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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 09/06/23 through 09/07/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Five complaints were investigated during the survey: VA00059636-substantiated with deficiency, VA00059459-substantiated with deficiency, VA00059195-substantiated with deficiency, VA00058896-substantiated with deficiency and VA00058832-unsubstantiated. The census in this 190 certified bed facility was 156 at the time of the survey. The survey sample consisted of 17 resident reviews.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility failed to	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/04/2023

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protect the resident's right to be free from physical abuse by another resident, for one of 17 residents in the survey sample, Residents #10.

The findings include:

The facility failed to protect Resident #10 from physical abuse by another resident, Resident #14 on 8/4/23.

Resident #10 was admitted to the facility on 10/8/19 with diagnoses that included but were not limited to: schizophrenia, psychosis not due to a substance and colostomy.

Resident #10's most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/14/23, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident was independent for bathing, transfers, bed mobility, dressing, eating and hygiene. Resident required supervision for locomotion and walking.

A review Resident #10's comprehensive care plan dated 2/7/23, which revealed, "FOCUS: The resident has a psychosocial well-being problem related to relationship in the facility. INTERVENTIONS: Provide privacy. Educate on Safety. Encourage resident to discuss feelings."

Resident #14 was admitted to the facility on 1/23/23 with diagnosis that included but were not limited to: hemiplegia, hemiparesis on left side and psychoactive substance abuse.

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Resident #14's most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/20/23, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired.

A review of Resident #14's comprehensive care plan dated 8/4/23, which revealed, "FOCUS: Resident engaged in physical altercation with another resident. INTERVENTIONS: Nursing to redirect negative behaviors that may lead to violence as indicated."

A review of the facility synopsis of event dated 8/4/23, revealed, "Charge nurse reported that (Resident #14) and (Resident #10) engaged in a verbal and physical altercation. (Resident #14) had his cane at the time and he used it to strike (Resident #10). Residents separated. Skin and pain assessments will be completed. (Resident #14) was moved further from (Resident #10)."

No previous physical events of resident to resident abuse by Resident #14 was evidenced either prior to or subsequent to this event.

A review of Resident #14's progress note dated 8/4/23 at 10:28 PM, revealed, "Resident engaged in a physical confrontation with another resident. Staff unable to separate the two residents and had to call police and ambulance for help. Resident refused to go to hospital for evaluation and also refused a skin assessment and vital signs. Nurse Practitioner (NP) notified; attempted to notify emergency contact 1 and 2 and message left in voice mail for them to call back for update."

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A review of Resident #10's progress notes dated 8/4/23 at 10:37 PM, revealed, "Resident was in his bed resting at 10:00 PM, then another resident came in his room and hit him while he was sleeping. Both residents engage in altercation, police and ambulance was called. Resident was checked by EMTs (emergency medical technicians). Resident refused to go to the ER (emergency room) to get evaluated. Resident refuse staff to assess injuries."

A review of Resident #10's progress note dated 8/5/23 at 6:15 AM, revealed, "Refused vital signs and neuro checks due to head injury related to physical altercation with another resident during previous shift. NP aware. Unable to reach RP (responsible party) via phone to notify but message left to voicemail."

A review of Resident #14's progress note dated 8/5/23 at 6:17 AM, revealed, "Resident outside in the courtyard for most of the shift, did not display violent behavior during this shift. Denies pain. Continues to refuse skin check related to physical altercation during previous shift. NP aware; own RP."

Resident #10 and Resident #14 declined to be interviewed.

An interview was conducted on 9/6/23 at 1:00 PM LPN (licensed practical nurse) #2. When asked what abuse is, LPN #2 stated, it can be verbal, physical, sexual or financial. When asked if one Resident hit another resident with a cane, is that abuse, LPN #2 stated, yes, it is abuse.

An interview was conducted on 9/7/23 at 10:00

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F 600	Continued From page 4 AM with LPN #1. When asked what abuse is, LPN #1 stated, abuse can be verbal, physical, sexual, financial, mental or emotional. When asked if one resident strikes another resident with a cane, is that abuse, LPN #1 stated, that is abuse. On 9/7/23 at approximately 4:00 PM, ASM #1, the executive director and ASM #2, the interim director of nursing was made aware of the findings. A review of the facility's "Abuse, Neglect, Exploitation and Misappropriation" policy, revised 11/16/22, revealed, "Acts of abuse directed against residents are absolutely prohibited. The center is committed to the prevention of abuse, neglect, misappropriation of resident property and exploitation. The following systems have been implemented: Monitoring of residents who may be at risk is the responsibility of all facility staff. This included monitoring residents who are at risk or vulnerable for abuse, for indications in changes in behavior, changes in condition or other non-verbal indication of abuse." No further information was provided prior to exit.	F 600		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		

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needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document

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review, it was determined the facility staff failed to develop/implement the care plan for two of 17 residents in the survey sample, Resident #10 and Resident #12.

The findings include:

1. For Resident #10, the facility staff failed to develop a comprehensive care plan for abuse for Resident #10.

Resident #10 was admitted to the facility on 10/8/19 with diagnoses that included but were not limited to: schizophrenia, psychosis not due to a substance and colostomy.

Resident #10's most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/14/23, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident was independent for bathing, transfers, bed mobility, dressing, eating and hygiene. Resident required supervision for locomotion and walking.

A review Resident #10's comprehensive care plan dated 2/7/23, which revealed, "FOCUS: The resident has a psychosocial well-being problem related to relationship in the facility. INTERVENTIONS: Provide privacy. Educate on Safety. Encourage resident to discuss feelings."

A review of the facility synopsis of events dated 8/4/23, revealed, "Charge nurse reported that (Resident #14) and (Resident #10) engaged in a verbal and physical altercation. (Resident #14)

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had his cane at the time and he used it to strike (Resident #10). Residents separated. Skin and pain assessments will be completed. (Resident #14) was moved further from (Resident #10)."

An interview was conducted on 9/7/23 at 3:45 with ASM (administrative staff member) #2, the interim director of nursing. When asked the purpose of the care plan, ASM #2 stated, purpose of the care plan to better help all staff take care of residents based on needs, preferences, orders and condition. When asked if a resident had been struck by another resident with a cane, should a care plan be developed to include abuse, ASM #2 stated, yes, it should be developed based on the resident-to-resident altercation.

On 9/7/23 at approximately 4:00 PM, ASM #1, the executive director and ASM #2, the interim director of nursing was made aware of the findings.

A review of the facility's "Plans of Care" policy, revised 9/17, revealed, "Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment."

No further information was provided prior to exit.

2. For Resident #12, the facility staff failed to implement the comprehensive care plan to check the wander guard (a bracelet worn by the resident used as monitoring device due to wandering) for placement each shift.

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A review of the comprehensive care plan dated 4/23/23 revealed, "FOCUS: The resident is an elopement risk/wanderer related to resident wanders aimlessly, exit seeking to go home, tugging on unit entrance door randomly, resident exit seeking walking out of door.
INTERVENTIONS: Assess for elopement risk. Check wander guard for placement/function/expiration date as ordered and as needed. Electronic monitoring device wander guard."

Resident #12 was observed with the wander guard on his right ankle on 9/6/23 at 1:00 PM.

A review of the physician orders dated 10/20/22, revealed "Wander guard check every shift for placement."

A review of the "Elopement Risk Evaluation" dated 4/22/23, revealed, "Resident is AT RISK for elopement".

A review of the TARs (treatment administration records) from June-September 2023 revealed the following documentation was missing for "Wander guard check every shift for placement and for monitoring" June: 2 out of 90 shifts, July: 2 out of 93 shifts, August: 7 out of 93 shifts and September: 3 out of 16 shifts.

An interview was conducted on 9/7/23 at 10:00 AM with LPN (licensed practical nurse) #1. When asked the purpose of the care plan, LPN #1 stated, to give us the goals and interventions needed for each resident. When asked if the care plan intervention included wander guard for placement and function, but there was no evidence of the wander guard being checked

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F 656	Continued From page 9 every shift, was the care plan being followed, LPN #1 stated, no, it is not being followed. On 9/7/23 at approximately 4:00 PM, ASM #1, the executive director and ASM #2, the interim director of nursing was made aware of the findings. No further information was provided prior to exit.	F 656		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide supervision for six of 17 residents in the survey sample, Resident #4, #5, #6, #7, #8, #12. The findings include: The facility staff failed to ensure a staff member supervised the residents during smoking times, and failed to ensure wander guard monitoring was performed per the plan of care. On 9/6/23 at 8:30 AM, during entrance, a list of smoking residents was requested. This list included the following	F 689		

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Residents: Resident #4, Resident #5, Resident #6, Resident #7 and Resident #8.

1. Resident #4 did not have interventions implemented to supervise smoking. On 9/6/23 at approximately 9:00 AM, Resident #4 was observed in the courtyard off the dining room, smoking without supervision. A smoking apron was on the resident. When asked who had provided his cigarette and lit it, Resident #4 would not answer. No burns noted on resident.

Resident #4 was admitted to the facility on 6/3/22 with diagnosis that included but were not limited to: Alzheimer's, Psychotic disorder and CVA (cerebrovascular attack).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/6/23, coded the resident as scoring a 05 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired.

A review of the comprehensive care plan revised 3/17/23 revealed, "FOCUS: The resident is a smoker. Resident has a history of taking cigarettes out of ashtray. Resident is at times non-compliant with facility smoking policy. INTERVENTIONS: The resident requires a smoking apron while smoking. The resident requires supervision while smoking. The resident's smoking supplies are store by the facility staff. Instruct resident about the facility policy on smoking: locations, times and safety concerns."

