DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SELLERSBURG HEALTHCARE CENTER	7823 OLD HWY # 60 SELLERSBURG, IN 47172

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 13, 14, 15, 16, and 17, 2023. Facility number: 010613 Provider number: 155659 AIM number: 200221040 Census bed type: SNF/NF: 101 Total: 101 Census Payor type: Medicare: 9 Medicaid: 79 Other: 13 Total: 101 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 27, 2023.	F 0000	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey conducted on August 13-17, 2023** **Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **Monica Dirbas, LNHA**	
F 0554 SS=E Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure appropriate oversight of medication administration during 5 of 6 random observations. (Residents 32, 37, 11, and	F 0554	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the**	09/18/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelly Duhaime	Interim Administrator	09/22/2023

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

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	38) Findings include: 1. During an observation of Resident 32 on 8/13/23 at 9:03 a.m., there was a medication cup sitting on the resident's bedside table with two round, white tablets, in the cup. The resident indicated she did not know what the tablets were. During an interview on 8/13/23 at 10:11 a.m., RN 9 indicated she had given Resident 32 her medications with water a while ago. She told the resident they were on her left side. She had not stayed to observe the resident taking the medication. The clinical record for Resident 32 was reviewed on 8/13/23 at 10:00 a.m. The resident's diagnoses included, but were not limited to, blindness of the right eye and weakness. The Annual MDS (Minimum Data Set) Assessment, dated 7/4/23, indicated the resident was cognitively intact. The physician's order, dated 6/29/22, indicated the resident received Tylenol 325 mg (milligrams) every 6 hours as needed for pain. The MAR (Medication Administration Record) lacked documentation of any administration of Tylenol to the resident on the morning of 8/13/23. The resident's record lacked documentation of any orders, care plan, or assessments for self-administration of medications, or any orders for the resident's medications to be left at her bedside.		**truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey conducted on August** **Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **Monica Dirbas, LNHA** **F554** **Corrective action for the residents found to have been affected by the deficient practice:** Residents 32, 37, 11 and 38 were not harmed by alleged deficient practice. Residents received medications per MD order. MD and RP were notified of medications left at bedside and any new orders implemented per MD request. Nursing assessments were complete per licensed nurses with no changes from baseline noted.	

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	2. During an observation of Resident 37 on 8/13/23 at 10:01 a.m., the resident was lying in bed. There was a medication cup with two white tablets with an imprint of 54/27 and one unmarked white capsule inside of it. The resident indicated she could not reach the tablets to take them. During an interview on 8/13/23 at 10:07 a.m., Resident 37's roommate, Resident 70, indicated they had not yet received their morning medications so the medications on Resident 37's table had to be her medications from the night prior. The Quarterly MDS Assessment for Resident 70, dated 7/3/23, indicated the resident was cognitively intact. During an interview on 8/13/23 at 10:09 a.m., RN 9 indicated she had not taken any medications to Resident 37 yet that morning and they appeared to be her evening medications. She thought they were her Tylenol and another medication she could not identify. There were some residents who wanted staff to leave their medications at the bedside, but she was aware they should stay with the residents until they took their medications. The clinical record for Resident 37 was reviewed on 8/13/23 at 11:30 a.m. The diagnoses included, but were not limited to, unspecified dementia, wedge compression fracture of lumbar vertebra, and need for assistance with personal care. The Annual MDS Assessment, dated 7/4/23, indicated the resident was cognitively intact. The physician's order, dated 5/23/23, indicated the resident received 2 tablets of Tylenol 325 mg every 6 hours as needed for pain.		**Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who are administered medications per MD order by licensed nurses in the facility have the potential to be affected by this alleged deficient practice. DON/Designee completed a full house audit to ensure medications were not left at bedside and administered as ordered per MD order. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee completed education with licensed nurses and QMAs regarding facilities policy “Medication Administration” with emphasis on leaving medication at bedside. DON/Designee complete medication observation with licensed nurses and QMAs to ensure no deficient practices noted, any corrective action completed immediately as needed. **Corrective actions to be monitored to ensure the deficient practice will not recur:** DON/Designee will observe medication administration 5 x’s a week x’s 4 weeks, then 4 x’s a	

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	The resident's record lacked documentation of any orders, care plan, or assessments for self-administration of medications, or any orders for the resident's medications to be left at her bedside. 3. During an observation of Resident 11 on 8/16/23 at 8:37 a.m., the resident was resting in bed. There was a medication cup on her bedside table containing several medications. The medications included a small, white, round tablet with an imprint of ZC41 (identified on a pill identifier website as Coreg 12.5 mg); a blue oblong tablet, stamped A on one side and 17 on the other side (identified on a pill identification website as Zoloft 50 mg); one white round tablet with no imprint; one red gel capsule; and 1 white round tablet with scoring down the middle and no imprint. The resident indicated she thought the medications included her pain reliever, a muscle relaxer, a stool softener, and her anti-anxiety medication, but was not certain what they all were. Staff ordinarily stayed with her until she took them. The clinical record for Resident 11 was reviewed on 8/16/23 at 9:00 a.m. The diagnoses included, but were not limited to, rheumatoid arthritis, constipation, hypertension, and depression. The Annual MDS Assessment, dated 6/23/23, indicated the resident was cognitively intact. The physician's orders included, but were not limited to, Coreg 12.5 mg twice daily, Colace 100 mg twice daily, Flexeril 5 mg every 8 hours as needed for pain, and sertraline 50 mg 3 tablets every morning.		week x's 4 weeks, then 3x's a week x's 4 weeks to ensure "Medication Administration" policy is being followed and no medications are left at bedside. The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	The MAR indicated the resident's morning medications for 8/16/23 had been marked as administered. The resident's record lacked documentation of any orders, care plan, or assessments for self-administration of medications, or any orders for the resident's medications to be left at her bedside. 4. a. During an observation on 8/13/23 at 11:25 a.m., Resident 38 was taking two pills on her bedside table. The nurse was not near the room. One pill was white and oblong with a score line. The other pill was round and white. The resident indicated they were pain pills and one was a Norco. During and interview on 8/13/23 at 12:24 p.m., RN 9 indicated she had left the medication for Resident 38 and she could take the Norco on her own. She would later check on the resident to make sure she had taken it after leaving the medication. b. During an observation of Resident 38 on 8/16/23 at 8:34 a.m., she had 11 medications in the medication cup, 2 pills were on the bed, and 2 others were under her forearm on her bed. The nurse was not on the hall. The resident indicated she fell asleep. The resident had a blue color substance on the left corner of her mouth. The record for Resident 38 was reviewed on 8/13/23 at 8:18 a.m. The diagnoses included, but were not limited to, chronic pain, neuropathy, GERD (gastro-esophageal reflux disease), RLS (restless leg syndrome), COPD (chronic obstructive pulmonary disease), diabetes mellitus, hyperlipidemia, and atrial fibrillation.			

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The Quarterly MDS (Minimum Data Set) assessment, dated 5/15/23, indicated the resident was cognitively intact.

The resident's record lacked documentation of any orders, care plan, or assessments for self-administration of medications, or any orders for the resident's medications to be left at her bedside.

The care plan, dated 10/6/20, indicated the resident had chronic pain related to headaches and was at further risk due to GERD, RLS, and neuropathy. The interventions included, but were not limited to, administer medication per physician's orders and observe for side effects of pain medication.

During an interview on 8/16/23 at 8:25 a.m., the DON (Director of Nursing) indicated LPN (Licensed Practical Nurse) 14 had administered the medications to her residents and left the building to take her family member to an appointment. She would be back later in the day.

During an interview on 8/16/23 at 8:51 a.m., the DON indicated they should stay with the residents while taking their pills.

The DON brought the medications to the medication cart where LPN 9 had returned to the nurse's station. The LPN identified the following medications she had provided to Resident 38:

-metformin HCL ER 500 mg give 2 tablets in the morning for diabetes.
-Colace capsule, 100 mg give 2 capsules in the morning.
-Cyclobenzaprine HCL 5 mg give 1 tablet three times daily for muscle spasms.

