" presented to the survey team on 2/28/23 listed the following food items: grilled ham & cheese, grilled cheese, deli sandwich, hamburger, cheeseburger, potato chips and soup of choice. These findings were reviewed with the administrator, director of nursing and regional nurse consultants on 2/27/23 at 5:30 p.m. 3. The facility failed to provide alternate menu items of similar nutritive value to residents. An initial tour of the kitchen was conducted on 02/26/23 at approximately 3:00 PM with the OS (other staff) #1, also known as the cook. At approximately 4:20 PM, after checking food temperatures, When asked what was the alternative food/meal choice, OS #1 stated that they have a list of foods "always available" and that is what they consider the alternate. OS #1 stated that today it was grilled cheese and cream of mushroom soup. At approximately 5:00 PM, the dietary manager, OS (other staff) #2, was asked for a list of alternate food choices that are offered, along with	F 806		

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F 806	Continued From page 52 a policy regarding alternate food choices. The DM stated that they offer an "always available" menu and would get the list. On 02/27/23 at approximately 1:00 PM, the OS #2 and the District Manager (known as OS #7) presented the always available menu items and a policy. The always available menu listed soup, salad, grilled cheese, peanut butter and jelly, hamburgers and cheeseburgers. The policy titled, "Menus" documented, "...menus will be planned in advance to meet the nutritional needs of the resident...The menu will identify the primary meal, the alternate meal, and any always offered food and beverage items...Menus will be posted in the dining services department, dining rooms, and resident/patient care areas..." The OS #7 and the DM were asked why an alternate menu was not being offered. The DM stated that they don't typically have an alternate listing. OS #7 stated that they (the facility) don't normally list an alternative because if a resident is on a certain type of diet, the resident may then want the alternate instead. OS #7 was made aware that was the point of having an alternate menu to give the residents a choice. The DM stated that the facility will usually do an alternate when they have fish for dinner and that it really depended on the meal they were serving, if alternate options were provided. On 02/28/23 at approximately 4:15 PM, the DON (director of nursing), administrator, AIT (administrator in training) and corporate nurses were made aware of these findings in a meeting with the survey team. No further information and/or documentation was	F 806		

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F 806	Continued From page 53 presented prior to the exit conference on 02/28/23.	F 806		
F 812 SS=E	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. §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 store, prepare and serve food in a sanitary manner in the main kitchen. Finding include: On 02/26/23 at 3:00 PM, a tour of the kitchen was conducted. OS #1 (other staff), also known as the cook, along with two Dietary Aides (OS #12 and OS#13) were working the kitchen. OS #1	F 812	(F812) Failed to store/serve in sanitary manner 1. No residents were identified with this alleged deficient practice. 2. Residents being served from the kitchen have the potential of being affected by this alleged deficient practice. The ED/designee conducted a quality review to ensure food is prepared in a sanitary manner. Follow up completed based on the findings. 3. The Dietary Manager/ designee reeducated the dietary staff on policy and procedure of proper food storage and preparing in a sanitary manner, kitchen cleanliness and appropriate dishwasher temps. 4. ED/AIT/ Designee to conduct QI monitoring of F812 to ensure the food is stored, prepared and served food in a sanitary manner. QI monitoring conducted via observations three times weekly x2 weeks, and twice weekly x2 weeks and then weekly x2 weeks. Findings to be reported to the QAPI committee and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Completion: April 11, 2023	4/11/2023

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F 812	Continued From page 54 stated that the DM (dietary manager) had left for the day. During the tour, the tops of the sugar, flour and thickner bins were visibly soiled and tacky to touch when opened. The sugar bin had a piece of black debris in the sugar. The thickner had specs of brown matter scattered on top of the thickner. The sink with the eye washing station had a pile of brown paper towels on the right side, with bunched up towels on the left side (unable to determine if they were used). OS #1 stated that he thought they were clean, but gathered them and put them in the trash. OS #1 stated that the paper towels were on the side of the sink because they (kitchen staff) didn't have a key to load the towel dispenser. Several gnats were observed near the vicinity of this sink. The kitchen floor was visibly soiled throughout with unidentified particles. Under the prep table was a bag of dry macaroni folded over, not sealed or covered, and not dated. At 3:15 PM, OS #13 was observed operating the dishwasher. OS #13 stated it was high temperature washer, but was unsure of the water temperature requirements/specs. The water temperature specs were found on the underside of the dishwasher and were listed as: wash 150 degrees F (Fahrenheit) minimum and rinse 180 F minimum. At 3:16 PM, OS #13 ran the dishwasher for observation of water temps. The wash temperature was 120 F and the rinse was 170 F.	F 812		

