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F 000	INITIAL COMMENTS	F 000		

The State Agency (SA) conducted an annual recertification survey and complaint investigations for CI MS #21345, CI MS #21398, and CI MS #21656 from 5/15/23 through 5/18/23. The SA extended the survey and entered the facility again on 05/31/23 and exited on 06/01/23. The SA found the facility to not be in compliance regarding CI MS #21656 related to the death of a resident. The facility was not in compliance with the requirements of participation in Medicare and Medicaid.

During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services and cited F578, F583 F644, F656, F 695, F801, and F812. The SA investigated CI MS #21345 for Respect/Resident Rights and did not cite deficiencies related to this allegation. The SA investigated CI MS #21398 for Physical Environment and did not cite any deficiencies related to this allegation.

During the survey, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 5/15/23, when the facility failed to accurately transcribe physician's orders, reconcile, and verify physician's orders resulting in the omission of an insulin order and develop a comprehensive care plan regarding the care needed for the diagnosis of diabetes for Resident #1. Resident #1's physician ordered long-acting insulin was not administered for five days following admission on 5/15/23 at approximately 4:49 PM and the resident had to be transferred to the Emergency Room on 5/20/23 at 5:10 AM, which revealed a blood sugar of 764 at 5:38 AM

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

Electronically Signed | 06/19/2023

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and resulted in death of the resident at 6:35 AM with a diagnosis of diabetic ketoacidosis (DKA).

The facility's failure to accurately transcribe physicians orders, reconcile and verify physicians orders to prevent Diabetic Ketoacidosis as a result of the omission of an insulin order and failure to develop and implement a comprehensive care plan regarding the care needed for the diagnosis of diabetes the facility placed Resident #1 and other residents with significant medication orders at risk of developing a situation that was likely to cause serious injury, harm, impairment, or death.

The SA notified the facility's Administrator of the IJ and SQC on 5/31/23 at 5:00 PM and provided the Administrator with the IJ templates.

The State Agency (SA) called Immediate Jeopardy (IJ) on 05/31/23 at 5:00 PM and provided the facility with the IJ templates.
Immediate Jeopardy was cited at:
42 CFR 483.21 (a) Baseline Care Plan (F655) at a scope and severity (S/S) of J;
42 CFR 483.21 (b)(3) Professional Standards (F658) at a S/S of J;
42 CFR 483.70 (i)(1)(ii) Medical Record Accurately Documented (F842) at a S/S of J

Immediate Jeopardy and Substandard Quality of Care (SQC) was cited at:
42 CFR 483.25 Quality of Care (F684) at a S/S of J;
42 CFR 483.45(f)(2) Free of Significant Medication Error (F760) at a S/S of J

The facility submitted an acceptable Removal Plan on 05/31/23 and the IJ was removed on

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F 000	Continued From page 2 05/31/23. The SA validated the Removal Plan on 06/01/23 and determined the IJ was removed on 05/31/23, prior to exit. Therefore, the scope and severity for 42 CFR 483.21 (a) Baseline Care Plan (F655), 42 CFR 483.21 (b)(3) Professional Standards (F658), 42 CFR 483.25 Quality of Care (F684), 42 CFR 483.45(f)(2) Free of Significant Medication Error (F760), and 42 CFR 483.70 (i)(1)(ii) Medical Record Accurately Documented (F842), were lowered from a "J" to a "D", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The facility was licensed for 73 beds and the census at the time of the survey was 67.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		6/22/23

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F 578	Continued From page 3 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, and facility policy review the facility failed to ensure a resident's Advance Directives were honored as evidenced by the facility did not correctly implement the resident's decision on the correct code status for two (2) of 24 resident's reviewed (Resident # 30 and # 51) and failed to have a copy of the Advanced Directive on the medical record for two (2) of 24 residents reviewed. (Resident # 45 and #58) Findings Include: A review of the facility policy titled, "Advance Directives", reviewed 11/2022, revealed, "Policy Statement The resident has the right to formulate	F 578	1. On 5/17/23, the correct code status for Residents #30 and #51 were implemented by the facility. On 5/16/23, a copy of the Advanced Directive was placed on the medical record for Residents #45 and #58 by Social Services. 5/17/23, all current resident medical records were audited by Clinical Educator to ensure the correct code status was implemented by the facility, issues were corrected immediately. 2. This alleged deficient practice has the potential to affect all residents. Audit of charts began on 5/17/23.	