A review of the "Smoking Evaluation" dated

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8/24/23, revealed, "Summary of evaluation: Resident is determined to be a safe smoker. Supervision needed while smoking: constant."

On 9/6/23 at 2:00 p.m. an interview was attempted with OSM #9, the activities director, who was responsible for overseeing the resident smoking time on 9/6/23, however OSM #9 was escorted out of the building by OSM #8, the HR director, as the surveyor approached him.

On 9/6/23 at approximately 5:40 PM, ASM (administrative staff member) #1, the executive director and ASM #2, the interim director of nursing was made aware of the findings. ASM #1 stated, "I understand you passed him in the hall as he was leaving. He was responsible for overseeing smoking." ASM #1 and ASM #2 stated OSM #9 was terminated.

On 9/7/23 at approximately 8:00 AM, ASM #1 stated, "I met with the residents last evening and outlined the smoking times, they requested to smoke more than one cigarette and we discussed the need for supervision and for them to wear their smoking apron."

On 9/7/23 at approximately 9:05 AM, CNA (certified nursing assistant) #4 was observed entering the courtyard with a container of cigarettes and lighter. When asked if she was assigned this, CNA #4 stated, it is a rotating assignment, and it is usually the responsibility of the activities department. CNA #4 stated to residents, no apron, no smoking and proceeded to light the residents' cigarettes.

A review of the facility's "Smoking-Supervised" policy, revised 2/7/20, revealed, "The Center will

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provide a safe, designated smoking area for residents. For the safety of all residents the designated smoking area will be monitored by a staff member during authorized smoking times. Smoking is only allowed in designated areas and during designated times. Oxygen is not permitted in the designated smoking area. The Center will have safety equipment available in designated smoking areas including smoking blankets, smoking aprons, a fire extinguisher and non-combustible self- closing ashtrays. The Center will retain and store matches, lighters, etc. for all residents."

No further information was provided prior to exit.

2. Resident #5 did not have interventions implemented to supervise smoking. On 9/6/23 at approximately 9:00 AM, Resident #5 was observed in the courtyard off the dining room, smoking without supervision. Smoking apron was on the resident. When asked who had provided her cigarette and lit it, Resident #5 would not answer. No burns noted on resident.

Resident #5 was admitted to the facility on 11/21/22 with diagnosis that included but were not limited to: schizophrenia, DM (diabetes mellitus) and ESRD.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/31/23, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired.

A review of the comprehensive care plan revised

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3/17/23, which revealed, "FOCUS: The resident is a smoker. INTERVENTIONS: The resident requires a smoking apron while smoking. The resident requires supervision while smoking. Instruct resident about the facility policy on smoking: locations, times and safety concerns."

A review of the "Smoking Evaluation" dated 3/1/23, revealed, "Summary of evaluation: Resident is determined to be a safe smoker. Supervision needed while smoking: constant."

On 9/6/23 at 2:00 p.m. an interview was attempted with OSM #9, the activities director, who was responsible for overseeing the resident smoking time on 9/6/23, however OSM #9 was escorted out of the building by OSM #8, the HR director, as the surveyor approached him.

On 9/6/23 at approximately 5:40 PM, ASM (administrative staff member) #1, the executive director and ASM #2, the interim director of nursing was made aware of the findings. ASM #1 stated, "I understand you passed him in the hall as he was leaving. He was responsible for overseeing smoking." ASM #1 and ASM #2 stated OSM #9 was terminated.

On 9/7/23 at approximately 8:00 AM, ASM #1 stated, "I met with the residents last evening and outlined the smoking times, they requested to smoke more than one cigarette and we discussed the need for supervision and for them to wear their smoking apron."

On 9/7/23 at approximately 9:05 AM, CNA (certified nursing assistant) #4 was observed entering the courtyard with a container of cigarettes and lighter. When asked if she was

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assigned this, CNA #4 stated, it is a rotating assignment, and it is usually the responsibility of the activities department. CNA #4 stated to residents, no apron, no smoking and proceeded to light the residents' cigarettes.

No further information was provided prior to exit.

3. Resident #6 did not have interventions implemented to supervise smoking. On 9/6/23 at approximately 9:00 AM, Resident #6 was observed in the courtyard off the dining room, smoking without supervision. Smoking apron was not on the resident. When asked who had provided her cigarette and lit it, Resident #6 would not answer. No burns noted on resident.

Resident #6 was admitted to the facility on 11/22/22 with diagnosis that included but were not limited to: schizophrenia, DM (diabetes mellitus) and COPD (chronic obstructive pulmonary disease).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/8/23, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired.

A review of the comprehensive care plan revised 3/17/23, which revealed, "FOCUS: The resident is a smoker. Resident is at times non-compliant with facility smoking policy. INTERVENTIONS: The resident requires a smoking apron while smoking. The resident requires supervision while smoking. Instruct resident about the facility policy on smoking: locations, times and safety

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concerns."

A review of the "Smoking Evaluation" dated 8/24/23, revealed, "Summary of evaluation: Resident is determined to be a safe smoker. Supervision needed while smoking: constant."

On 9/6/23 at 2:00 p.m. an interview was attempted with OSM #9, the activities director, who was responsible for overseeing the resident smoking time on 9/6/23, however OSM #9 was escorted out of the building by OSM #8, the HR director, as the surveyor approached him.

On 9/6/23 at approximately 5:40 PM, ASM (administrative staff member) #1, the executive director and ASM #2, the interim director of nursing was made aware of the findings. ASM #1 stated, "I understand you passed him in the hall as he was leaving. He was responsible for overseeing smoking." ASM #1 and ASM #2 stated OSM #9 was terminated.

On 9/7/23 at approximately 8:00 AM, ASM #1 stated, "I met with the residents last evening and outlined the smoking times, they requested to smoke more than one cigarette and we discussed the need for supervision and for them to wear their smoking apron."

On 9/7/23 at approximately 9:05 AM, CNA (certified nursing assistant) #4 was observed entering the courtyard with a container of cigarettes and lighter. When asked if she was assigned this, CNA #4 stated, it is a rotating assignment, and it is usually the responsibility of the activities department. CNA #4 stated to residents, no apron, no smoking and proceeded to light the residents' cigarettes.

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No further information was provided prior to exit.

4. Resident #7 did not have interventions implemented to supervise smoking. On 9/6/23 at approximately 9:00 AM, Resident #7 was observed in the courtyard off the dining room, smoking without supervision. Smoking apron was not on the resident. When asked who had provided her cigarette and lit it, Resident #7 would not answer. Resident #7 was sitting in the corner of the building at least six feet from the other residents while smoking. On 9/6/23 at approximately 1:45 PM, Resident #7 was followed out into the courtyard and was observed to take a cigarette and lighter from a container on her wheelchair seat and light her own cigarette. Resident #7 again refused to state who kept her cigarettes and lighter. No supervision was present at this time. No burns noted on resident.

Resident #7 was admitted to the facility on 10/19/22 with diagnosis that included but were not limited to: DM (diabetes mellitus), pancreatitis, epilepsy, bipolar, alcohol abuse and COVID positive on 9/3/23.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/19/23, coded the resident as scoring a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired.

A review of the comprehensive care plan revised 11/15/22, which revealed, "FOCUS: The resident is a smoker. Resident became verbally aggressive with staff when she could not have a

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second cigarette. INTERVENTIONS: The resident requires a smoking apron while smoking. The resident requires supervision while smoking. Instruct resident about the facility policy on smoking: locations, times and safety concerns."

A review of the "Smoking Evaluation" dated 7/7/23, revealed, "Summary of evaluation: Resident is determined to be an unsafe smoker. Supervision needed while smoking: constant."

On 9/6/23 at 2:00 p.m. an interview was attempted with OSM #9, the activities director, who was responsible for overseeing the resident smoking time on 9/6/23, however OSM #9 was escorted out of the building by OSM #8, the HR director, as the surveyor approached him.

On 9/6/23 at approximately 5:40 PM, ASM (administrative staff member) #1, the executive director and ASM #2, the interim director of nursing was made aware of the findings. ASM #1 stated, "I understand you passed him in the hall as he was leaving. He was responsible for overseeing smoking." ASM #1 and ASM #2 stated OSM #9 was terminated.

On 9/7/23 at approximately 8:00 AM, ASM #1 stated, "I met with the residents last evening and outlined the smoking times, they requested to smoke more than one cigarette and we discussed the need for supervision and for them to wear their smoking apron."

On 9/7/23 at approximately 9:05 AM, CNA (certified nursing assistant) #4 was observed entering the courtyard with a container of cigarettes and lighter. When asked if she was assigned this, CNA #4 stated, it is a rotating

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assignment, and it is usually the responsibility of the activities department. CNA #4 stated to residents, no apron, no smoking and proceeded to light the residents' cigarettes. When asked about Resident #7 lighting her own cigarette, CNA #4 stated, she must have been smoking outside of the smoking times.

No further information was provided prior to exit.

5. Resident #8 did not have interventions implemented to supervise smoking. On 9/6/23 at approximately 9:00 AM, Resident #8 was observed in the courtyard off the dining room, smoking without supervision. Smoking apron was not on the resident. When asked who had provided her cigarette and lit it, Resident #8 stated, "I am not telling you anything. Leave me alone." No burns noted on resident.