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F 812	Continued From page 55 At 3:20 PM, OS #13 ran the dishwasher again and the wash temperature was 130 F and the rinse was 170 F. At 3:24 PM, OS #12 ran the dishwasher and the wash temperature was 130 F and the rinse temperature was 160 F. OS #12 stated that they (the facility) had problems with the dishwasher a couple of months back and that the maintenance director looked at it. OS #12 stated that it (hot water concern) comes and goes. The top of the dishwasher was soiled and had visible buildup. OS #12 was asked for the temperature logs for the dishwasher. OS #12 presented a sheet for February 2023. There were no dishwasher temperatures recorded for February 24th, February 25th and/or February 26th. The temp log titled, "Dish Machine Log" documented, "...High Temp Wash: 150-160 F and Rinse: 180 F. According to the log the wash and rinse temps were to be checked/recorded at breakfast, lunch and dinner each day. The temps documented for 02/01/23 through 02/23/23 were within limits except for one, which was dated 02/12/23 for the dinner check. The temps that day were recorded as 120 F for the wash and 160 F for the rinse. OS #12 was unable to explain why the temps were not recorded the last three days. At 3:25 PM, OS #12 continued the tour to the dry storage area. A pair of soiled gloves were observed laying on a shelf. OS #12 stated that the gloves should have been thrown away. The walk-in refrigerator was observed with a pan	F 812		

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F 812	Continued From page 56 of jelly that was partially covered with the plastic wrap laying in the jelly, there was no date. A pan of rice was partially covered with plastic wrap; the exposed rice had changed color due to cold exposure. There were approximately 20 slices of cheese that had no label and/or date. Approximately 30 Styrofoam cups of juices on a tray were observed, no type of cover and no dates. The cups of juice had spilled out onto the tray and the cups were standing in spilled juice/liquid. The walk-in freezer ceiling had condensation that had dripped down onto the floor, there was ice on the ceiling near the fan and ice accumulation on the floor of the freezer. The juice machine dispensing nozzle was hanging down, laying against the leg of the shelf. The nozzle had dried and gummy juice buildup was observed on the end of the nozzle. The holding tray for the nozzle had dried juice in the bottom of it. On 02/26/23 at 4:22 PM, the DM arrived and ran the dishwasher again. The wash temp reached 158 F and the rinse reached between 173-175 F. The DM stated that it (dishwasher temp) was so hot earlier that day that she could hardly touch the plates when the cycle was completed. The DM was asked if there was any type of strips/thermal check to ensure the water temperatures were accurate and safe. The DM stated that she was unaware of anything like that. The DM stated she would check with the maintenance department. The DM was asked about documenting the dishwasher temperatures. The DM stated that	F 812		

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F 812	Continued From page 57 the dietary staff should be checking on each shift for each meal. The DM was asked for policies regarding the above listed concerns to include: dating items in the kitchen, general cleanliness and sanitation, and dishwasher care and maintenance. At 4:44 PM, the maintenance director stated that when he came in at approximately 3:30 PM (02/26/23), the boiler was off and it had to be lit. The maintenance director stated that it does occasionally go out. The maintenance director stated that it's back on now and the temperature is going up, as expected. The maintenance director stated the system was checked on 02/17/23 and would produce that work order to show what was done and what they are working on to remedy the problem. On 02/27/23 at approximately 1:00 PM, the DM presented several policies. A policy titled, "Environment" documented, "...all food preparation areas, food service areas...will be maintained in a clean and sanitary manner...director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation...will ensure all employees are knowledgeable...for cleaning and sanitizing of all food equipment and surfaces..." A policy titled, "Equipment" documented, "...food service equipment will be clean, sanitary, and in proper working order...routinely cleaned and maintained...all staff members will be properly trained in the cleaning and maintenance of all equipment...food contact equipment will be clean and sanitized after every use...non-food contact	F 812		