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	-Meclizine 12.5 mg give 1 tablet two times daily for dizziness. -Carafate 1 gram give 1 tablet before meals for GERD -Gabapentin 600 mg give 1 tablet three times daily for neuropathy. -Fenofibrate 48 mg give 1 tablet in the morning for hyperlipidemia. -Glimepiride 1 mg give 1 tablet in the morning for diabetes. -Reglan 5 mg give 1 tablet before meals and at bedtime for GERD. -Phenergan 12.5 mg every 24 hours as needed for nausea. -Lasix 40 mg 1 tablet daily for edema. -Metoprolol tartrate 25 mg give 1 tablet in the morning for atrial fibrillation. -Norco 5-325 mg give 1 tablet every 4 hours for increased abdominal pain. -Modafinil 200 mg give 1 tablet in the morning for COPD. During an interview on 8/16/23 at 8:52 a.m., LPN 9 indicated she sat with the resident while she took her medication. She guessed she didn't pay attention to her when she gave the resident her the pills. The blue medication was her Keppra. At noon she would have had more than one pill, she did get a pain pill. The procedure was to sit with the resident while they took their medications. The current Medication Administration policy included, but was not limited to, "... I. General Procedures... i. Safety and avoiding adverse effects is considered a high priority for medication administration and may preclude some preferences... bb. Do not leave medication at bedside..." 3.1-11(a)			

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F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident			

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	representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on record review and interview, the facility failed to notify the physician of a resident's blood sugar levels over 400 mg/dL (milligrams per milliliter) for 1 of 3 residents reviewed for Notification of Change. (Resident 1) Findings include: The record for Resident 1 was reviewed on 8/14/23 at 10:48 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes and acute kidney failure. The Admission MDS (Minimum Data Set) assessment, dated 7/11/23, indicated the resident was rarely or never understood. The physician's order, dated 7/17/23, indicated staff were to administer the resident's Humalog 100 units per mL (milliliters) solution per sliding scale for a blood sugar of 151 to 200 mg/dL, administer 3 units; 201 to 250 mg/dL administer 6 units; 251 to 300 mg/dL administer 9 units; 301 to 350 mg/dL administer 12 units; 351 to 400 mg/dL administer 15 units. If the blood sugar is less than 70 mg/dL or greater than 400 mg/dL contact the physician or NP (Nurse Practitioner).	F 0580	**F580** **Corrective action for the residents found to have been affected by the deficient practice:** Resident 1 was not harmed by this alleged deficient practice. Notifications were made to MD and RP with no concerns and no new orders implemented. Resident 1 was assessed per licensed nurse with no change from baseline. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who require monitoring of blood glucose levels were reviewed for any readings outside of parameters to ensure notifications were made to NP/MD per physician order. Any residents found to not have notifications made related to readings outside of parameters	09/18/2023

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	The care plan, dated 7/5/23, indicated the resident had diabetes. The interventions included, but were not limited to, administer insulin injections per orders and rotate injection sites, administer medications per medical provider's orders and observe for side effects and effectiveness, obtain and monitor laboratory or diagnostic studies, obtain blood sugars per orders, report abnormal findings to medical provider, resident, and the resident's representative. The July and August 2023 Blood Sugar Records for Resident 1 indicated on the following days the resident's blood sugars exceeded the set parameter of over 400 mg/dL: - On 7/11/23 at 4:11 p.m., the resident's blood sugar was 500 mg/dL. - On 7/12/23 at 4:37 p.m., the resident's blood sugar was 547 mg/dL. - On 7/13/23 at 10:43 p.m., the resident's blood sugar was 439 mg/dL. - On 7/19/23 at 9:58 a.m., the resident's blood sugar was 453 mg/dL. - On 7/20/23 at 7:49 a.m., the resident's blood sugar was 501 mg/dL. - On 7/26/23 at 7:46 a.m., the resident's blood sugar was 436 mg/dL. - On 8/1/23 at 4:13 p.m., the resident's blood sugar was 500 mg/dL. - On 8/2/23 at 11:29 a.m., the resident's blood sugar was 485 mg/dL. - On 8/8/23 at 11:55 a.m., the resident's blood sugar was 549 mg/dL. - On 8/9/23 at 4:35 p.m., the resident's blood sugar was 505 mg/dL. - On 8/12/23 at 7:43 a.m., the resident's blood sugar was 485 mg/dL. - On 8/12/23 at 11:22 a.m., the resident's blood sugar was 570 mg/dL.		had notifications made immediately and any new orders carried out as indicated per MD. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee educated licensed nurses regarding facilities policy “Notification of Change in Condition” with emphasis on notification to MD related to blood glucose readings outside of parameters. **Corrective actions to be monitored to ensure the deficient practice will not recur:** DON/Designee will monitor through review of clinical documentation 5x’s a week x’s 4 weeks, then 4x’s a week x’s 4 weeks, then 3x’s a week x’s 4 weeks for notification to MD for glucose readings outside of parameters. The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	- On 8/13/23 at 8:52 a.m., the resident's blood sugar was 500 mg/dL. - On 8/13/23 at 11:46 a.m., the resident's blood sugar was 500 mg/dL. The record lacked documentation to indicate the NP or the physician had been notified of the resident's blood sugars over 400. During an interview on 8/16/23 at 1:41 p.m., RN 7 indicated when a blood sugar was over 400 according to the residents sliding scale, she would give the units according to the sliding scale and call the NP for additional orders. She would recheck the blood sugar according to the NP orders and if the blood sugar was still high, she would call the NP for further orders. She would document in the nurse's notes that the NP was notified. During an interview on 8/16/23 at 2:10 p.m., RN 8 indicated he documented he had given 15 units per the sliding scale and documented per the NP orders. He called the NP and he should have documented that he called her and if additional insulin was given or not. The Notification of Change in Condition policy dated 2017, included but was not limited to, "... The attending practitioner is promptly notified of significant changes in condition, and the medical record must reflect the notification, response, and interventions implemented to address the resident's condition ..." 3.1-5(a)(2)			
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process			

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	The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact			

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	agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.			
	Based on record review, observation, and interview, the facility failed to develop and implement an effective discharge planning	F 0660	**F660** **Corrective action for the**	09/18/2023

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	process that focused on the resident's discharge goals for 1 of 1 resident reviewed for discharge. (Resident 76) Findings Include: During an interview on 8/13/23 at 10:06 a.m., Resident 76 indicated he wanted to get out of the facility and go to his own place. No one was helping him to get out of the facility. The Annual MDS (Minimum Data Set) assessment, dated 7/4/22, indicated the resident's discharge plan was checked yes. The resident's diagnosis included, but were not limited to, hypertension and peripheral vascular disease. The resident required extensive assistance of one staff member for mobility and toileting assistance. He was cognitively alert and oriented and had no behaviors. The resident's expectation was to be discharged. A Quarterly MDS assessment, dated 5/14/23, indicated the resident's active discharge plan was blank and not documented. The resident's expectation goals for discharge were left blank. A Quarterly MDS assessment, dated 7/5/23, indicated the resident's discharge plan was checked yes. The resident was alert and oriented. He required only set up assistance for all activities of daily living. The resident's expectation goals for discharge were left blank. A current Focused Care Plan, dated 7/7/22, indicated Resident 76 had no plans for discharge secondary to being homeless. The goal was for the resident to participate in care decisions for long term stay with a target date of 10/15/23.		**residents found to have been affected by the deficient practice:** Resident 76 was not harmed by this alleged deficient practice. Social worker has reviewed with resident and his responsible party plans for discharge and efforts are in process of meeting this resident's goals to discharge and plan of care was updated as indicated. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents with plans to discharge have the potential to be affected by this alleged deficient practice. An audit was conducted per ED/Social worker/Designee to identify all residents with plans to discharge, ED/Social worker/Designee ensured all residents with goals to discharge were reviewed and plan in place and plan of care update to reflects discharge goals. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** RDCO educated ED/DON/Social Worker to facilities policy "Discharge Planning" with emphasis on ensuring discharge goals are meet and plan of care in	