Resident #8 was admitted to the facility on 4/4/23 with diagnosis that included but were not limited to: DM (diabetes mellitus), COPD (chronic obstructive pulmonary disease), acute respiratory failure and congestive heart failure.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 7/15/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired.

A review of the comprehensive care plan dated 4/17/23, which revealed, "FOCUS: The resident is a smoker. INTERVENTIONS: The resident requires a smoking apron while smoking. The resident requires supervision while smoking.

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Instruct resident about the facility policy on smoking: locations, times and safety concerns."

A review of the "Smoking Evaluation" dated 8/23/23, revealed, "Summary of evaluation: Resident is determined to be a safe smoker. Supervision needed while smoking: constant."

On 9/6/23 at 2:00 p.m. an interview was attempted with OSM #9, the activities director, who was responsible for overseeing the resident smoking time on 9/6/23, however OSM #9 was escorted out of the building by OSM #8, the HR director, as the surveyor approached him.

On 9/6/23 at approximately 5:40 PM, ASM (administrative staff member) #1, the executive director and ASM #2, the interim director of nursing was made aware of the findings. ASM #1 stated, "I understand you passed him in the hall as he was leaving. He was responsible for overseeing smoking." ASM #1 and ASM #2 stated OSM #9 was terminated.

On 9/7/23 at approximately 8:00 AM, ASM #1 stated, "I met with the residents last evening and outlined the smoking times, they requested to smoke more than one cigarette and we discussed the need for supervision and for them to wear their smoking apron."

On 9/7/23 at approximately 9:05 AM, CNA (certified nursing assistant) #4 was observed entering the courtyard with a container of cigarettes and lighter. When asked if she was assigned this, CNA #4 stated, it is a rotating assignment, and it is usually the responsibility of the activities department. CNA #4 stated to residents, no apron, no smoking and proceeded

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to light the residents' cigarettes.

No further information was provided prior to exit.

6. For Resident #12, the facility staff failed to monitor his wander guard for placement and functioning.

A review of the 4/21/23 facility synopsis of events, revealed, "(Resident #12) was noted pushing on the back door of the secure unit. Staff redirected resident away from door. Later during the shift while staff were in other patient rooms providing care, (Resident #12) pushed again on the back door of the secure unit and after the time delay was able to exit the building. Staff heard the alarm and responded. A quick head count was done and it was identified that (Resident #12) was missing. The aide exited the building and found (Resident #12) walking towards the front of the center. He was recovered and brought back to the building without injury."

Resident #12 was admitted to the facility on 4/22/22 with diagnoses that included but were not limited to: alcoholic cirrhosis of liver, traumatic hemorrhage of cerebrum, convulsions and encephalopathy.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 7/31/23, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for dressing, and supervision for walking, locomotion, transfers and

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bed mobility.

A review of the comprehensive care plan dated 4/23/23 which revealed, "FOCUS: The resident is an elopement risk/wanderer related to resident wanders aimlessly, exit seeking to go home, tugging on unit entrance door randomly, resident exit seeking walking out of door.
INTERVENTIONS: Assess for elopement risk. Check wander guard for placement/function/expiration date as ordered and as needed. Electronic monitoring device wander guard.

Resident #12 was observed with the wander guard on his right ankle on 9/6/23 at 1:00 PM

A review of the physician orders dated 10/20/22, revealed "Wander guard check every shift for placement."

A review of the "Elopement Risk Evaluation" dated 4/22/23, revealed, "Resident is AT RISK for elopement".

A review of the TARs (treatment administration record) June-September 2023 revealed the following documentation was missing: "Wander guard check every shift for placement and for monitoring" June: 2 out of 90 shifts, July: 2 out of 93 shifts, August: 7 out of 93 shifts and September: 3 out of 16 shifts.

An interview was conducted on 9/7/23 at 10:00 AM with LPN (licensed practical nurse) #1. When asked if there are holes/blanks in the documentation, is there evidence that the wander guard is being checked. LPN #6 stated, no, if there are holes, we cannot validate that it was

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F 689	Continued From page 22 checked. On 9/7/23 at approximately 4:00 PM, ASM #1, the executive director and ASM #2, the interim director of nursing was made aware of the findings. A review of the facility's "Elopement/Wandering Risk Guideline" policy, revised 8/20, revealed, "To evaluate and identify patient/residents that are at risk for elopement and develop individualized interventions. Initiate individualized interventions based on Patient/Residents' risk. Document individualized interventions in the patient/resident Care Plan and Kardex. If utilizing a wander monitoring system device check placement of the device every shift and functionality every day." No further information was provided prior to exit.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to	F 692		

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maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to monitor weights as directed for one of 17 residents in the survey sample, Resident #13.

The findings include:

For Resident #13 (R13), the facility staff failed to obtain an order for, and obtain weekly weights as documented by the nurse practitioner on 5/25/2023, and the dietician on 8/18/2023.

R13 was admitted to the facility with diagnoses that included but were not limited to unspecified protein-calorie malnutrition and abnormal weight loss.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/9/2023, coded the resident as scoring a 3 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. The assessment documented R13 having a weight loss of 5% or more in the last month or 10% or more in the last 6 months.

Review of the clinical record documented weight values obtained for R13 monthly on 12/29/22, 1/10/23, 2/9/23, 3/8/23, 4/10/23, 5/15/23, 6/6/23,

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6/13/23, 7/17/23 and 8/15/23. The record failed to evidence documentation of weekly weights.

On 07/17/2023, the resident weighed 110.4 lbs.
On 08/15/2023, the resident weighed 108.8 pounds which is a -1.45 % Loss.
On 06/13/2023, the resident weighed 110.4 lbs.
On 08/15/2023, the resident weighed 108.8 pounds which is a -1.45 % Loss.
On 05/15/2023, the resident weighed 114.8 lbs.
On 08/15/2023, the resident weighed 108.8 pounds which is a -5.23 % Loss.

The nurse practitioner progress note dated 5/25/2023 for R13 documented in part, "...Plan: Discussed with nursing staff in detail. Labs and medications were reviewed. Recommend to continue with current diet and start Ensure to support weight gain with continuation of Med Pass (supplement) and monitor closely for any aspiration, nausea/vomiting and diarrhea. Maintain weekly weight monitoring..."

The progress notes for R13 evidenced a registered dietician note which documented, "8/18/2023 10:15 (10:15 a.m.) Weight Warning: Value 108.8 (pounds)... BMI (body mass index) 19.9, -1.4% wt (weight) loss x 1 month. Resident's wt (weight) trending down x 8 months. Reg diet, fortified foods, medpass 120ml TID (three times a day), health shake BID (twice a day). Eating 51-100%. MD (medical doctor) advised weekly wt checks. Recommend adding large portions to promote wt gain."

A review of the physician order summary dated 9/7/2023 documented in part,
- "Regular diet, Regular texture, Regular/Thin Liquids consistency, fortified foods, large

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portions. Order Date: 06/21/2023."
- "Med Pass 2.0 -Give 237ml (milliliter) three times a day for supplement. Order Date: 08/25/2023."
The physician orders failed to evidence an order for weekly weights.

The comprehensive care plan documented in part, "The resident has nutritional problem r/t (related to) PCM (protein calorie malnutrition), asthma, fx (fracture), HTN (hypertension), dementia, CAD (coronary artery disease), anemia, depression, frostbite."

On 9/7/2023 at approximately 10:00 a.m., a request was made for evidence of all weights for R13 since 5/1/2023.

On 9/7/2023 at approximately 1:45 p.m., ASM (administrative staff member) #1, the executive director provided weights from the dates listed above. The weights provided failed to evidence documentation of weekly weights obtained.

On 9/7/2023 at 11:52 a.m., an interview was conducted with OSM (other staff member) #4, registered dietician. OSM #4 stated that they had been working at the facility for about a month and was coming onsite to see residents three days a week. She stated that when she assesses a resident and determined that they needed to be monitored with weekly weights they were put on a spreadsheet that she maintained and sent to the unit managers, director of nursing, dietary manager and administrator. She stated that she monitors the residents on the list and removes them as needed. She stated that she had issues with the facility staff not obtaining the weekly weights for residents and had repeatedly

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requested the staff to implement her recommendations to the administration.

On 9/7/2023 at 2:44 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that residents who needed weekly weights had them generated on the eTAR (electronic treatment administration record) to let them know they needed to be obtained. She stated that she was not sure what generated them to show up on the eTAR.

On 9/7/2023 at 2:48 p.m., an interview was conducted with LPN #1. LPN #1 stated that when residents were placed on weekly weights the dietician normally spoke to the nurse practitioner about it and let them know. She stated that the nurse practitioner put in an order for weekly weights or the nurse put the order in. She stated that they read the nurse practitioner's note and the dietician's notes and put in any orders for weekly weights so they generated on the eTAR to let the staff know that they needed to be obtained.

The facility policy "Weighing the Resident" revised 10/4/2021 documented in part, "Policy: Residents will be weighed unless ordered otherwise by the physician: - Admission/re-admission x 3 days. - Weekly x 4 weeks. - Monthly thereafter. - As needed. Procedure: Weights will be completed as indicated and documented in the clinical record..."

On 9/7/2023 at approximately 4:30 p.m., ASM #1, the executive director and ASM #2, the interim director of nursing were made aware of the concern.

No further information was provided prior to exit.

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F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to provide sufficient staffing to meet resident needs for one of three resident hallways which affected 35 residents on 8/6/23. The findings include:	F 725		

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The facility staff failed to provide sufficient staffing to meet resident needs.