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F 578	Continued From page 4 an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy ...Determining Existence of Advance Directive ...2. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so ...If the Resident has an Advance Directive ... 2. The director of nursing services (DOS) or designee notifies the attending physician of advance directives (or changes in advance directives) so that appropriate orders can be documented in the resident medical record and plan of care ....3. The resident's wishes are communicated to the resident direct care staff and physician by placing the advance directive in a prominent, accessible location in the medical record and discussing resident wishes in care planning meetings..." Resident #30 A review of Resident #30's profile screen in the Electronic Medical Record (EMR) revealed code status: "CPR" (cardiopulmonary resuscitation). A record review of the Order Summary Report with active orders as of 5/17/23, revealed a physician's orders for Resident #30 with an order date of 7/14/20 for "CPR". A continued review of discontinued Code Status orders revealed "CPR" for all the orders since admission 8/11/2016. A review of the Advance Health Care Directive signed 6/29/2016 by Resident #30 revealed Part one (1)- Power of Attorney of Health Care: "I designate the following individual as my agent to	F 578	3. On 5/17/23, the social worker was in-serviced on the facility policy on Advanced Directives, code status, reviewing the Advanced Directives during admission. On 5/17/23, Clinical Educator in-serviced licensed nurses and certified nursing assistants on policy regarding code status including policy on advanced directives. On 5/17/23, all current resident medical records were audited by Clinical Educator to ensure the correct code status was implemented by the facility, issues were corrected immediately. Starting 05/17/23, all current resident medical records were audited to ensure a copy of the Advanced Directive was placed on the medical record for all current residents, issues identified and Responsible Party (RP) and/or Power of Attorney (POA) were notified and requested to review and sign advanced directives with date certain 6/22/23. Medical Director also made aware of all findings. 4. On 05/17/23, Administrator to review all new admissions and changes in status weekly x 4 weeks, bi-weekly x 2, monthly x 4 months to ensure the correct code status and advanced directive are accurately reflected in the resident chart and orders. Any issues will be immediately corrected. The administrator will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x 6 months starting 6/22/2023 and as needed for review/revision.	

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make decisions for me." naming his sister ... Part two (2)-Instructions for Health Care: (6) End-Of-Life Decisions: "I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below":(a) Choice: "Not to prolong Life." ...

A phone interview with Resident #30's sister who is the designated Durable Power of Attorney (POA) on 5/17/23 at 6:00 PM, confirmed she was the POA and confirmed her brother's Living Will stated he does not want CPR. She went on to say her brother has been chronically ill for a long time with Cerebral Palsy and she confirmed she has made no changes to his code status.

A review of the advance directive physician's orders with Social Service staff on 5/17/23 at 9:10 AM, confirmed the advance directives stated that Resident # 30 does not wish to prolong life, and the physician's orders have Resident # 30 as wanting CPR. A continued review of all social notes, progress notes with the social services staff revealed there was no documentation of Resident #30 or POA changing the Advance Directive and confirmed the facility only reviewed the code status after admission if there had been a change and she would have the resident or designee complete a new advance directive code status form.

A review of the advance directive and code status order with the Administrator on 5/17/23 at 9:36 AM, confirmed the Advance Directive did not match the code status order and revealed Resident #30 should be a DNR (Do Not Resuscitate).

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An interview with Licensed Practical Nurse (LPN) #1 on 5/17/23 at 11:14 AM, she revealed she looks at the code status order and the code status listed on the resident profile in the electronic record to know what the code status is.

A review of the EMR for Resident #30 under tab labeled "Code Status" revealed, a red sheet of paper reading "Full Code", no copy of the advance directive was located on the paper chart.

Record review of the "Admission Record" revealed that the facility admitted Resident #30 to the facility on 8/11/2016 with diagnoses of Cerebral Palsy.

Record review of the Minimum Data Set (MDS) Section C with an ARD of 3/29/23, revealed that Resident # 30 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated that she was moderately cognitively impaired.