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	The resident's record lacked a care plan for discharge planning. The Nursing Note, dated 7/28/23, indicated the resident was to have a right total knee replacement in a couple of weeks. The Pre-op testing was ordered, and the resident was aware. During an interview on 08/14/23 at 11:44 a.m., RN 8 indicated the resident had indicated he wanted to be in an assisted living facility with his own apartment. The current plan was for the resident to continue living in the facility. He was not aware of any planning for the resident to be discharged from skilled long-term care. During an interview on 08/15/23 at 11:01 a.m., SSD (Social Service Director) indicated the resident fixates on things. He came to the facility from an acute hospital, and he was homeless. When he was admitted to the facility the resident had some health concerns of edema. The resident wanted to leave, and the NP (Nurse Practitioner) did not feel he was safe to be alone in an apartment. The facility offered to assist him with assisted living placement, the resident had even toured an assisted living facility. The SSD did not have any documentation of the resident's tour or plan for discharge. The current plan was for the resident to stay at the facility long term. The resident had improved since arrival and the plan was for him to stay at the facility. There was no documented plan of care for discharge. The resident had voiced he wanted to go to his own apartment. He wanted a stove to do his own cooking and he had been deemed unsafe to do his own cooking. The NP wrote a note to indicate the resident was not appropriate for assisted living at this point related to being scheduled for a knee replacement surgery in the future.		place. **Corrective actions to be monitored to ensure the deficient practice will not recur:** ED/DON/Social worker/Designee will review 10 residents weekly to include new admissions x's 4 weeks, then 5 resident's weekly x's 4 weeks, then 1 resident weekly x's 4 weeks to ensure discharge goal are noted and in process and plan of care update to reflect discharge goals. The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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During an observation and interview on 08/16/23 at 10:33 a.m., the resident was alone walking through the facility. He indicated he wanted to be discharged from the facility, but had no money and nowhere to go. He wanted to live in his own apartment.

The Social Service notes were provided on 8/17/23 at 10:15 a.m. and had the following effective dates:

- An effective date of 7/5/23, indicated the resident was up daily and ambulated throughout the facility and went to the gym on his own to keep his strength up. He was planning on transitioning to assisted living faculty due to wound needs and a history of not doing well or taking care of himself.

- An effective date of 4/20/23, indicated the resident was up daily and ambulated throughout the facility and went to the gym on his own to keep his strength up. He was planning on transitioning to assisted living faculty. They will continue to assist as needed.

- An effective date of 10/18/22, indicated the resident was up daily and ambulated throughout the facility and went to the gym on his own to keep his strength up. He was planning on transitioning to assisted living faculty. They will continue to assist as needed.

- An effective date of 10/4/22, indicated the resident was up daily and ambulated throughout the facility and went to the gym on his own to keep his strength up. He was planning on transitioning to assisted living faculty. They will continue to assist as needed.

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	The current facility policy, titled "Discharge Planning", with an effective date of 7/17/20, indicated the process that generally begins on admission and involves identifying each resident's discharge goals and needs. The procedure was to ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. to include regular re-evaluation of the resident's, identify changes that require modifications of the discharge plan. 3.1-12(a)(18)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure a dependent resident received assistance with hygiene and bathing for 1 of 3 residents reviewed for activities of daily living care. (Resident 91) Findings include: During an observation on 8/13/23 at 9:48 a.m., Resident 91 was lying in bed with his eyes wide open. The resident was non-verbal. There was a white crusty substance on his lips. During an observation on 8/13/23 at 2:01 p.m., Resident 91 was observed lying in bed with his eyes wide open. The resident was non-verbal. There was a crusty white substance on his lips. During an interview on 08/14/23 at 11:34 a.m., the	F 0677	**F677** **Corrective action for the residents found to have been affected by the deficient practice:** Resident 91 was not harmed by this alleged deficient practice. Resident 91 no longer resides in the facility. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who are dependent for ADL care have the potential to be affected by this alleged deficient practice. DON/Designee completed a full	09/18/2023

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	resident's family member indicated the resident was often not bathed. He did not receive his planned baths. The family member would often have to wash him up herself. During an observation on 8/14/23, the resident was lying on a cot to be transferred. The resident's appearance was clean and well groomed. The SSD (Social Service Director) Note, dated 4/27/23, indicated the resident was not able to use the call light and was fully dependent on staff for all his needs and wants. The SSD Note, dated 5/17/23, indicated the resident was not able to respond to any questions asked. He was fully dependent on staff for all needs and wants. The Weekly Care Management Care Note, dated 7/12/23, indicated nursing provided total assistance with all ADLs (activities of daily living). The Admission MDS (Minimum Data Set) assessment, dated 4/27/23, indicated the resident required total assistance with ADL's. He had no behaviors. The Admission MDS assessment, dated 7/15/23, indicated the resident required total assistance with ADL's. He had no behaviors. The resident's diagnosis included, but were not limited to: Type 2 Diabetes Mellitus, tracheostomy, Anoxic Brain Damage, and muscle weakness. The current 400 Hall Shower Schedule, indicated Resident 91 was to receive two baths a week. He was scheduled to have a bath on second shift		house audit to ensure all showers were completed per resident preference and schedule. All those found to not have showers were immediately given showers per staff. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee educated staff related to facilities policy “Routine resident care” with emphasis on providing showers per resident preference and schedule. **Corrective actions to be monitored to ensure the deficient practice will not recur:** DON/Designee will review per shower schedule 10 resident’s weekly x’s 4 weeks, 5 resident’s weekly x’s 4 weeks and 2 residents weekly x’s 4 weeks to ensure showers are given per resident preference and schedule. The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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Sundays and Thursdays (7/2,/7/6, 7/9, 7/13, 7/16, 7/20, 7/23, 7/27, 7/30, 8/3, 8/6, 8/10, and 8/13).

The Bathing Sheets, dated 7/1/23 and 7/8/23, indicated the resident had refused his bed baths or showers.

The Bathing Sheets, dated 7/5, 7/12, 7/15, 7/20, 7/27, 7/29, 8/3, 8/9, and 8/12/23 indicated the resident received a bath. Only three of the bathing sheets indicated the resident received a complete bed bath (7/15, 7/29, and 8/2).

During an interview with the DON (Director of Nursing) on 8/17/23, she indicated the staff were to follow the electronic shower schedule and not the paper copy. The electronic shower schedule indicated the resident was only scheduled to received one bath a week unless otherwise needed.

During a confidential interview from 8/13/23 through 8/17/23, a staff member indicated the resident never refused his baths. He never refused care. The resident was to receive a complete bath twice a week. His normal bathing schedule was for Sundays and Thursdays on second shift. There were times when the resident had not received his scheduled bath. The next shift staff would try to wipe the resident off; however, they did not always have the time to clean him up.

During a confidential interview from 8/13/23 through 8/17/23, a staff member indicated she was not aware of any residents that were only scheduled for one bath a week. The residents did not always receive the scheduled baths, several of the residents were larger and it took two staff to position them. There was often only one aide on the hallway and sometimes residents did not get

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	bathed. During a confidential interview from 8/13/23 through 8/17/23, a resident indicated receiving assistance with care was the worst on the weekends or when staff called off work. The staff did not have time to provide incontinence or bathing care. They have had to wait up to two hours for incontinence care. The current facility policy, titled "Routine Resident Care", provided on 8/17/23, indicated the policy was to promote resident centered care. The procedure included, but was not limited to, provide care for incontinence with dignity and maintaining skin integrity, routine personal care for bathing, toileting, and medication administration. 3.1-38(a)(2)(A)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			
	Based on observation, record review, and interview, the facility failed to ensure emergency respiratory supplies were available for residents with a tracheostomy for 3 of 12 residents reviewed for Respiratory Care. (Residents 7, 79 and 54)	F 0695	**F695** **Corrective action for the residents found to have been affected by the deficient practice:**	09/18/2023