On 9/6/23 at approximately 8:30 AM, a request was made during the entrance conference to ASM (administrative staff member) #1, the executive director and ASM #2, the interim director of nursing to provide the as worked staffing schedules from 8/6/23-9/6/23. When asked during the entrance conference if there were any staffing waivers, ASM #2 stated, "No, there are no waivers." ASM #2 stated, "We did not have RN (registered nurse) coverage for a couple of days and we did not have an LPN (licensed practical nurse) on a unit for one day 8/6/23."

A review of the as worked staffing sheet for 8/6/23, revealed no LPN or RN worked on Wing 3, the secured unit hallway.

An interview was conducted on 9/6/23 at approximately 12:35 PM, with ASM #2, the interim director of nursing and discussed medication error reports from 1/1/23-9/6/23. ASM #2 explained that all medication errors occurred on 8/6/23, and all on one unit, Wing 3 the locked side. A nurse did not show up or one was not scheduled for that shift. There was no nurse back there. On 8/6/23 there were 35 residents and all had med errors from missing their morning medications. ASM #2 stated they came in about 1:30 PM to move furniture and found out from the Wing 2 nurse that there was no nurse on the locked side of Wing 3. The Wing 2 nurse was running back and forth checking on the residents and giving the medicines she could. ASM #2 stated, "We do not currently have any supervisors hired. Nobody called me to report they did not

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F 725	Continued From page 29 have a nurse. I call the beginning of every shift to check on staffing and have implemented a manager on call. The CNAs (certified nursing assistants) all have my number to call me. Since 9/4/23 the staff have to call me for all call outs or scheduling issues." A review of the medication error report for 8/6/23 revealed one of three hallways which affected thirty-five residents, no medication administration occurred on the day shift 7:00 AM-3:00 PM. The LPN working Wing 2 on 8/6/23 was unavailable for interview. No policy was provided related to staffing. On 9/7/23 at approximately 4:00 PM, ASM #1, the executive director and ASM #2, the interim director of nursing was made aware of the findings. No further information was provided prior to exit.	F 725		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an	F 727		

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average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide RN (registered nurse) coverage 8 hours a day, 7 days a week, with the potential to affect all residents that require RN services.

The findings include:

The facility staff failed to provide RN (registered nurse) coverage 8 hours a day for 2 of 30 days.

On 9/6/23 at approximately 8:30 AM the ASM (administrative staff member) #1, the executive director and ASM #2, the interim director of nursing were asked to provide the as worked staffing schedules from 8/6/23-9/6/23. When asked during the entrance conference if there were any staffing waivers, ASM #2 stated, "No, there are no waivers." ASM #2 stated, we did not have RN (registered nurse) coverage for a couple of days.

A review of the as worked staffing sheets evidenced no RN worked on 2 of 30 dates requested, 8/19/23 and 9/2/23.

An interview was conducted on 9/6/23 at approximately 12:35 PM, with ASM #2, the interim director of nursing. When asked the standard for RN coverage, ASM #2 stated, "RN coverage should be in building 8 hours a day. RN walked out on 9/1/23 when I asked her to work this weekend [9/2/23-9/3/23] and another nurse has not shown up for the last three days." ASM #2 stated, "There are currently no supervisors hired.

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F 727	Continued From page 31 We are looking for weekend, day, evening and night supervisors. Since 9/4/23, I call the beginning of every shift to check on staffing and are implementing a manager on call schedule. The staff have my number to call for any issues staffing or otherwise." On 9/7/23 at approximately 4:00 PM, ASM #1, the executive director and ASM #2, the interim director of nursing was made aware of the findings. No policy was provided related to staffing. No further information was provided prior to exit.	F 727		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review it was determined facility staff failed to administer medications on one of three hallways of Wing 3, which affected 35 residents. The findings include: A review of the medication error report for 8/6/23 revealed on one of three hallways, which affected thirty-five residents, no medication administration occurred on the day shift 7:00 AM-3:00 PM. A review of the medication error report of medications missed on 8/6/23, revealed three medications which met the criteria for a significant medication error:	F 760		

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1. Insulin Lispro Sliding scale subcutaneously before meals: Notify provider if BS (blood sugar) less than 60, 151-200: 3 units, 201-250: 6 units, 251-300: 9 units, 301-350: 12 units, 351-400: 15 units, greater than 400: 18 units and check again in one hour and notify the provider missed on Resident #15 at 11:30 AM.
2. Vancomycin 1 gram intravenously, once a day for leukocytosis missed on Resident #16 at 9:00 AM. 3. Tegretol 6.25 milliliter by mouth three times a day, missed on Resident #17 at 9:00 AM and 2:00 PM.

There were no adverse effects identified for the residents identified above. There were no current significant medication errors identified.

An interview was conducted on 9/6/23 at approximately 12:35 PM, with ASM #2, the interim director of nursing who stated that all med errors occurred on 8/6/23 and all on one unit, Wing 3 the locked side. A nurse did not show up or one was not scheduled for that shift. There was no nurse back there. ASM #2 stated, "On 8/6/23 there were 35 residents all had med errors from missing their morning medications. I came in about 1:30 PM, assessed the residents and informed the medical director of the missed medications."

An interview was conducted on 9/6/23 at 2:00 PM LPN (licensed practical nurse) #2. When asked what a medication error was, LPN #2 stated, if the medication is given to the wrong person or the wrong time, route, dose or form, those are all errors.

An interview was conducted on 9/7/23 at 10:00 AM with LPN #1. When asked what a medication

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F 760	Continued From page 33 error was, LPN #1 stated, if medications are not given on time to the right person, by the right route and in the right dose; that would be an error. On 9/7/23 at approximately 4:00 PM, ASM #1, the executive director and ASM #2, the interim director of nursing was made aware of the findings. The facility's "Medication Administration" policy dated 1/2022, revealed, "Facility staff should also refer to Facility policy regarding medication administration and should comply with Applicable Law and the State Operations Manual when administering medications." The facility's "Medication Administration Errors" policy dated 5/2010, revealed, "Administration Errors: In the event of an administration error, Facility staff should follow Facility policy relating to medication administration errors. Examples of administration errors include but are not limited to: Omission error: Facility fails to administer an ordered dose to the resident, unless refused by the resident or not administered because of recognized contraindication." No further information was provided prior to exit.	F 760		
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 preferences of each resident.	F 800		

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This REQUIREMENT is not met as evidenced by:
Based on resident interviews, responsible party interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to prepare and provide well-balanced meals that take into consideration the needs and choices of the residents, in one of one kitchen.

The findings include:

Residents and family members voiced complaints about the food, to include, but not limited to, the amount, taste, and temperature, however, facility staff have not resolved the concerns/complaints.

On Resident #3's (R3) most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/25/2023, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. On 9/6/2023 at 11:30 a.m., an interview was conducted with R3. R3 stated that the food at the facility was horrible with no flavor and was often served cold when it was supposed to be hot. R3 stated that they had been served undercooked vegetables and overcooked meats. R3 stated that they felt like the facility kitchen staff did not care what they gave to the residents because they thought everyone had dementia and did not know what was going on. R3 stated that they wanted to have fresh fruit and alternate food options, that they were only given sandwiches when they did not like what was served currently. R3 stated that they had talked to kitchen staff about their complaints about the food but no one

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had done anything to improve anything.

On 9/6/2023 at approximately 9:00 AM an interview was conducted with Resident #5 (R5) and Resident #9 (R9) who were both assessed as being cognitively intact. When asked were there any concerns regarding the food, R9 stated that the food was terrible and seemed like it had gotten worse. R9 stated that the taste was bad and it was cold, no matter which meal it was. R5 agreed and stated that the food did not taste good and there was so little food on the plate and there was no fresh fruit served at all.

On Resident #13's (R13) most recent MDS, a quarterly assessment with an ARD of 6/9/2023, the resident scored 3 out of 15 on the BIMS assessment, indicating the resident was severely impaired for making daily decisions. On 9/6/2023 at approximately 12:50 p.m., an interview was conducted with the family of R13. The family stated, "Do you see the time and lunch is not here?" The family stated that the meals were always late, the food was bad and always cold so they came almost every day to bring food in for R13 to eat.

On Resident #11's (R11) most recent MDS, a quarterly assessment with an ARD of 6/13/2023, the resident scored 11 out of 15 on the BIMS assessment, indicating the resident was moderately impaired for making daily decisions. On 9/6/2023 11:15 a.m., an interview was conducted with R11. When asked about the food served at the facility, R11 stated, "The food here is [expletive]." R11 stated that the breakfast was usually some cubed eggs which were not enough and cold oatmeal if they asked for it. R11 stated that they had complained to the nursing staff,

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dietary staff and the executive director about the food and they said that they put it on the meal cart to keep it warm but it was still cold when it got to the room. R11 stated that the food was cold even when they were using regular plates and the plate covers to keep them warm. R11 stated that often the food served on the plate was not what was posted on the menu in the hallway and the alternate posted on the menu was not available when they asked for it. R11 stated that the only thing they could get was a sandwich usually if they didn't like the meal served. R11 stated that the meals were always late and they never knew when the trays were coming.

Review of the Resident Council Minutes from April of 2023 documented in part, "Food getting better at times cold, want more portions for breakfast, they want more food to hold them over till lunch..."

Review of the Resident Council Minutes from May of 2023 documented in part, "Food always cold, it is not good, no taste, no snacks being offered at all. Meal trays running late all the time..."