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F 812	Continued From page 58 equipment will be clean and free of debris..." A policy titled, "Warewashing" documented, "...all dishware, serviceware, and utensils will be cleaned and sanitized after each use...dining services staff will be knowledgeable in proper technique for processing dirty dishware through the dish machine...all dish machine water temperatures will be maintained in accordance with manufacturer recommendations for high temperature or low temperature machines...temperature and/or sanitizer concentrations logs will be completed, as appropriate...Attachments: 1. Dish Machine Log...[as described above]." A polity titled, "Food Storage: Cold Foods" documented, "...All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination..." A policy titled, "Pest Control" documented, "...for control of insects and rodents for the dining services department...director coordinates with the director of maintenance to arrange pest control services on a monthly basis, or as needed...areas will be monitored for regularly any signs of pest/vermin..." A policy titled, "Food Storage: Dry Goods" documented, "...regularly inspect the dry storage areas...food items will be kept clean, dry, and properly sealed..." The administrator, DON (director of nursing), corporate nurses, and AIT (administrator in training) were informed of the above findings in a meeting with the survey team on 02/27/23 at	F 812		

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F 812	Continued From page 59 approximately 5:00 PM and again on 02/28/23 at approximately 4:30 PM. No further information and/or documentation was presented prior to the exit conference on 02/28/23.	F 812		
F 814 SS=C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to ensure garbage and refuse were disposed of properly. Findings include: On 02/26/23 at 3:40 PM, the garbage and refuse area was observed with OS (Other Staff) #12 (a dietary aide). One dumpster was observed. The area around the dumpster had scattered pieces of trash/paper and debris laying around, that included 2 latex gloves, plastic drink lids, scattered brown paper towels, plastic pieces, and scattered broken glass pieces around the dumpster. The above findings were reviewed with the DM at approximately 4:15 PM. The DM was asked for a policy on garbage and refuse disposal. The policy was presented, titled "Dispose of Garbage and Refuse" and documented, "...All garbage and refuse will be collected and disposed of in a safe and efficient manner. The dining services director coordinates with the	F 814	(F814) Dispose Garbage and Refuse Properly 1. No residents were identified with this alleged deficient practice. The area around the dumpster was cleaned immediately after notification. 2. No other dumpster at the facility. 3. The ED/ designee reeducated the dietary and maintenance staff on properly disposing of garbage and refuse. . 4. The Maintenance Director/ designee to conduct QI monitoring of F814 to ensure garbage and refuse are properly disposed. QI monitoring conducted via observations twice weekly x2 weeks and then weekly x4 weeks. Findings to be reported to the QAPI committee and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Completion: April 11, 2023	4/11/2023

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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 814	**Continued From page** 60 **director of maintenance to ensure that the area surrounding the exterior dumpster area is maintained in a manner free of rubbish or other debris..."** **The DON (director of nursing), administrator,** AIT **(administrator in training), and corporate nurses were made aware of the above in a meeting with the the survey team on** 02/27/23 **at approximately 4:15 PM.** **No further information and/or documentation was provided prior to the exit conference on 02/28/23.**	F 814		
F 842 SS=D	**Resident Records - Identifiable Information CFR(s): 483.20(f)(5),** 483.70(i)(1)-(5) **§483.20(f)(5) Resident-identifiable information.** **(i) A facility may not release information that is resident-identifiable to the public.** **(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.** §483.70(i) **Medical records.** §483.70(i)(1) **In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-** **(i) Complete;** **(ii) Accurately documented;** **(iii) Readily accessible; and** **(iv) Systematically organized** §483.70(i)(2) **The facility must keep confidential all information contained in the resident's records,**	F 842	(F842) Resident Records – Identifiable Information 1. Resident #2 no longer residents in the facility. 2. Residents receiving hospice services were reviewed by the DON/ designee to ensure documentation of nursing visits. Follow up completed based on findings. 3. The DON/ designee reeducated the Medical Records Coordinator on the facility's hospice care policy. 4. DON/Designee to conduct QI monitoring of F842 to ensure a complete medical records including documentation of nursing visits by hospice. QI monitoring conducted via medical record review of hospice residents twice weekly x2 weeks and then weekly x4 weeks. Findings to be reported to the QAPI committee and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Completion: April 11, 2023	4/11/2023