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	Findings include: 1. During an observation on 8/13/23 starting at 11:00 a.m., Resident 7 did not have an AMBU (artificial manual breathing unit) bag at the bedside. The record for Resident 79 was reviewed on 8/15/23 at 11:43 a.m. The diagnoses included but were not limited to chronic respiratory failure with hypoxia, asthma, anxiety disorder, obstructive sleep apnea, malignant neoplasm of the esophagus, and tracheostomy (trach). The Quarterly MDS (Minimum Data Set) Assessment, dated 4/22/23, indicated the resident was cognitively intact and required assistance with oxygen therapy, suctioning, tracheostomy care and ventilator. The care plan initiated on 8/26/22, indicated the resident was currently receiving ventilator care due to respiratory failure. The interventions included, but were not limited to, evaluate changes in the resident's mental status, agitation, restlessness, and confusion; maintain ventilator setting as ordered by RT (Respiratory Therapist) and or the medical provider; and provide ventilation care and suctioning per physician orders. 2. During an observation on 8/13/23 starting at 11:00 a.m., Resident 54 did not have an AMBU bag at the bedside. The record for Resident 54 was reviewed on 8/15/23 at 1:00 p.m. The diagnoses included but were not limited acute respiratory failure with hypoxia, chronic kidney disease stage 3, atelectasis, and tracheostomy.		Residents 7, 79 and 54 were not harmed by alleged deficient practice. Residents 7,79,54 were assessed per licensed nurse and remained at baseline. Residents 7,79, and 54 immediately had AMBU bags placed at bedside per respiratory therapist. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** DON/Designee/Respiratory therapist conducted an audit on all residents with a tracheostomy to ensure emergency respiratory supplies were available for residents. Any found without needed emergency respiratory supplies had them provided immediately. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee/Respiratory Therapist Manager educated licensed nursing staff and respiratory staff regarding facilities policy “The Respiratory Role in Emergency Preparedness Plan for Ventilator” with emphasis on having AMBU bag at bedside for tracheostomy patients.	

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	The Quarterly MDS Assessment, dated 7/20/23, indicated the resident was moderately cognitively impaired and required assistance with oxygen therapy, suctioning, tracheostomy care and ventilator. The care plan, initiated on 5/9/22, indicated the resident was currently receiving ventilator care due to respiratory failure. The interventions included, but was not limited to, evaluate changes in the resident's mental status, agitation, restlessness, confusion; maintain ventilator setting as ordered by RT and or the medical provider[; and provide ventilation care and suctioning per physician orders. 3. During an observation on 8/13/23 starting at 11:00 a.m., Resident 79 did not have an AMBU bag at the bedside. The record for Resident 7 was reviewed on 8/15/23 at 11:43 a.m. The diagnoses included but were not limited to cerebral palsy, acute and chronic respiratory failure with hypoxia, tracheostomy, and dependence on a respiratory ventilator. The Quarterly MDS assessment, dated 4/22/23, indicated the resident was severely cognitively impaired and required assistance with oxygen therapy, suctioning, tracheostomy care and ventilator. The physician's order, dated 5/16/23, indicated staff were to verify tracheostomy equipment was in the resident's room which included an AMBU bag and mask every shift. The care plan, dated 6/30/23, indicated Resident 7 had a history of acute respiratory failure with		**Corrective actions to be monitored to ensure the deficient practice will not recur:** DON/Designee will monitor through observation 10 resident's weekly x's 4 weeks, then 5 resident's weekly x's 4 weeks, then 2 resident's weekly x's 4 weeks with tracheostomy to ensure emergency respiratory supplies are available. The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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hypoxia. Staff were to elevate the head of the bed as needed, for ease of breathing; monitor vitals; report abnormal findings to medical provider and family representative; observe for signs and symptoms of respiratory distress; oxygen therapy as ordered; and change the tubing per facility policy.

During an interview on 8/13/23 at 11:00 a.m., RT 3 indicated all residents with a trach and on a ventilator should always have an AMBU bag available at the bedside. He did not know why the 3 residents did not have one in their rooms. He felt like the housekeepers were throwing them away when they cleaned the resident's rooms.

During an interview on 8/16/23 at 2:00 p.m., RT 4 indicated each resident should have their own AMBU bag at the bedside. It was part of the trach kit and supplies that are stocked at the bedside either before the resident arrived or right after they arrived. There would be no resident sharing of the AMBU bags. The supplies would be checked every shift and that included checking for the AMBU bag.

During an interview on 8/17/23 at 8:35 a.m., Housekeeper 5 indicated she did not know what an AMBU bag was. After showing the housekeeper what the bag was, she indicated we would never throw one of those away. The housekeepers did not touch anything pertaining to the resident's equipment related to the ventilator or trach.

During an interview on 8/17/23 at 8:40 a.m., The Housekeeping District Manager indicated she did not know what an AMBU bag was and what it was for. After observing what an AMBU bag was she indicated the housekeepers were educated on

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	how to clean the vent rooms. The housekeepers would not throw away anything pertaining to the vent equipment. The Respiratory Role in Emergency Preparedness Plan for Ventilator policy included, but was not limited to, "... d. The following equipment will be present in the resident room including but not limited to the following: i. suction machine including tubing and appropriate catheters ii. Bag valve mask (also known as Ambu bag) iii oxygen e-cylinder (15 1/m or greater) or liquid base oxygen concentrator iv. Extra appropriately sized tracheostomy tubes..." 3.1-47(a)(6)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §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			

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	(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.			
	Based on observation, interview, and record review, the facility failed to ensure there were enough staff to assist residents with medication administration and activities of daily living in a timely manner. This deficient practice had the potential to affect for 92 of 101 resident reviewed for sufficient staffing. Findings include: Review of the Facility Assessment Tool, dated 11/1/22 through 10/31/23, indicated the purpose of the assessment was to determine what resources were necessary to care for the residents. The tool indicated the average daily census was 97. The facility had 21 residents on ventilators or respirators. The general staffing plan included, but was not limited to, 2 to 8 licensed nurses providing direct care per day, 4 to 14 nurse aides per day, and 1 to 2 respiratory care services staff per day. During a continuous observation on 8/13/23 from 9:40 a.m. until 9:51 a.m., indicated the call lights for Rooms 213 and 215 were alarming. Two CNAs were removing food trays from other rooms and were walking down the hallway. One of the CNAs walked into Room 213 at 9:46 a.m. and she walked out at 9:47 a.m. The call light for Room 215 continued to alarm. The nurse walked by Room 215 and did not answer the call light. The CNA walked by Room 213 and walked to the lounge area. The CNA walked out of the lounge area then	F 0725	**F 725** **Corrective action for the residents found to have been affected by the deficient practice:** No residents were harmed by this alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** The alleged deficient practice has the potential to affect 101 of 101 residents residing in the facility. As a result of this noted alleged deficient practice, there was no negative outcome. The facility staffing patterns have been reviewed to ensure adequate staffing is in place to meet the needs of the residents. The facility has incentives in place to promote hiring of nurses and CNAs.	09/18/2023

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	walked past Room 213 and 215 without answering the call lights. At 9:51 a.m., the CNA walked back to Room 215 and walked into the resident's room. During a continuous observation on 8/13/23 from 9:30 a.m. until 10:17 a.m., indicated Room 200's call light was alarming. The RT entered the resident's room at 10:17 a.m. and the resident told her she wanted a bath. She left the light on and told the nurse. The RT checked on the resident again at 11:07 a.m. The CNA indicated she had just gone into the room a few minutes ago and all the resident wanted was her lunch tray. She'd had a bath the night before. She had turned the resident's light off and indicated the resident immediately turned her light back on and would not turn it off. During a confidential interview on 8/13/23, the RN indicated they were short staffed on that day. Normally they had two nurses to split the hall and she had two aides. She was the only nurse that day and only had one aide. It was not enough with one nurse and one aide. The hall had resident who had a tracheostomy (trach) and/or ventilator. They had to turn and reposition most of the patients, the residents needed to be changed, and they had trays to pass. There were times she ran late with medications. During a confidential interview on 8/13/23, the RN indicated he was caring for 33 patients. Usually he had a nurse to split the hall and he had 24 patients. Today things were short staffed. He did not typically have that many patients. If he was alone he struggled to get the passing of medications done. He did not have enough time to do it. About 20% (percent) of the time they did not have a nurse to split the hall.		**Measures/systemic changes put into place to ensure the deficient practice does not recur:** The RDO/RDCO educated Executive Director/Director of Nursing on adequate staffing and expectations **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/DON/Schedule Coordinator/Designee will review the daily schedules Monday through Friday to include weekend schedules to ensure adequate staffing is in place as an ongoing practice. This will occur for no less than 3 months and compliance is maintained. The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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During a confidential interview on 8/13/23, the RT indicated she felt there needed to be two RT's on the hall at all times to provide the care the residents needed. She did not think the amount of work required for a patient load of 12 to 13 ventilators for one RT was safe. They were running the entire time, it created burnout, and she did not feel safe. She could handle the bare minimum care, but was not sure if there was an emergency she could handle it. She was concerned about what could happen if there were more than one ventilator going off at a time, which did happen at times.