No resident council minutes for June, July or August 2023 were available for review.

Review of the facility provided menus served between 5/1/2023-6/30/2023 documented in part,
- "Week 1: Breakfast: Regular: Sunday: Scrambled Eggs; Glazed Cinnamon Roll;...Wednesday: Biscuit; Hashbrown;..."
- "Week 2: Breakfast: Regular: Wednesday: Biscuit, Hashbrown;...Friday: Scrambled Eggs, English Muffin;..."
- "Week 3: Breakfast: Regular: Tuesday: Biscuit,

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Hashbrown;...Wednesday: Scrambled Eggs, English Muffin;..."
- "Week 4: Breakfast: Regular: Friday: Biscuit, Hashbrown;..."
The menu's failed to document serving portions.

Review of the facility provided menus served between 7/1/2023-present documented in part,
- Breakfast Day 1 (Week: 1-Sunday)
Regular: Scrambled Eggs- 1/4 cup, Glazed cinnamon roll 1 ea (each);
CCD (carbohydrate controlled diet): Scrambled Eggs- 1/4 cup, Toast 1 sl (slice), diet jelly 1 ea, margarine 1 ea;
Renal: Scrambled eggs- 1/4 cup, White toast 1 sl, margarine 1 ea, Jelly 1 ea;
CCD Renal: Scrambled eggs- 1/4 cup, White toast 1 sl, margarine 1 ea, Diet jelly 1 ea;
Gluten Free: Scrambled eggs- 1/4 cup, Gluten free toast 1 sl, margarine 1 ea, Jelly 1 ea;
Lacto-Ovo Vegetarian: Scrambled Eggs- 1/4 cup, Glazed cinnamon roll 1 ea;
2 Gm (gram) NA (sodium): Scrambled Eggs- 1/4 cup, Toast 1 sl, margarine 1 ea, Jelly 1 ea;
CCD 2 Gm NA: Scrambled Eggs- 1/4 cup, Toast 1 sl, margarine 1 ea, diet jelly 1 ea;
TLC (therapeutic lifestyle change): Scrambled Eggs- 1/4 cup, Toast 1 sl, margarine 1 ea, Jelly 1 ea;

- Breakfast Day 3 (Week: 1-Tuesday)
Renal: Scrambled eggs- 1/4 cup, English muffin 1 ea, margarine 1 ea, Jelly 1 ea;
CCD Renal: Scrambled eggs- 1/4 cup, White toast 1 sl, margarine 1 ea, Diet jelly 1 ea;
2 Gm NA: Scrambled Eggs- 1/4 cup, English muffin 1 ea, margarine 1 ea, Jelly 1 ea;
CCD 2 Gm NA: Scrambled Eggs- 1/4 cup, Toast 1 sl, margarine 1 ea, diet jelly 1 ea;

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TLC: Scrambled Eggs- 1/4 cup, English muffin 1 ea, Jelly 1 ea, margarine 1 ea;

- Breakfast Day 4 (Week: 1-Wednesday)
CCD: Scrambled eggs- 1/4 cup, Hashbrown-1/2 cup;
Renal: Scrambled eggs- 1/4 cup, White toast 1 sl, margarine 1 ea, Jelly 1 ea;
CCD Renal: Scrambled eggs- 1/4 cup, White toast 1 sl, margarine 1 ea, Diet jelly 1 ea;
Gluten free: Scrambled eggs- 1/4 cup, Hashbrown- 1/2 cup;
Lacto-Ovo Vegetarian: Scrambled eggs- 1/4 cup, Hashbrown- 1/2 cup;
2 Gm NA: Scrambled eggs- 1/4 cup, Hashbrown- 1/2 cup;
CCD 2 Gm NA: Scrambled eggs- 1/4 cup, Hashbrown- 1/2 cup;
TLC: Scrambled Eggs- Scrambled eggs- 1/4 cup, Hashbrown- 1/2 cup;

- Breakfast Day 5 (Week: 1-Thursday)
Regular: Scrambled Eggs- 1/4 cup, Streusel Coffee Cake 1 square;
CCD: Scrambled Eggs- 1/4 cup, Toast 1 sl, diet jelly 1 ea, margarine 1 ea;
Renal: Scrambled eggs- 1/4 cup, Streusel Coffee Cake 1 square, margarine 1 ea;
CCD Renal: Scrambled eggs- 1/4 cup, white toast 1 sl, diet jelly 1 ea, margarine 1 ea;
Gluten Free: Scrambled eggs- 1/4 cup, Gluten free toast 1 sl, margarine 1 ea, Jelly 1 ea;
Lacto-Ovo Vegetarian: Scrambled Eggs- 1/4 cup, Streusel Coffee Cake 1 square, margarine 1 ea;
2 Gm NA: Scrambled Eggs- 1/4 cup, Streusel Coffee Cake 1 square, margarine 1 ea;
CCD 2 Gm NA: Scrambled Eggs- 1/4 cup, Toast 1 sl, margarine 1 ea, diet jelly 1 ea;
TLC: Scrambled Eggs- 1/4 cup, Streusel Coffee

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Cake 1 square;

- Breakfast Day 6 (Week: 1-Friday)
Regular: Western scrambled Eggs- 1/4 cup, toast 1 sl, margarine 1 ea, jelly 1 ea;
CCD: Western scrambled Eggs- 1/4 cup, toast 1 sl, margarine 1 ea, diet jelly 1 ea;
Renal: Scrambled eggs- 1/4 cup, White toast 1 sl, margarine 1 ea, Jelly 1 ea;
CCD Renal: Scrambled eggs- 1/4 cup, White toast 1 sl, margarine 1 ea, Diet jelly 1 ea;
Gluten Free: Western scrambled eggs- 1/4 cup, Gluten free toast 1 sl, margarine 1 ea, Jelly 1 ea;
Lacto-Ovo Vegetarian: Western scrambled Eggs- 1/4 cup, toast 1 sl, margarine 1 ea, Jelly 1 ea;
2 Gm NA: Western scrambled Eggs- 1/4 cup, toast 1 sl, margarine 1 ea, Jelly 1 ea;
CCD 2 GM NA: Western Scrambled eggs- 1/4 cup, toast 1 sl, margarine 1 ea, Diet jelly 1 ea;
TLC: Western scrambled Eggs- 1/4 cup, toast 1 sl, margarine 1 ea, Jelly 1 ea;

- Breakfast Day 8 (Week: 2-Sunday)
Regular: Scrambled eggs- 1/4 cup, Blueberry muffin 1 ea, margarine 1 ea;
CCD: Scrambled eggs- 1/4/ cup, Toast 1 sl, Diet jelly 1 ea, margarine 1 ea;
Renal: Scrambled eggs- 1/4 cup, White toast 1 sl, margarine 1 ea, Jelly 1 ea;
CCD Renal: Scrambled eggs- 1/4 cup, White toast 1 sl, margarine 1 ea, Diet jelly 1 ea;
Gluten free: Scrambled eggs- 1/4 cup, Gluten Free muffin 1 ea, margarine 1 ea;
Lacto-Ovo Vegetarian: Scrambled eggs- 1/4 cup, Blueberry muffin 1 ea, margarine 1 ea;
2 Gm NA: Scrambled eggs- 1/4 cup, toast 1 sl, margarine 1 ea, Jelly 1 ea;
CCD 2 Gm NA: Scrambled eggs- 1/4 cup, toast 1 sl, margarine 1 ea, Diet jelly 1 ea;

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TLC: Scrambled Eggs- Scrambled eggs- 1/4 cup, toast 1 sl, margarine 1 ea, Jelly 1 ea;

The menu's further documented 1/4 cup of scrambled eggs with one slice of toast or one muffin or one biscuit served for breakfast on Day 10-Week 2-Tuesday, Day 13- Week 2- Friday, Day 16-Week 3-Monday, Day 18-Week 3-Wednesday, Day 22- Week 4-Sunday, and Day 24-Week 4-Tuesday for all diets. The menu's documented 1/4 cup of scrambled eggs with 1 slice of toast on Day 14-Week 2-Saturday, for Renal, CCD Renal, 2 GM NA, CCD 2 GM NA, and TLC diets. The menu's documented 1/4 cup of scrambled eggs with 1 slice of toast on Day 17-Week 3-Tuesday for Renal and CCD Renal diets and all other diets receiving 1/4 cup of scrambled eggs with 1/2 cup of hashbrowns. On day 19-Week 3-Thursday, Renal, CCD Renal, 2 GM NA, CCD 2 GM NA, and TLC diets received 1/4 cup of scrambled eggs and 1 slice of toast for breakfast. On day 21-Week 3-Saturday, Renal and CCD Renal diets received 1/4 cup of scrambled eggs and 1 slice of toast. All other diets received 1/4 cup of western scrambled eggs and 1 slice of toast. On day 26-Week 4-Thursday, renal, CCD renal and gluten free diets received 1/4 cup of scrambled eggs and 1 slice of toast for breakfast. On day 27-Week 4-Friday, renal and CCD renal diets received 1/4 cup of scrambled eggs and 1 slice of toast and other diets received 1/4 cup of scrambled eggs with 1/2 cup of hashbrowns with the exception of regular diets who received 1 biscuit, 3 ounces of sausage gravy and 1/2 cup of hashbrowns. On day 28-Week 4-Saturday, Renal, CCD renal, 2 GM NA, CCD 2 GM NA and TLC diets received 1/4 cup of scrambled eggs and 1 slice of toast.