Resident #51

An interview with Licensed Practical Nurse (LPN) #2 on 5/17/23 at 11:10 AM, revealed if a resident had a cardiac or respiratory arrest, she would first check the initial profile screen in the computer which would indicate if a resident was a full code status where cardiopulmonary resuscitation (CPR) would be performed or a do not resuscitate (DNR) status where CPR would not be performed. She stated if a DNR status was indicated, she would verify that with the handwritten physician order in the paper chart, which is in the sheet protector sleeve with the red code status sheet. She stated if both of those indicated a DNR status, a full code with CPR would not be done. She opened the computer to

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Resident #51's initial profile page and stated that a DNR status was indicated. She then checked the paper chart and noted the handwritten physician order with the red code status sheet for DNR status. She confirmed that if Resident #51 had a cardio-pulmonary arrest, CPR would not be performed.

An interview with the Licensed Social Worker (LSW) on 5/17/23 at 11:40 AM, revealed that when State Agency (SA) asked for a copy of Resident #51's Advance Directive, she realized that the Advance Directive did not match the physician's order, so she spoke with the Administrator to ask about correcting the form. She stated the Administrator told her she could correct by marking through the incorrect information, adding the correct information, and initialing the change. She stated the copy she gave the State Agency (SA) was the changed copy and not the original copy. She revealed that on admission, she filled out the information with the resident's representative and with the resident. The resident's representative came in prior to the resident arriving at the facility and filled out all the paperwork except for the Advance Directive and the resident's representative signed for a DNR on the code status form. When the resident arrived, the Advance Directive was discussed with the resident and the section to prolong life was marked and this was signed by the resident. She stated she did not note the discrepancy until the SA asked for a copy of the Advance Directive and at that time it was changed to what she thought was correct which was a DNR status that matched the DNR status form signed by the resident's representative and the physician's order. The LSW confirmed this information should have been verified with the

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resident to ensure the Physician's Orders, the Advance Directive, and the Code Status form all matched and indicated the resident's wishes for her code status.

An interview with the Medical Record's Licensed Practical Nurse on 5/17/23 at 12:05 PM, revealed if a resident had a cardio-pulmonary arrest, she would check the profile page of the computer and if a DNR was indicated, she would verify this with the handwritten order in the resident's paper chart. She stated if both areas indicated DNR, CPR would not be done. She stated there was a mistake in the documentation for this resident and the Code Status form and order did not match the resident's wishes according to the Advance Directive she signed. She confirmed that Resident #51 Advanced Directive paperwork revealed that the resident wished to have CPR performed and this was not indicated on her orders, Code Status form, or care plan and this could have led to Resident #51's wishes not being honored.

An interview with LPN #3 on 5/17/23 at 3:10 PM revealed if a resident has a cardio-pulmonary arrest, she will first check the computer for their code status and verify this with the paper chart code status alert sheet. She stated if the resident was listed as a DNR in the computer chart and it matched with the handwritten physician's order in the paper chart, CPR would not be done. She stated that she would not typically look on the actual paperwork for the Advance Directive, but she felt certain that the computer code status, the code status alert form in the paper chart, and the physician's handwritten order (if a DNR) in the paper chart would indicate the resident's wishes. She stated, "That would be horrible if something

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different was done from what the family and the resident wanted done."

An interview with Resident #51 on 5/17/23 at 3:20 PM revealed the staff discussed the Advance Directive with her on admission and again today and she confirmed that if something happened to her, she wanted a full code. She stated, "I would hope they would do something to help me live. I hope they won't just turn around and walk out the door and leave me there."

An interview with the Administrator on 5/17/23 at 4:00 PM, revealed she verified with the resident what her preference was for her Advance Directive and the resident wanted CPR performed as indicated on the Advance Directive signed by the resident on admission. She confirmed the facility failed to accurately document the resident's choice for her Advance Directive care related to end of life wishes.

Record review of the Admission Record revealed the resident was admitted to the facility on 12/8/22 with diagnoses that included Hypertensive Heart Disease with Heart Failure, Type 2 Diabetes Mellitus, Heart Failure, and Stage 3 chronic kidney disease. The face sheet revealed an Advance Directive with code status of DNR.