During an observation and interview on 8/13/23 at 9:23 a.m., CNA (certified nurse aide) 11 indicated she was trying to take care of the residents, but she was trying to get them up for church and all the call lights would have to wait. The 200 Hall had multiple call lights going off. During a continuous observation Rooms 209 and 213 were flashing at 9:23 a.m., The nurse walked out of another resident's room and walked up to her medication care. She walked past the call lights and stood at her cart. The two alarms continued to alarm at 9:28 a.m., the aide walked into Room 209 and turned off the light and walked right back out of the room. The CNA then she walked straight into Room 213, turned off the call light, and walked right back out of the room.

During an interview on 8/13/23 at 9:52 a.m., Resident 6 indicated the aide just walked in and turned off her light. She did not help her. The staff do that often and then do not come back for a long time.

During a confidential interview on 8/13/23, the nurse indicated she was running behind today with passing medications. The residents would

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	have to wait since she was behind on her medications. During a confidential interview on 8/13/23 through 8/17/23, a resident indicated the facility needed more CNAs. There was often only one aide on the hall and that was not enough, the residents needed more CNAs. The respiratory staff will jump in and help the residents with incontinence care and that took them away from their work. During a confidential interview on 8/13/23 through 8/17/23, a resident indicated the facility was short for CNAs. There was a lot of times there was only one aide on the hall. She had to wait a long time for incontinence care. One time she pushed her call light and had to wait three hours. She just wanted some ice water and was able to see the clock hanging on her wall. She has had to wait longer than an hour over 15 times since she came to the facility. During a confidential interview on 8/13/23 through 8/17/23, a family member indicated the facility seemed short of staff. His family member had pushed her call light on and they had waited over 30 minutes or more before staff would come in. He had even walked out into the hall looking for staff without finding any staff to help her. During a confidential interview on 8/13/23 through 8/17/23, a resident indicated the weekends were the worst for receiving timely care. On one Saturday night she had to wait till 1:00 a.m., to receive her evening medications. During a confidential interview on 8/13/23 through 8/17/23, a resident indicated she has had to wait as long as 45 minutes for care. One day she had a bowel movement in the bed because she could			

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not wait any longer.

During a confidential interview on 8/13/23 through 8/17/23, a resident indicated the facility needed some more staff. They could use at least a couple more CNAs. When there was not enough staff, it affects us, like sometimes there was only 4 CNAs for all 4 halls. The staff cannot complete all the needed resident showers, pass trays, and answer call lights timely. It happened often and was on all shifts. Many of the residents required two staff to help them properly. It took a while to get staff to answer your call light. It was not always an hour, but had most definitely been longer than an hour at times. The resident had a clock on her bed side table. She indicated she purposely would look at the clock and had told staff how long she had waited. The staff would often say no way and she would tell them she had been watching her clock.

During a confidential interview on 8/13/23 through 8/17/23, a staff member indicated she was usually the only staff member on the hall passing the residents food trays. Once in a while there would be two aides. Before she could get the trays out to all the residents the food would get cold and she would have to reheat a lot of them. We have never had as many staff passing food trays to the residents as there was today.

During a confidential interview on 8/13/23 through 8/17/23, a resident indicated staff have not had time to answer the call lights. She observed two CNAs crying on Sunday after their shift because they could not keep up. They normally only had one CNA per hallway.

During a confidential interview on 8/13/23 through 8/17/23, a resident indicated she was not getting her showers as scheduled and went four days

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waiting for a shower. She was told she had to wait since there was no time for the CNAs to get to her. Getting her showers on time were important to her.

During a confidential interview on 8/13/23 through 8/17/23, a resident indicated she did not get her showers as scheduled. When she eats she gets food on her clothing and had difficulty getting staff to clean it up.

During a confidential interview on 8/13/23 through 8/17/23, a resident indicated staff did not answer the call lights. She was admitted to the facility for therapy. She had been late a few times for her therapy because staff did not have time to get her out of bed. One day staff finally came in her room and got her up at 3:00 p.m. Three hours later they asked her if she was ready to go back to bed. She liked to get up in the morning and stay up during the day until bedtime, but getting up so late she did not want to go back to bed.

During a confidential interview on 8/13/23 through 8/17/23, a resident indicated she was sick and tired of not having enough staff. She had seen the nurse's and CNA's leave at the end of their shift crying and exhausted. The residents were the ones who had to suffer because of low staffing. The care does not get done on time and she has had to wait hours just for the staff to answer her call light.

During an interview on 08/16/23 at 9:06 a.m., the Resident council president indicated the main problem with staff was long times for call light answering. The residents had to learn they were not in their own home and would often have to wait. There was not enough help to work the floor related to long call light waits. There were many

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	residents that took two staff members to help with care and there was most often only one aide on the floor. Review of the Resident Council minutes, dated January 2023, indicated the call lights on night shift were not being answered in a timely manner and the residents' showers were not offered before 10 to 11 p.m. During an observation and interview on 8/16/23 at 9:27 a.m., CNA 13 needed help to turn a resident. The CNA had the Medical Records staff member to help her to turn a resident. The CNA indicated she was often the only aide on the hall, and it took two staff to turn most of the residents on the hall. Review of the as worked schedule, from 8/2/23 through 8/15/23, indicated the 100 Hall and 400 Hall only had one CNA scheduled, for the 6:00 a.m. to 6:30 p.m. shift, on 10 of 14 days scheduled. The facility had no aide scheduled for the 100/400 Hall split on 5 of the 14 days reviewed. The current Routine Resident Care policy, included but was not limited to, "routine Resident Care: care that is not necessarily medically or clinically based but necessary for quality of life promoting dignity and independence, as appropriate...administration of medication...Provide routine daily care...Assisting and teaching activities of daily living...Toileting, providing care for incontinence with dignity and maintaining skin integrity..." 3.1-17(a)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals			

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	Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, record review, and interview, the facility failed to ensure appropriate storage and labeling of multiple medications for 2 of 4 medication carts observed for medication storage and labeling. (300 Hall Back and 300 Hall Back Medication Carts) Findings include: 1. During an observation of the 300 Hall Back Medication Cart with Unit Manager 15 on 8/15/23 at 10:15 a.m., the following concerns were observed:	F 0761	**F761** **Corrective action for the residents found to have been affected by the deficient practice:** No residents were harmed by this alleged deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who receive medications administered per	09/18/2023