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On 9/6/2023 at 2:45 p.m., an interview was conducted with OSM (other staff member) #6, the cook. OSM #6 stated that they had been at the facility for about a month. She stated that the menu was posted in the kitchen and told them what was served for the day and what scoops to use for the portions served for each meal.

On 9/6/2023 at 2:57 p.m., an interview was conducted with OSM #5, dietary aide. OSM #5 stated that they had worked at the facility for over a year and residents had complained about the food to them at times. OSM #5 stated that a lot of the residents complained about the food being cold and they thought that it took the nurses a long time to pass out the trays after they were delivered to the floors. He stated that they delivered the trays to the floor in a closed cart to keep them warm but at times the nursing staff left the cart sitting in the hallway for a long time and they felt that it caused the food to get cold. He stated that they offered the alternate meal or sandwiches to the residents when they did not like what was being served and the CNA (certified nursing assistant) came to get other food for the residents.

On 9/6/2023 at 5:20 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that at times residents complained about the food taste and temperature. She stated that when they did, they offered the alternate to the resident and normally they accepted it. She stated that dinner normally arrived around 5:00 p.m. and the nursing staff passed the trays, and then snacks around 7:00 p.m.

On 9/6/2023 at 5:24 p.m., an interview was conducted with CNA #1. CNA #1 stated that

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dinner normally arrived to the floor between 5-5:30 p.m. She stated that the dietary staff parked the cart on the hallway and no one announced when the cart arrived so they had to wait and watch for it. She stated that most of the residents complained about the food all of the time and they did not like the taste and said that it was cold when it got to them. She stated that they offered the alternate meal or the sandwiches that were available and would go get them from the kitchen. She stated that residents did not fill out menu slips and they were not sure how they communicated whether or not they wanted the alternate meal to the kitchen because they only offered it to them if they refused the main meal that was sent down. She said that it slowed down the meal process because they had to go to the kitchen and wait for the tray for every resident who wanted the alternate meal or a sandwich and was not very efficient. She stated that there were times when the residents complained about the food portions and said that they were still hungry after meals and they would go get more food for them or offer them snacks.

On 9/6/2023 at 5:28 p.m., an interview was conducted with CNA #2. CNA #2 stated that no one alerted them when the dinner trays arrived to the floor so they had to wait around and watch for them. She stated that most of the residents complained about the food taste and temperature. She stated that the dietary manager was aware and the staff and the residents all had complained about the portions and the food quality. She stated that it had been that way for a long time and that a lot of the residents ordered food from the outside or got their families to bring food in for them because nothing was done about it. She stated that she

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felt that the portions served to the residents were very small and the residents complained that they were hungry an hour after eating and they brought them snacks. She stated that it had been that way for at least three years and had not improved.

On 9/7/2023 at 11:52 a.m., an interview was conducted with OSM #4, registered dietician. OSM #4 stated that they had been working at the facility for about a month. When asked if they were aware of any concerns from residents about the food served, OSM #4 stated, "Yes, there are a lot of complaints about the food." She stated that she received complaints about the food from residents, nursing staff, doctors, and nurse practitioners. She stated that she had passed on the concerns to the administration at the facility and the administration at the food service contract vendor. She stated that there were concerns voiced regarding the portions being too small. She stated that the menu's were made by their corporate office and approved by the corporate dietician. She stated that she went to the facility and spoke with the district manager because of the complaints that she heard on the floor regarding the portion sizes and was assured that the dietary staff were using the correct scoop sizes for portions on the menu. She stated that the staff complained about the portion sizes of the scrambled eggs being too small. When asked about the provided menu's documenting breakfast meals of "1/4 cup Scrambled eggs and 1 slice of toast" and "1/4 cup Scrambled eggs and 1 biscuit", she stated that it correlated with what the staff said to them about breakfast being just eggs and toast. She stated that she was constantly hearing complaints about portion sizes and food and she believed that it was the

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contracted vendor corporate office that controlled the menus served at the facility. She stated that in her professional opinion that 1/4 cup of scrambled eggs and 1 slice of toast would not hold anyone until lunch and she would expect to see fruit, yogurt or cereal on the menu's as well.

On 9/7/2023 at 12:30 p.m., an interview was conducted with OSM #2, dietary manager. OSM #2 stated that they had been at the facility for about a month and were still working to train the new cooks and dietary staff. She stated that the scoop sizes were posted in the kitchen and staff were trained on which scoops to use for portions. She stated that the meal tickets tell them which portion was needed and the menu tells them the scoop size. She stated that the menus come from the contracted vendor corporate office and were approved by their dietician. She stated that she worked at the facility previously for the same company about a year ago and they used to serve a full breakfast including bacon, sausage, fresh fruit and yogurt. She stated that she still served breakfast meats for residents who requested them but they were not on the menu for everyone. She stated that the corporate office had removed yogurt and fresh fruits off the menu prior to them coming back in July of 2023. She stated that she had an order guide that she had to follow and the residents would get upset with her because they remembered the full breakfast she used to be able to serve them when she worked there previously. She stated that the eggs and toast they served was not a substantial meal to last them until lunchtime and residents complain that they were still hungry so they gave them more food. She stated that some of the residents understood that she had to go by the menus and what the corporate office had them

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serve. When asked about the always available menu including salads, she stated that she would make salads for some residents but had to be careful because if other residents saw the salads they would want them too and she was not able to do that for everyone just yet. She stated that she was working to get to the point where she could. She stated that she had oatmeal, grits and cold cereals that she provided to residents who requested them but they were not listed on the menu.

On 9/7/2023 at 1:23 p.m., an interview was conducted with OSM #3, district manager of contracted vendor for food services. OSM #3 stated that the dietary staff follow the menus for the portions by using the correct scoop sizes and if the resident's complain they provide large portions to meet their needs. He stated that each building he goes into the residents complain about the serving size of the eggs so he has reported that to his upper management. He stated that he has educated the staff to give cereal to the residents also and it should be reflected on the tray cards. He stated that the dietary manager at the facility was new and was just getting into the position and getting everything together. He stated that they did have fresh fruit and yogurt on the menu and they needed to make some changes and work out some kinks.

On 9/7/2023 at 1:35 p.m., an observation was made of the facility kitchen walk-in refrigerator with OSM #2, dietary manager. When asked to see the fresh fruit and yogurt that OSM #3 stated that they had, OSM #2 stated that they did not have any. OSM #2 stated that they had ordered bananas recently but they had been sent back

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due to being rotten on arrival. She stated that she had not ordered any other fresh fruit or yogurt because it was not on the menu to be served and would go bad.

On 9/7/2023 at approximately 2:30 p.m., a request was made to ASM (administrative staff member) #2, the interim director of nursing, for evidence of a professional reference documenting the breakfast menus served were based on nutritional standard of practice for residents in a long term care setting and evidence that the meal served provided the nutritional recommendations for breakfast.

On 9/7/2023 at approximately 3:15 p.m., ASM #2 provided an email from the senior director of operations with an attachment documenting the contracted vendor corporate "Master Menu Template Diet Average Detail Report." The attachment failed to evidence a professional reference documenting the breakfast menus served were based on nutritional standard of practice for residents in a long term care setting and evidence that the meal served provided the nutritional recommendations for breakfast. ASM #2 stated that they had spoken with the CEO (chief executive officer) of the contracted vendor corporate who told them that there should be a corporate staff member onsite to answer any questions. No corporate staff member from the contracted vendor company was onsite on 9/7/2023.

On 9/7/2023 at 3:32 p.m., an interview was conducted with ASM #1, the executive director and ASM #2, the interim director of nursing. ASM #1 stated that the former dietary manager had left since they had come to the facility and they had

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focused on improving the kitchen since they had arrived. ASM #1 stated that both he and ASM #2 had come in on the weekends and assisted in the kitchen when needed and they had contacted the contracted vendor for food services corporate to bring in a new manager and new staff. ASM #1 stated that they had some improvement and had conducted some test trays and he had not received any complaints regarding the food recently. He stated that the kitchen was much cleaner than when he first arrived because he had been tirelessly critical of the staff because dietary had the most concerns. ASM #1 stated that some residents had voiced concerns about the food portions and they had taken some trays back to the kitchen, questioned the staff what kind of scooper they were using, and questioned whether they were trained on using the correct size. ASM #2 stated that they report directly to the chief nursing officer and they had taken a picture of the breakfast served that morning and sent it to her for her to reach out to the contract vendor food service.