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F 842	Continued From page 61 **regardless of the form or storage method of the records, except when release is-** **(i) To the individual, or their resident representative where permitted by applicable law;** **(ii) Required by Law;** **(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;** **(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.** §483.70(i)(3) **The facility must safeguard medical record information against loss, destruction, or unauthorized use.** §483.70(i)(4) **Medical records must be retained for-** **(i) The period of time required by State law; or** **(ii) Five years from the date of discharge when there is no requirement in State law; or** **(iii) For a minor, 3 years after a resident reaches legal age under State law.** §483.70(i)(5) **The medical record must contain-** **(i) Sufficient information to identify the resident;** **(ii) A record of the resident's assessments;** **(iii) The comprehensive plan of care and services provided;** **(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;** **(v) Physician's, nurse's, and other licensed**	F 842		

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F 842	Continued From page 62 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete medical record for one of twenty-nine residents in the survey sample (Resident #2). The findings include: Resident #2's clinical record did not include documentation of nursing visits by hospice. Resident #2 was admitted to the facility with diagnoses that included cerebral infarction, hernia, congestive heart failure, protein-calorie malnutrition, atherosclerotic heart disease, and hypothyroidism. The minimum data set (MDS) dated 2/8/23 assessed Resident#2 as cognitively intact. Resident #2's clinical record documented a physician's order dated 11/1/22 for hospice care. The resident's clinical record included a hospice plan of care and care visits by hospice certified nurses' aides. The clinical record from 11/1/22 through 2/27/23 documented no ongoing visits from hospice nurses. On 2/28/23 at 8:30 a.m., the licensed practical nurse unit manager (LPN #5) was interviewed about any hospice nurse visits for Resident #2. LPN #5 stated the nurses came about twice per week, but she was not provided any notes from their visits. LPN #5 stated the aides left a sheet documenting the care provided but she had no documentation of nursing visits. LPN #5 stated	F 842		

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F 842	Continued From page 63 the nurses verbally communicated as needed about any changes in care but did not provide documentation of their visits. On 2/28/23 at 8:41 a.m., the medical records clerk (other staff #10) was interviewed about Resident #2's hospice nursing notes. Other staff #10 stated the hospice nurses did not leave records of their visits. other staff #10stated, "I've asked for them and asked for them and never get them." Other staff #10 stated that the nurses documented in their own system and refused to forward the notes to the nursing facility. Other staff #10 stated, "We've asked multiple times and they [hospice] don't respond." On 2/28/23 at 11:00 a.m., the director of nursing (DON) was interviewed about hospice nursing notes. The DON stated, "We've told them [hospice] we need them, and they say they will send them but we don't get them." On 2/28/23 at 1:48 p.m., the DON stated she contacted hospice and they reported nursing visit notes were supposed to be forwarded to the facility at least weekly. The DON stated hospice nurses visited the resident routinely but had not provided visit notes for Resident #2. This finding was reviewed with the administrator, director of nursing and regional nurse consultants during a meeting on 2/28/23 at 3:10 p.m.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880	(F880) Infection Prevention and Control 1. Resident #40 no longer resides in the facility. 2. The DON/ designee completed a Treatment observation to ensure proper hand hygiene was performed. Follow up completed based on the findings.	4/11/2023

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F 880	Continued From page 64 **comfortable environment and to help prevent the development and transmission of communicable diseases and infections.** §483.80(a) **Infection prevention and control program.** **The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:** **§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to** §483.70(e) **and following accepted national standards;** **§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:** **(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;** **(ii) When and to whom possible incidents of communicable disease or infections should be reported;** **(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;** **(iv)When and how isolation should be used for a resident; including but not limited to:** **(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and** **(B) A requirement that the isolation should be the least restrictive possible for the resident under the**	F 880	3. The DON/designee reeducated the licensed nurses on the facility's hand hygiene policy. 4. The DON/ designee to conduct QI monitoring of F880 to ensure proper hand hygiene. QI monitoring conducted via observations twice weekly x3 weeks and then weekly x3 weeks using a sample size of 5 random residents. 5. Date of Completion: April 11, 2023	

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F 880	Continued From page 65 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review the facility staff failed to ensure proper hand hygiene for one of 29 residents (Resident #40). The Findings Include: Proper hand hygiene was not performed during a dressing change for Resident #40. Diagnoses for Resident #40 included; Adult failure to thrive, diabetes, major depression, and stage three pressure ulcer. The most current MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 1/12/2023. Resident #40 was assessed	F 880		