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	a. Resident 258's insulin glargine injector pen was opened and contained 140 units of insulin. The pen was not marked with an open date. The clinical record for Resident 258 was reviewed on 8/15/23 at 1:00 p.m. The diagnosis included, but was not limited to, Diabetes Mellitus type 2. The physician's order, dated 8/1/23, indicated the resident received Lantus 100 unit/mL (milliliters) 5 units subcutaneously at bedtime. b. Resident 67's Lantus injector pen had a sticker on the outside of it which indicated it had been opened on 7/8/23 and should have been discarded on 8/5/23. During an interview on 8/15/23 at 10:17 a.m., Unit Manager 15 indicated the resident did not have any other Lantus pens in the medication cart and it had to have been used to administer the resident's Lantus that same morning. The clinical record for Resident 67 was reviewed on 8/15/23 at 1:05 p.m. The diagnosis included, but was not limited to, Diabetes Mellitus type 2. The physician's order, dated 7/2/23, indicated the resident received Lantus 100 unit/mL 5 units subcutaneously in the mornings. The resident's MAR (Medication Administration Record) indicated the resident had last received the medication on the morning of 8/15/23. c. Resident 57's Lantus injector pen had been opened as indicated by the tamper evident seal being broken. The insulin pen had not been marked with an open date.		facility have the potential to be affected by this alleged deficient practice. DON/Designee completed a full house audit of all medication carts to ensure all medications were appropriately labeled and stored. Any found not to be properly labeled or stored were immediately corrected. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee educated licensed nurses and QMAs regarding facilities policy “Storage of Medication Policy” with emphasis on proper labeling and storage of medication. **Corrective actions to be monitored to ensure the deficient practice will not recur:** DON/Designee will complete audits through observation 5x’s weekly x’s 4 weeks then 4x’s weekly x’s 4 weeks the 3 x’s weekly x’s 4 weeks of medication carts to ensure mediations are properly labeled and stored. The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan	

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	The record for Resident 57 was reviewed on 8/15/23 at 1:10 p.m. The diagnosis included, but was not limited to, Diabetes Mellitus type 2. The physician's order, dated 5/9/23, indicated the resident received Lantus 100 unit/mL 25 units subcutaneously at bedtime. 2. During an observation of the 300 Hall Front Medication Cart on 8/15/23 at 11:00 a.m., with LPN (Licensed Practical Nurse) 16, the following concerns were observed: a. Resident 16's albuterol sulfate HFA (hydroflouroalkane) inhaler was lying in the top drawer of the medication cart on its side. The side of the box indicated the inhaler should be stored with the mouthpiece down. During an interview on 8/15/23 at 11:02 a.m., LPN 16 indicated she was not aware some of the inhalers needed to be stored with the mouthpiece down. The record for Resident 16 was reviewed on 8/15/23 at 1:15 p.m. The diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease) and congestive heart failure. The physician's order, dated 7/15/23, indicated the resident received albuterol sulfate HFA 90 mcg/act (micrograms per actuation) every 4 hours as needed for wheezing. b. There was an opened albuterol sulfate HFA inhaler lying on its side in the top drawer. There was no pharmacy labeling to identify who the medication belonged to. There was permanent marker smudged on the side of the inhaler.		initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	During an interview on 8/15/23 at 11:04 a.m., LPN 16 indicated she did not know who it belonged to and it needed to be thrown out. c. There was a fluticasone proprionate and salmeterol inhalation powder 250 mcg (micrograms)/50 mcg with only 51 out of 60 doses left in it and an Advair diskus inhaler. The medications did not have any pharmacy labeling and were not in the original packaging. During an interview on 8/15/23 at 11:06 a.m., LPN 16 indicated she believed the inhalers belonged to Resident 30 because they had the resident's first name written on them in ink pen. The record for Resident 30 was reviewed on 8/15/23 at 1:20 p.m. The diagnoses included, but were not limited to, history of COVID-19 and COPD. The physician's order included, but were not limited to, albuterol HFA 90 mcg/act every 4 hours as needed for shortness of breath and fluticasone-salmeterol inhalation aerosol powder 250-50 mg 1 puff inhaled every morning for lung health. d. Resident 84's albuterol HFA inhaler was stored lying on its side in a plastic bag. The box indicated the medication should be stored mouthpiece down. Resident 84's Symbicort was in the same plastic bag, with the resident's first name written on the side of the inhaler in black permanent marker, however there was no original pharmacy packaging or label on the medication. The record for Resident 84 was reviewed on			

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	8/15/23 at 1:25 p.m. The diagnoses included, but were not limited to, respiratory failure and pneumonia. The physician's order included, but were not limited to, albuterol sulfate HFA 90 mcg/act inhaler 2 puffs three times daily for wheezing or shortness of breath and Symbicort 160/4.5 mcg/act 2 puffs twice daily for lung health. The Storage of Medication policy, last revised 9/2018, included but was not limited to, "... Medications and biologicals are stored safely, securely, and properly, following manufacturers recommendations or those of the supplier... General guidance... 1. The provider pharmacy dispenses medications in containers that meet regulatory requirements, including standards set forth by the United States Pharmacopeia (USP). Medications are kept in these containers. Nurses may not transfer medications from one container to another... 3. All medications dispensed by the pharmacy are stored in the pharmacy container with the pharmacy label... III. Expiration Dating... 3. Certain medications or package types, such as... multiple dose injectable vials... require an expiration date shorter than the manufacturers expiration date once opened to ensure medication purity and potency... 5. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. a. The nurse shall place a 'date opened' sticker on the medication and record the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days from opening, unless the manufacturer recommends another date or regulations/guidelines require different dating... 6. The nurse will check the expiration date of each medication before administering it. 8. All expired medications will be removed from the active			

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	supply and destroyed in accordance with facility policy, regardless of amount remaining..." 3.1-25(j)			
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.			
	Based on observation, record review, and interview, the facility failed to ensure a sputum culture was sent to the laboratory for testing as ordered by the physician for 1 of 6 resident's reviewed for laboratory testing. (Resident 48) Findings include: The clinical record for Resident 48 was reviewed on 8/16/23 02:18 PM. The diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, COPD (Chronic Obstructive Pulmonary Disease), acute on chronic congestive heart failure, streptococcus group B, pseudomonas aeruginosa, resistance to beta lactam antibiotics, and tracheostomy status. The Quarterly MDS (Minimum Data Set) assessment, dated 6/1/23, indicated the resident was cognitively intact and received oxygen therapy, suctioning, and tracheostomy care. The care plan, dated 9/9/21, indicted the resident received tracheostomy care related to her disease	F 0770	**F770** **Corrective action for the residents found to have been affected by the deficient practice:** Resident 48 was not harmed by alleged deficient practice. Notification was made to MD related to failure to send sputum culture to laboratory, with no new orders. Resident was assessed per MD, licensed nurse staff and respiratory therapist with improvement noted from baseline. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who receive lab orders per MD have the potential to be affected by this alleged deficient practice.	09/18/2023

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process. The interventions included, but were not limited to, obtain and monitor laboratory and diagnostic studies as ordered, report abnormal findings to medical provider, the resident, and her representative.

The physician's progress note, dated 8/10/23 at 8:41 p.m., indicated the resident was seen and examined with the respiratory team. The physician ordered to obtain a sputum culture and start empiric (relying on observation or experience) levofloxacin (an antibiotic medication).

The physician's order, dated 8/11/23 at 7:00 a.m., indicated to obtain a sputum culture related to possible pneumonia and increased secretions one time on 8/11/23.

The Medication Administration Record (MAR) indicated the resident's sputum culture was documented as obtained by RT (Respiratory Therapist) 17 on 8/11/23.

The clinical record lacked documentation of the sputum culture being given to the laboratory services provider or any results of the culture.

During an observation of the Medication Storage Room on 8/16/23 at 1:55 p.m., with LPN (Licensed Practical Nurse) 14, a specimen collection bag was lying on the draw inside the specimen refrigerator. Inside the bag was a specimen bottle, which contained 10 mL of a whiteish-yellow fluid. The label on the bottle, indicated it was a sputum culture for Resident 48, which was obtained on 8/11/23 at 3:10 p.m.

During an interview on 8/16/23 at 1:56 p.m., LPN 14 indicated she did not know why the specimen was still in the refrigerator.

DON /Designee completed a 30-day look back audit to ensure all labs orders were completed fully per MD order. Any found to not have been completed, had notification to MD and any new orders implemented per MD as indicated.

Measures/systemic changes put into place to ensure the deficient practice does not recur:
DON/Designee educated licensed nurses regarding facilities policy “Physician Orders” with emphasis on following all labs orders per MD.

Corrective actions to be monitored to ensure the deficient practice will not recur:

DON/Designee will review through clinical meeting any new labs orders to ensure completed as ordered per MD 5x’s weekly x’s 12 weeks.
The DON/Unit Manager/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.