The facility policy "Menus" revised 9/2017, documented in part, "Menus will be planned in advance to meet the nutritional needs of the residents/patients in accordance with established national guidelines. Menus will be developed to meet the criteria
through the use of an approved menu planning guide... Menus will be periodically presented for resident review, including the resident council, menu review meetings, or other review board as indicated by the center. The menu will identify the primary meal, the alternate meal, and any always offered food and beverage items... Menu cycles will include nutrient analysis to ensure that all client (adolescent, adult, geriatric) nutritional

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F 800	Continued From page 48 needs are met in accordance with the most recent edition of the Food and Nutrition Board, Institute of Medicine, National Academies, and the Dietary Guidelines for Americans, 2015-2020 edition..." According to the Dietary Guidelines for Americans, 2015-2020, Eighth edition, it documented in part on page 15, "...A healthy eating pattern includes: ·A variety of vegetables from all of the subgroups-dark green, red and orange, legumes (beans and peas), starchy, and other · Fruits, especially whole fruits ·Grains, at least half of which are whole grains · Fat-free or low-fat dairy, including milk, yogurt, cheese, and/or fortified soy beverages ·A variety of protein foods, including seafood, lean meats and poultry, eggs, legumes (beans and peas), and nuts, seeds, and soy products ·Oils..." It further documented on page 38, "Follow a healthy eating pattern across the lifespan. All food and beverage choices matter. Choose a healthy eating pattern at an appropriate calorie level to help achieve and maintain a healthy body weight, support nutrient adequacy, and reduce the risk of chronic disease. 2. Focus on variety, nutrient density, and amount. To meet nutrient needs within calorie limits, choose a variety of nutrient-dense foods across and within all food groups in recommended amounts..." On 9/7/2023 at 4:30 p.m., ASM #1, the executive director and ASM #2, the interim director of nursing were made aware of the concern. No further information was presented prior to exit.	F 800		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)	F 803		

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§483.60(c) Menus and nutritional adequacy.
Menus must-

§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;

§483.60(c)(2) Be prepared in advance;

§483.60(c)(3) Be followed;

§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;

§483.60(c)(5) Be updated periodically;

§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and

§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, the facility staff failed to follow dietary menus for for one of five meals served during the survey dates, lunch service on 9/6/2023.

The findings include:

During lunch service on 9/6/2023, the facility staff failed to prepare a sufficient amount of food for

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service which resulted in the kitchen not being able to follow the posted menu.

The scheduled lunch menu posted for residents for 9/6/23 documented:
Main:
- Cheese ravioli with marinara sauce
- Caesar salad
- Garlic bread
- Oranges
Alternate:
- Ham sandwich

On 9/6/2023 at 12:40 p.m., observation of the lunch meal pre-service line temperatures was conducted with OSM (other staff member) #2, dietary manager. The following food was prepared and available for lunch:
- Cheese ravioli with marinara sauce
- Caesar salad
- Garlic bread
- Oranges
- Green beans
- Mashed potatoes
OSM #2 stated that the alternate meal of Ham sandwiches were prepared to order at the time of request.

On 9/6/2023 at 2:00 p.m., observation of the tray line preparation was conducted. Kitchen staff were observed preparing a meal cart that OSM #2 stated was the last cart to go to the floor and was to go to Wing Two. OSM #2 was observed preparing ham slices on the flattop grill and placing them in Styrofoam trays with mashed potatoes, green beans and garlic bread, the trays were placed with meal tickets documenting the main meal of ravioli listed on the ticket. When asked about the trays being prepared, OSM #2

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F 803	Continued From page 51 stated that they had run out of the ravioli due to multiple residents being on double portions and had to substitute the ham for some of the trays. On 9/6/2023 at 2:45 p.m., an interview was conducted with OSM #6, the cook. OSM #6 stated that they normally worked the dinner service but was working breakfast and lunch that day. She stated that the menu was posted in the kitchen and they used that to know what they were cooking each day. She stated that they went by the number of residents in the building that day and the number of residents getting double portions to determine how much food to make. She stated that they had run out of the ravioli during lunch and it was "on her" and normally she made more than enough to not run out. The facility policy titled, "Menus" revised 9/2017, documented in part, "...Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal..." On 9/7/2023 at approximately 4:30 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the interim director of nursing were made aware of the above concern. No further information was provided prior to exit.	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that	F 804		

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conserve nutritive value, flavor, and appearance;

§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.
This REQUIREMENT is not met as evidenced by:
Based on resident interviews, responsible party interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide food that was palatable or served at an appetizing temperature.

The findings include:

On 9/6/2023 at 11:30 a.m., an interview was conducted with Resident #3 (R3) who was assessed as cognitively intact. R3 stated that the food at the facility was horrible with no flavor and was often served cold when it was supposed to be hot. R3 stated that they had been served undercooked vegetables and overcooked meats. R3 stated that they felt like the facility kitchen staff did not care what they gave to the residents because they thought everyone had dementia and did not know what was going on. R3 stated that they wanted to have fresh fruit and alternate food options, that they were only given sandwiches when they did not like what was served currently. R3 stated that they had talked to kitchen staff about their complaints about the food but no one had done anything to improve anything.

On 9/6/2023 at approximately 9:00 AM an interview was conducted with Resident #5 (R5) and Resident #9 (R9), who were both assessed as cognitively intact. When asked were there any concerns regarding the food, R9 stated that the

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food was terrible and seemed like it had gotten worse. R9 stated that the taste was bad and it was cold, no matter which meal it was. R5 agreed and stated that the food did not taste good and there was so little food on the plate and there was no fresh fruit served at all.

On Resident #13's (R13) most recent MDS, a quarterly assessment with an ARD of 6/9/2023, the resident scored 3 out of 15 on the BIMS assessment, indicating the resident was severely impaired for making daily decisions. On 9/6/2023 at approximately 12:50 p.m., an interview was conducted with the family of R13. The family stated, "Do you see the time and lunch is not here?" The family stated that the meals were always late, the food was bad and always cold so they came almost every day to bring food in for R13 to eat.

On 9/6/2023 11:15 a.m., an interview was conducted with Resident #11 (R11), who was assessed with moderate cognitive impairment. When asked about the food served at the facility, R11 stated, "The food here is [expletive]." R11 stated that the breakfast was usually some cubed eggs which were not enough and cold oatmeal if they asked for it. R11 stated that they had complained to the nursing staff, dietary staff and the executive director about the food and they said that they put it on the meal cart to keep it warm but it was still cold when it got to the room. R11 stated that the food was cold even when they were using regular plates and the plate covers to keep them warm. R11 stated that often the food served on the plate was not what was posted on the menu in the hallway and the alternate posted on the menu was not available when they asked for it. R11 stated that the only thing they could

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get was a sandwich usually if they didn't like the meal served. R11 stated that the meals were always late and they never knew when the trays were coming.

Review of the Resident Council Minutes from April of 2023 documented in part, "Food getting better at times cold, want more portions for breakfast, they want more food to hold them over till lunch..."

Review of the Resident Council Minutes from May of 2023 documented in part, "Food always cold, it is not good, no taste, no snacks being offered at all. Meal trays running late all the time..."

No resident council minutes for June, July or August 2023 were available for review.

Review of the "Service Line Checklist" completed daily in the kitchen failed to evidence lunch or dinner food temperatures were checked on 5/24/2023, 5/25/2023 and 5/27/2023.
The checklist further documented the following:
- 5/1/2023- Documented the Pellet warmers/Lowerators (used to keep plates warm/heat plate holders and/or insulated dome lids) were both not working properly.
- 5/2/2023- Documented the Pellet warmers/Lowerators were serviced but not working properly.
- 5/3/2023- Documented the Pellet warmers/Lowerators had been worked on but still not working.
- 5/4/2023- Documented the Pellet warmers/Lowerators were not working properly, but still being used as directed.
- 5/7/2023- Documented the Pellet

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warmers/Lowerators needed the machine to be reset.
- 5/8/2023- Documented the Pellet warmers/Lowerators needed the warmers need to be reset.
- 5/10/2023- Documented the Pellet warmers/Lowerators needed to be reset.
- 5/11/2023- Documented the Pellet warmers/Lowerators needed to be reset.
- 5/23/2023- Documented the Pellet warmers/Lowerators needed to be reset, so not hot.
- 5/24/2023- Failed to evidence lunch or dinner temperatures.
- 5/24/2023- Failed to evidence lunch or dinner temperatures.
- 5/27/2023- Failed to evidence lunch or dinner temperatures.

On 9/6/2023 at 12:40 p.m., observation of the lunch meal pre-service line temperatures was conducted with OSM (other staff member) #2, dietary manager. The temperatures of the food were within acceptable parameters.

On 9/6/2023 at 1:43 p.m., an interview was conducted with OSM (other staff member) #1, the director of maintenance. When asked about the pellet warmer/lowerator not working as documented in the service line checklists above, OSM #1 stated that the kitchen staff called them when something was not working there and they looked at it to see if they could fix it and if not they called an outside vendor to come in. OSM #1 explained that the plate warmer was used to hold the dishes and the pellet warmer was a metal piece that the staff put the plate on top of. OSM #1 stated that they used the pellet warmer to keep the plate warm and according to their repair

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invoices it was fixed on 5/25/2023. He stated that when it needed to be reset they had replaced a part but they were not sure when and the vendor had come in but ordered the wrong part prior to 5/17/2023 and then gotten the correct part on 5/25/2023.

On 9/6/2023 at 2:25 p.m., a test tray was conducted with another surveyor and OSM #2. There were no concerns with the test tray regarding palatability or food temperature.

On 9/6/2023 at 2:57 p.m., an interview was conducted with OSM #5, dietary aide. OSM #5 stated that a lot of the residents complained about the food being cold and they thought that it took the nurses a long time to pass out the trays after they were delivered to the floors. He stated that they delivered the trays to the floor in a closed cart to keep them warm but at times the nursing staff left the cart sitting in the hallway for a long time and they felt that it caused the food to get cold.

On 9/6/2023 at 5:20 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that at times residents complained about the food taste and temperature. She stated that when they did, they offered the alternate to the resident and normally they accepted it. She stated that dinner normally arrived around 5:00 p.m. and the nursing staff passed the trays and then snacks around 7:00 p.m.