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F 880	Continued From page 66 with a cognitive score of 13 out of 15, indicating cognitively intact. On 2/27/23 at 9:53 AM, registered nurse (RN #6) performed a dressing change on Resident #40. RN #6 removed the old dressing, cleaned the wound using wound cleanser, removed gloves and reached into her pocket and pulled out another pair of gloves, applied the gloves (without doing any hand hygiene), applied wound medication, and redressed the wound. After the dressing was completed, RN #6 was asked about cleaning or washing hands in-between glove changes. RN #6 verbalized that she should have used hand sanitizer between glove changes. On 2/27/23 at 5:26 PM, the above information was presented to the administrator and director of nursing. The administrator verbalized that hand hygiene should have taken place between changing gloves. A policy titled "Dressing Changes" was presented and read in part: "[...] Perform hand hygiene, apply gloves, remove and depose of soiled dressing, remove gloves, perform hand hygiene, apply gloves [...]." No other information was provided prior to exit conference on 2/28/22.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.	F 908	(F908) Essential equipment in safe operating condition 1. No residents were identified with this alleged deficient practice. Pilot light was relit immediately and machine came back up to temp. Ecolab came out on Monday, February 27, 2023 and serviced the dishwasher and performed preventative maintenance. Technician ensured that the machine was holding temps.	4/11/2023

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F 908	Continued From page 67 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure essential equipment was in good working order. Finding include: On 02/26/23 at 3:15 PM during the initial tour of the kitchen, OS #13 (Other Staff) was observed operating the dishwasher. OS #13 stated it was high temperature washer, but was unsure of the water temperature requirements/specs. The water temperature specs were found on the underside of the dishwasher and were listed as: wash 150 degrees F (Fahrenheit) minimum and rinse 180 F minimum. At 3:16 PM, OS #13 ran the dishwasher for observation of water temps, the wash temperature was 120 F and the rinse was 170 F. At 3:20 PM, OS #13 ran the dishwasher again, the wash temperature was 130 F and the rinse temp was 170 F. At 3:24 PM, OS #12 (dietary staff) ran the dishwasher, The wash temperature was 130 F and the rinse temperature was 160 F. OS #12 stated that they (dietary staff) had problems with the dishwasher a couple of months back and that the maintenance director looked at it. OS #12 stated that the hot water comes and goes. On 02/26/23 at 4:22 PM, the DM (dietary manager) ran the dishwasher again. The wash temp reached 158 F and the rinse reached between 173-175 F. The DM stated that the dishwasher temp was so hot earlier that she	F 908	2. The Dietary Manager/designee reviewed the daily temps for the dishwasher for the last week to ensure the temps within the necessary ranges. 3. The ED/designee reeducated the dietary staff on ensuring the temps are taken every shift before using the machine and the subsequent steps to follow if the machine is not holding temperatures. 4. Maintenance Dir./ED/AIT or Designee to conduct QI monitoring of F908 to ensure essential equipment is in good working order. QI monitoring conducted via observations three times weekly x2 weeks, twice weekly x2 weeks and then weekly x2 weeks. Findings to be reported to the QAPI committee and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Completion: April 11, 2023	

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F 908	Continued From page 68	F 908		

could hardly touch the plates. The DM was asked if there was any other way to check the water temperatures, beside the temperature gauges to ensure accuracy. The DM denied knowing of other methods, but would check with the maintenance department.

At 4:44 PM, the maintenance director was interviewed regarding the variances in the hot water temperature. The maintenance director stated that when he came in that day (02/26/23) at approximately 3:30 PM, the boiler was off. The maintenance director stated he had to light it and that it does occasionally go out. The maintenance director went on to say that no one from the facility had contacted him with concerns regarding hot water that day (02/26/23) until 'you all' came in. The maintenance director stated that they sometimes have problems with the boiler staying lit, but they are working on that. The maintenance director stated that it is back on now and that the water temperature if going up, as expected. The maintenance director stated that the facility had the system checked on 02/17/23 for that specific concern and would produce that work order to show what was done and what was being worked on to remedy the problem.

On 02/27/23 at approximately 1:30 PM, the maintenance director provided a work order for the boiler that documented there had been a 'flame failure' and that it was resolved on 02/17/23. The work order also documented a solution that was being recommended to prevent this from happening in the future, but that fix had not been implemented at this point.

On 02/27/23 at approximately 4:45 PM, the DON

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F 908	Continued From page 69 (director of nursing) and the administrator were made aware of these findings in a meeting with the survey team. No further information and/or documentation was presented prior to the exit conference on 02/28/23.	F 908		