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During an interview on 8/16/23 at 2:00 p.m., Unit Manager 15 indicated she was unsure when the culture was ordered but it was obtained on 8/11/23. The laboratory services usually picked up the same day or the next day. They picked up specimens daily and it should not still be in the refrigerator.

During an interview on 8/16/23 at 2:04 p.m., the RT Director indicated they collected the culture one day last week and immediately put it into the fridge. He didn't think they were good for much more than 24 hours. The specimen should have been picked up. The lab came nightly for specimen pickups. The nurse should have checked the fridge and brought out any samples.

During an interview on 8/16/23 at 2:16 p.m., the RT Director indicated the specimen had not been re-obtained. He had contacted the physician to see what he would like to have done. He believed the physician had ordered the sputum culture the week prior to rule out pneumonia.

During an interview on 8/16/23 at 2:24 p.m., MD 18 indicated he had ordered a sputum culture and an antibiotic, levofloxacin, the week prior. He was just informed on 8/16/23 they had not obtained the culture. He felt the culture now would not be significant since the patient had already received the antibiotics. He did not feel they needed to get it at this point, but last week she was having more cough, shortness of breath, and increased secretions, which was why he started the antibiotics and the culture. He did want the order obtained when he gave the order. It should have been sent.

During an interview on 8/17/23 at 9:11 a.m., RT 17

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indicated she had obtained the sputum culture as the MD ordered due to increased secretions. MD 18 had told her he had prescribed an antibiotic, but she did not know what it was. She did not speak to the nurses after obtaining the culture about the results. She had at some point asked the doctor, but he didn't know about the results.

During an interview on 8/16/23 at 4:07 p.m., the RDCO (Regional Director of Clinical Operations indicated the resident had not received any doses of the ordered antibiotic.

During an interview on 8/16/23 at 4:22 p.m., MD 18 indicated apparently the resident did not get her antibiotic. The orders were not carried out. While he did not feel, as the patient had clinically improved since his initial assessment when he ordered the culture and antibiotics, they should have been more vigilant. He came and rounded late, and someone did not get the report. Nursing put his orders in for him, he thought he should have communicated better. He could not recall if he had told anyone the order.

During an interview on 8/16/23 at 4:39 p.m., the Director of Nursing (DON) indicated the physician needed to write his orders on a form like all the other physicians did. He rounded late when no management was in the building. She had expressed to him when he rounded late, he needed to write a physical order. The Interdisciplinary team reviewed the clinical notes in their morning meetings, but did not read every physician's note as they could be lengthy. If she had to read all the notes, she would not have time to get anything done.

The most current, but undated, Physician Orders policy, included, but was not limited to, " ... It is

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	the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents ... III. Execution of Order and Notifications a. The nurse that takes the physician order will be responsible for executing the order or provide safe hand-off to the next nurse ... i. Contact laboratory services, radiology services, pharmacy services, therapy or other outside vendors as required to execute the medical order ..." 3.1-49(a)			
F 0803 SS=E Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §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			

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	§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. Based on observation, record review, and interview, the facility failed to make a reasonable effort to meet the preferences of the residents' meal choices in that scheduled menu items were being substituted due to unavailability with the same food items being served almost daily. This deficient practice affected 93 of 101 residents who received meals in the facility. Findings include: During an interview on 8/13/23 at 9:36 a.m., Resident 8 indicated weekends were the worst and the food was the same thing over and over. During an interview on 8/13/23 at 10:08 a.m., Resident 11 indicated the facility served the same food multiple times in one week. During an interview on 8/13/23 at 10:11 a.m., Resident 56 indicated the food was "bad". The facility kept running out and portions were small. They have rice and peas for several meals every week. During an interview on 8/13/23 at 11:14 a.m., Resident 58 indicated the food lacked seasoning and quality. Sometimes it tasted or smelled spoiled and they frequently served the same foods every day. On 8/13/23 at 11:50 a.m., the following items were observed to be served at lunch: pork loin slice, peas, and pinto beans. Review of the scheduled menu for that meal indicated the pork loin slice was supposed to be barbequed, seasoned greens and baked beans were supposed to be served.	F 0803	F 803 **Corrective action for resident found to have been affected by the deficient practice**: Resident 11, 56 and 58 were not affected by the alleged deficient practice. Resident 11, 56 and 58 food preferences were reviewed and updated accordingly. **How other resident having the potential to be affected by the same deficient practice will be identified –** All residents that are receiving a meal tray have the potential to be affected. **Corrective action taken for those residents having the potential to be affected by the same deficient practice.** 100% audit of resident preference was completed. No other concerns noted. All resident food preferences are completed upon admission, reviewed quarterly and updated as needed. 100% audit of 4-week menu cycle was completed to ensure all items were available per the seasonal menu **Measure /systemic changes put into place to ensure the deficient practice does not recur?**	09/18/2023

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	During an interview with the Dietary Manager on 8/14/23 at 11:15 a.m., he indicated why peas and pinto beans were served on yesterday's lunch meal instead of the menu of seasoned greens and baked beans was because they were only allowed to order from the list of available items from their food vendor. They were not allowed to go out and buy anything else. Seasoned greens were not on their order list and he pulled up the list from the computer to verify any type of seasoned green were not on the list. Certain vegetables and rice were constantly on the menu as main entree or as an alternate because of this order issue. Peas, green beans, mixed vegetables, and okra were on the order list so they just substituted unavailable vegetables with those items. During an interview on 8/14/23 at 11:20 a.m. the Registered Dietitian indicated one of their other facilities had the same issue as this facility with the same vegetables being offered so often. The facilities up North had a different list of vegetables they could order from their food vendor than they could down here. The available lists were different depending on the State. During an interview with the Dietary Manager on 8/15/23 at 8:10 a.m., he indicated that if they ran out of food, then they would use the emergency food supply on the shelf. The menus were the same for the whole company, but there were different food vendors for different areas. The menus were repeating the same items every week, but they just tried to mix it up and fix it differently. What was the main course or vegetable one day could be the alternate the next day or so as it was either unavailable or to add it to the food line as an extra alternate. So it was like having the same thing frequently. He was aware that the residents		Dietary Manager/Registered Dietician was educated on completing resident preferences upon admissions, annually and updated as needed. **Corrective action to be monitored to ensure the deficient practice will not recur:** DM/Registered Dietician/Designee will review resident preferences 5 resident per week x 4 weeks, 3 resident x4 weeks and 2 resident x 4 weeks. The ED/Dietary Manager will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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were noticing the same food items being repeated over and over, he could only order what was on the list and not go over budget or he would get a call from Corporate questioning why he went over budget.

During an interview on 8/15/23 at 9:36 a.m., Resident 57 indicated the facility kept running out of food and drink. The drink they served was mostly water with a powdered mix and he questioned why would they keep running out of powdered mix.

During an interview with the Dietary Manager on 8/15/23 at 11:40 a.m., he indicated he could only serve what was scheduled on the menu. If chicken thighs were on the menu, then the residents could not have a chicken breast. If they did not like the chicken thighs or the alternate, they could have a hamburger patty.

The Registered Dietitian also indicated the residents could have a sandwich instead of the meal if they asked. Sandwiches were made daily and put in the refrigerator. The residents could not order a grilled cheese though as a alternate if they did not like the items on the menu.