On 9/6/2023 at 5:24 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated that dinner normally arrived to the floor between 5-5:30 p.m. She stated that the dietary staff parked the cart on the hallway and no

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one announced when the cart arrived so they had to wait and watch for it. She stated that most of the residents complained about the food all of the time and they did not like the taste and said that it was cold when it got to them. She stated that they offered the alternate meal or the sandwiches that were available and would go get them from the kitchen. She stated that residents did not fill out menu slips and they were not sure how they communicated whether or not they wanted the alternate meal to the kitchen because they only offered it to them if they refused the main meal that was sent down. She said that it slowed down the meal process because they had to go to the kitchen and wait for the tray for every resident who wanted the alternate meal or a sandwich and was not very efficient.

On 9/6/2023 at 5:28 p.m., an interview was conducted with CNA #2. CNA #2 stated that no one alerted them when the dinner trays arrived to the floor so they had to wait around and watch for them. She stated that most of the residents complained about the food taste and temperature. She stated that the dietary manager was aware and the staff and the residents all had complained about the portions and the food quality. She stated that it had been that way for a long time and that a lot of the residents ordered food from the outside or got their families to bring food in for them because nothing was done about it. She stated that it had been that way for at least three years and had not improved.

On 9/7/2023 at 11:52 a.m., an interview was conducted with OSM #4, registered dietician. OSM #4 stated that they had been working at the facility for about a month. When asked if they

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were aware of any concerns from residents about the food served, OSM #4 stated, "Yes, there are a lot of complaints about the food." She stated that she received complaints about the food from residents, nursing staff, doctors, and nurse practitioners. She stated that she had passed on the concerns to the administration at the facility and the administration at the food service contract vendor.

On 9/7/2023 at 12:30 p.m., an interview was conducted with OSM #2, dietary manager. OSM #2 stated that they had been at the facility for about a month and were still working to train the new cooks and dietary staff. She stated that some residents complained about the food and she did what she could to offer them an alternate and honor their preferences. She stated that she knew what some residents liked and disliked and was working to be able to accommodate what everyone wanted but was still training the staff. She stated that the menus come from the contracted vendor corporate office and were approved by their dietician. When asked about the lunch and dinner temperatures on 5/24/23, 5/25/23 and 5/27/23, OSM #2 stated that if the temperatures were blank it meant that they were not done and they could not say what the temperature was or that the food was sent out at a palatable temperature.

On 9/7/2023 at 3:32 p.m., an interview was conducted with ASM #1, the executive director and ASM #2, the interim director of nursing. ASM #1 stated that the former dietary manager had left since they had come to the facility and they had focused on improving the kitchen since they had arrived. ASM #1 stated that both he and ASM #2 had come in on the weekends and assisted in the

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F 804	Continued From page 59 kitchen when needed and they had contacted the contracted vendor for food services corporate to bring in a new manager and new staff. ASM #1 stated that they had some improvement and had conducted some test trays and he had not received any complaints regarding the food recently. He stated that the kitchen was much cleaner than when he first arrived because he had been tirelessly critical of the staff because dietary had the most concerns. The facility policy "Food: Quality and Palatability" revised 9/2017, documented in part, "Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature. Food and liquids are prepared and served in a manner, form, and texture to meet resident's needs..." On 9/7/2023 at 4:30 p.m., ASM #1, the executive director and ASM #2, the interim director of nursing were made aware of the concern. No further information was presented prior to exit.	F 804		
F 806 SS=D	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	F 806		

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by:
Based on resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to review food preferences/dislikes with one of 17 residents in the survey sample, Resident #3.

The findings include:

For Resident #3 (R3), the facility staff failed to obtain the resident's food preferences and dislikes.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/25/2023, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.

A review of R3's clinical record failed to evidence a review of the resident's food preferences.

On 9/6/2023 at 11:30 a.m., an interview was conducted with R3. R3 stated that the food at the facility was horrible with no flavor and was often served cold when it was supposed to be hot. R3 stated that they had been served undercooked vegetables and overcooked meats. R3 stated that they felt like the facility kitchen staff did not care what they gave to the residents because they thought everyone had dementia and did not know what was going on. R3 stated that they wanted to have fresh fruit and alternate food options, that they were only given sandwiches when they did not like what was served currently. R3 stated that they had talked to kitchen staff about their complaints about the food but no one

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had ever asked them what they would like to have or their likes and dislikes.

On 9/7/2023 at 11:52 a.m., an interview was conducted with OSM (other staff member) #4, registered dietician. OSM #4 stated that they did not complete food preference assessments with residents and they thought that the facility staff did that.

On 9/7/2023 at 12:30 p.m., an interview was conducted with OSM #2, dietary manager (employed by a contracted vendor to provide food services at the facility). OSM #2 stated that they had been assigned to the facility for about a month and was working to train the cooks and staff currently. She stated that resident preferences were obtained by the dietary manager or the dietician on admission and re-evaluated about a month after admission and then annually.

The facility policy titled, "Dining and Food Preferences" revised 9/2017 documented in part, "... Individual dining, food, and beverage preferences are identified for all residents/patients... 2. The 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, including times outside of the routine schedule, food, and beverage preferences. 3. The Food Preference Interview will be entered into the medical record... 8. Upon meal service, any resident/patient with expressed or observed refusal of food and/or beverage will be offered an alternate selection of comparable nutrition

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F 806	Continued From page 62 value..." On 9/7/2023 at approximately 4:30 p.m., ASM (administrative staff member) #1, the executive director and ASM #2, the interim director of nursing were made aware of the above concern. No further information was provided prior to exit.	F 806		
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, 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;	F 842		

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(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 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, clinical record review

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ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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and facility document review, it was determined the facility staff failed to maintain a complete record for one of 17 residents, Resident #12.

The findings include:

For Resident #12, the facility staff to document if a wander guard was checked for placement and functionality on each shift.

A review of the comprehensive care plan dated 4/23/23 which revealed, "FOCUS: The resident is an elopement risk/wanderer related to resident wanders aimlessly, exit seeking to go home, tugging on unit entrance door randomly, resident exit seeking walking out of door.
INTERVENTIONS: Assess for elopement risk. Check wander guard for placement/function/expiration date as ordered and as needed. Electronic monitoring device wander guard.

Resident #12 was observed with the wander guard on their right ankle on 9/6/23 at 1:00 PM

A review of the physician orders dated 10/20/22, revealed "Wander guard check every shift for placement."

A review of the "Elopement Risk Evaluation" dated 4/22/23, revealed, "Resident is AT RISK for elopement".

A review of the TARs (treatment administration records) June-September 2023 revealed documentation was missing on the following shifts, "Wander guard check every shift for placement and for monitoring" June: 2 out of 90 shifts, July: 2 out of 93 shifts, August: 7 out of 93

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F 842	Continued From page 65 shifts and September: 3 out of 16 shifts. An interview was conducted on 9/7/23 at 10:00 AM with LPN (licensed practical nurse) #1. When asked if there are holes/blanks in the documentation, is there evidence that the wander guard is being checked. LPN #6 stated, no, if there are holes, we cannot validate that it was checked. On 9/7/23 at approximately 4:00 PM, ASM #1, the executive director and ASM #2, the interim director of nursing was made aware of the findings. A review of the facility's "Clinical Medical Records" policy, revised 5/17, revealed, "Clinical Records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care." No further information was provided prior to exit.	F 842		
F 880 SS=E	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 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	F 880		

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F 880	Continued From page 66 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 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.	F 880		

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§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 staff interview, resident interview, clinical record review and facility document review, it was determined the facility staff failed to follow infection control practices for twelve of seventeen COVID-19 positive resident isolation rooms.

The findings include:

On 9/6/23 at 8:30 AM, a list of COVID-19 positive residents was requested and received. The list included room numbers with COVID positive residents on the 100, 200, and 300 hallways (rooms numbers are redacted in this report to maintain resident personal health information confidentiality).

The facility staff failed to follow infection control practices for COVID-19 positive resident rooms. Twelve rooms were observed with their doors open on 9/6/23 at 9:40 AM: (three rooms on the 100 hallway, eight rooms on the 200 hallway, and one room on the 300 hallway). One room on the 100 hallway and one room on the 200 hallway did

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not have a contact/airborne precautions sign.

On 9/7/23 at 9:30 AM, three rooms on the 100 hallway, one room on the 200 hallway, and one room on the 300 hallway were observed with doors to the COVID positive resident rooms open.

An interview was conducted on 9/6/23 at 11:00 AM with LPN (licensed practical nurse) #4. When asked if the doors to the rooms with COVID positive residents should be closed, LPN #4 stated, yes, they absolutely should be closed.

An interview was conducted on 9/7/23 at 10:35 AM with CNA (certified nursing assistant) #5. When asked if the doors to the rooms with COVID positive residents should be closed, CNA #5 stated, yes, we close them and the residents open them back up.

An interview was conducted on 9/7/23 at 3:45 PM with ASM (administrative staff member) #2, the interim director of nursing. When asked about the isolation doors being opened, ASM #2 stated, "These are the doors that are open today: [three rooms on 100 hallway and one room on 200 hallway]. We have closed them multiple times and educated the residents, the residents still open the doors."

On 9/6/23 at approximately 5:40 PM, ASM #1, the executive director and ASM #2, the interim director of nursing was made aware of the findings.

A review of the facility's "COVID-19 Resident" policy dated 5/15/23 revealed, "The center will follow current guidance for managing COVID-19. Managing a resident with a COVID-19 infection:

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F 880	Continued From page 69 Place the resident in a single-person room with the door closed if safe, with a dedicated bathroom. Limit movement outside room to medically essential needs." No further information was provided prior to exit.	F 880		