The review of the 4 week cycle of menus indicated the following food items were to be served and did not include when the cook made substitutions in order to add previous food items as alternatives or unavailability:

- Week 1: Rice: As the main course = 1 time; As the alternate = 3 times
Peas: As the main course = 4; As the Alternate = 2
Green beans: As the main course = 2; As the alternate = 1

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	- Week 2: Rice: As the main course = 3; As the alternate = 3 Peas: As the Main course = 3; As the alternate = 3 - Week 3: Rice: As the main course = 1; As the alternate: 4 Peas: As the main course = 2; As the alternate = 2 - Week 4: Rice: As the main course = 2; As the alternate = 2 Peas: As the main course = 2; As the alternate = 1 During an observation of the lunch meal being served on 8/15/23 at 11:00 a.m., lima beans and Au gratin potatoes were being served. Review of the menu for that meal indicated sugar snap peas and oven brown potatoes were supposed to be served. The Dietary Manager indicated since the peas were served the other day, he substituted lima beans instead. During the Resident Council meeting on 8/15/23 at 2:10 p.m., the following concerns were voiced: - There were no condiments available for the food and no seasoning. - The facility served too many of the same foods and the cheapest food possible. - The food on the trays was different from the menu. The residents had talked to the dietary staff about the problem and they always had an excuse. 3.1-21(a)(1) 3.1-21(a)(2) 3.1-21(a)(4)			
F 0812 SS=E	483.60(i)(1)(2) Food			

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Bldg. 00	Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure food was served and stored under sanitary conditions and served at the appropriate temperatures during 5 of 5 kitchen observations. Findings include: 1. During an observation of the kitchen on 8/13/23 at 9:15 a.m. while accompanied by Cook 20, the following concerns were observed: - The floor under the shelves in dry storage had a build-up of black grime; around the baseboards and corners in the dry storage, there was a heavy build-up of black grime. - The floor, corners and baseboards in the kitchen under all the preparation tables, convection oven,	F 0812	F-812 **Corrective action for resident found to have been affected by the deficient practice**: No resident were harmed by this alleged deficient practice. All sanitization concerns were identified and immediately corrected. All food temps were checked and immediately corrected to facility policy **How other resident having the potential to be affected by the same deficient practice will be identified**	09/18/2023

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	refrigerators and freezers, and ice machine had a heavy build up of black grime. - The floor under the stove had a heavy build up of black grime with a bottle of seasoning half way under the stove. - The ovens had a moderate amount of white and black spills on the bottom of both ovens. - The walk-in refrigerator floor had milk spills under the crates of milk sitting on a stool. - The walk in freezer had one box of chocolate and one box of strawberry shakes that were frozen together inside due to the condenser unit dripping onto them. There was a three inch hanging icicle from the pipe underneath the condenser unit; seven 2 inch wide by 3 inch high frozen drips on the rack under the condenser unit; a five inch high icicle coming up from the left side of the floor by the rack and a 12 inch long by 2 1/2 inch high ice build up under the rack under the condenser unit; a 3 inches high by 2 inches wide ice build up on the right side of the floor under the rack. An interview with Cook 20, during the observation, he indicated staff cleaned up the ice every day but it just re-formed again by the next day. The freezer was just fixed but he guessed it was not really fixed. - Both faucets at the 3 compartment sink continued to leak even after the Cook tried to turn them off hard. He indicated that it just started to drip last night. During an interview on 8/13/23 at 9:50 a.m., Resident 53 indicated the food was not good and it was cold half the time.		All residents have the potential to be affected by the deficient practice- ED immediately reviewed with DM on safe sanitary practice and proper food temperatures. **Corrective action taken for those residents having the potential to be affected by the same deficient practice.** Internal Sanitization audit was completed and any concerns that were identified were immediately corrected. DM and Dietary staff educated on sanitary conditions and proper food temperature **Measure /systemic changes put into place to ensure the deficient practice does not recur?** DM/Designee will completed quick round sheet daily x 4 weeks, 3 x a week x 4 weeks and 2 x a week for 4 weeks. Until compliance is met Test tray will be completed 3 x week x 4 weeks, 2 x a week x 4 weeks, weekly x 4 weeks. The ED/Dietary Manager will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 8/13/23 at 9:58 a.m., Resident 30 indicated food was cold most of the time. During an interview on 8/13/23 at 10:11 a.m., Resident 56 indicated the food was "bad". 2. During an observation 8/13/23 at 11:06 a.m., the ice had been cleaned up in the walk in freezer and the shakes removed. 3. During an observation on 8/14/23 at 11:03 a.m., the same issues identified on 8/13/23 at 9:15 a.m. were observed. No ice was observed on the floor or pipes in the walk-in freezer but the Dietary Manager indicated it was not as bad as it was yesterday, but staff did clean it up this morning. The maintenance staff was able to fix one of the leaky faucets. On 8/14/23 at 10:10 a.m., the Maintenance Director presented a copy of the invoice, dated 7/29/23, to indicated the refrigeration company had come in to check the walk-in freezer. The review of this invoice indicated the freezer was holding at -10 degrees Fahrenheit, refrigerant level was good, and the freezer was operating as designed. 4. During an observation on 8/15/23 at 11: 00 a.m., the following concerns were observed: - The same issues observed on 8/13/23 at 9:15 a.m. and 8/14/23 at 11:03 a.m. remained an issue. Both leaky faucets at the 3 compartment sink were observed to no longer be dripping. - Five half dollar size ice spots on the floor in the walk-in freezer were observed under the condenser unit. The Dietary Manager indicated that they continued to clean it every day and it		achieved or if ongoing monitoring is required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155659	A. BUILDING 00 B. WING	08/17/2023

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was not as bad. It was supposed to be fixed, but there was a guy supposed to be coming in to look at it.

A temperature of the lunch meal in the main kitchen was obtained on 8/15/23 at 11:35 a.m. by the Dietary Manager. The following temperatures were obtained:
Chicken thighs = 153 degrees Fahrenheit (F)
lima beans = 176 degrees F
Au gratin potatoes = 165 degrees F

During a re-check of the food temperatures of a 300 unit tray by the Dietary Manager on 8/15/23 at 12:08 p.m., after all the trays were passed, the following temperatures were obtained:
chicken thigh = 133 degrees F
lima beans = 126 degrees F
Au gratin potatoes = 143 degrees F

On 8/15/23 at 12:00 p.m., when the second 300 Unit cart arrived to the floor, there was an additional lunch tray was on top of the closed food tray cart. The Executive Director (ED) indicated that whenever there were additional trays on top of the food cart, as they did not fit inside, staff were to always make sure to serve them first so the food stayed warm. A staff member indicated the staff did not always make sure the tray on top of the food cart was the first to be delivered.

During the Resident Council meeting with 14 residents on 8/15/23 at 2:10 p.m., the following concerns were voiced:

- Felt like no one knew how to cook. They had served raw meat and the food was usually cold. The facility served the cheapest food possible.

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- At least 2-3 times a week the meat was not done.

5. During an observation on 8/17/23 at 8:17 a.m., the following concerns were observed:
- The same issues identified on 8/13/23 at 9:15 a.m., 8/14/23 at 11:00 a.m., and 8/15/23 at 11:00 a.m. remained an issue.

- The milk spills remained under the rack holding the cartons of milk below the condenser unit and were observed to now also be running under the left wall side of the racks.

- A three foot wide by two inches long strip of ice with various sized drips in it was under the condenser unit; three 3 inch icicles hung from the pipes under the condenser unit; a dinner plate size ice drip was on the floor which was 3 inches high in the middle and in front of the strip of ice and three 1 inch by 1 inch high ice drips were on the floor.

- The right faucet to the 3 compartment sink continued to drip even after being tightened.

On 8/17/23 at 9:30 a.m., the Dietary Manager presented a copy of the cleaning schedule that was hung on the wall for the dietary staff to follow daily. He indicated his staff did not sign off on the schedule to indicate they had completed the work daily, but that he did check it daily along with his check off sheet to make sure the cleaning had been done.

The review of the cleaning schedule, dated 8/16/23, that the Dietary Manager completed daily indicated all areas were cleaned and in good shape. The "Nutrition Services: Quick Rounds" dated 8/16/23 presented by the Dietary Manager

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	indicated "...#6 General Sanitation:...B. In general, kitchen is clean& free of dust/dirt accumulation, i.e. ceilings, shelving, floors, walls, hoods...#7 Maintenance:...B. All equipment in good working order..." In confidential interviews during the survey period between 8/13/23 and 8/17/23, the following concerns were voiced: - If management wasn't here helping to pass trays, she would be doing it by herself. Management was not normally here on the weekend. By the time she would get the food trays passed to every resident on the unit, the food was cold and the residents would ask her to reheat the food. - Only today did any management staff come out on the floor to help. There was usually only one staff member on the hall passing the trays, sometimes there were 2 aides and they never had this many people helping to serve as they did today. 3.1-21(a)(1) 3.1-21(a)(2) 3.1-21(i)(3)			