Record review of the Advance Health-Care Directive dated 12/8/22 and signed by Resident #51 revealed the instructions for health care which indicated the resident's wishes for "Choice to prolong life. I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards." This copy indicated this choice to prolong life was changed

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to choose not to prolong life. This was the copy that was changed when the SA was in the facility requesting the Advance Directive for this resident and the LSW changed it to match what the family had signed on admission.

Record review of Code Status form, undated, signed by the Resident Representative revealed choice for "Do Not Attempt Resuscitation".

Record review of electronic Physician's Orders revealed an order for DNR dated 12/8/22.

Record review of red Code Status sheet in the paper chart revealed Resident #51's code status of DNR.

Record review of handwritten and signed Physician's Order dated 12/8/22 revealed DNR.

Record review of the computer profile page for Resident #51 revealed the code status of DNR.

Record review of a statement from Resident #51 with the Administrator as witness dated 5/17/23, revealed, "I want my code status to be CPR. I fully understand what will occur and wish to be a full code."

Record review of admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/15/22 revealed resident with a Brief Interview for Mental Status (BIMS) of 11 which indicated moderate cognitive impairment.

Record review of quarterly MDS with ARD of 3/8/23 revealed a BIMS of 8 which indicated moderate cognitive impairment.

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Resident #45

An interview on 5/16/23 at 4:00 PM, with Social Services revealed Resident #45 did not have a signed "Code Status Form" because the staff had been trying to catch the resident's representative to sign the Code status paperwork.

An interview on 5/17/23 at 9:20 AM, with Social Services confirmed that Resident #45 did not have an Advanced Directive for code status signed but should have and revealed she should have documented that she was not able to get the resident representative to sign the Advance Directive for end of life wishes for the resident.

An interview on 5/17/23 at 9:45 AM, with the Administrator confirmed it is the facility staff's responsibility to make sure follow-up is completed regarding the resident's wishes for their care.

Record review revealed Resident #45 did not have a copy of her Advance Directive on her record, but the record review revealed that the medical record had a red piece of paper in the record that indicated the resident's code status is Do Not Resuscitate (DNR) but it was not signed by the responsible party.

Record review of Resident #45's Admission Record revealed the resident was admitted to the facility on 10/28/20 with medical diagnoses that included Dementia in Other Diseases Classified Elsewhere, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety.

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Record review of Resident #45's MDS with an ARD of 3/15/23 revealed under Section C a BIMS score of 04, which indicates the resident is severely cognitively impaired.

Resident #58

An interview on 5/16/23 at 4:00 PM, with Social Services revealed Resident #58 did not have an Advanced Directive code status form signed until today but that the resident should have had one on his medical record.

An interview on 5/17/23 at 9:20 AM, with Social Services revealed that the reason Resident #58 did not have an Advanced Directive code status form signed prior to yesterday 5/16/23 was because he refused to sign it. She revealed there is no documentation that the resident refused to sign the Advance Directive and she confirmed that she is responsible for following up and getting the Advance Directives signed on admission and the purpose of the Advance Directive is to make sure the resident's wishes for care and code status are known and implemented.

An interview on 5/17/23 at 4:30 PM, with Resident #58 revealed the staff came to him yesterday and asked him to sign a paper regarding if he wanted Cardiopulmonary Resuscitation (CPR) or not. He revealed the staff had never mentioned him signing a paperwork regarding his choice of CPR before yesterday.

An interview on 5/18/23 at 9:08 AM, with the Director of Nurses (DON) revealed that the Advanced Directives let the staff know the resident's end of life care wishes and the

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F 578	Continued From page 13 importance of updating the code status is to make sure the staff knows the correct code status based on the resident's wishes. Record review revealed Resident#58 did not have a signed Advance Directive on his record and social services had not revised the resident's code status on the record after code status changes had occurred. Record review of Resident #58's Admission Record revealed the resident was admitted to the facility on 4/22/22 with medical diagnoses that included Chronic Kidney Disease Stage 3 Unspecified. Record review of Resident #58's MDS with an ARD of 04/13/23, revealed under Section C a BIMS score of 10, which indicated the resident is moderately cognitively impaired.	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken),	F 583		6/22/23

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F 583	Continued From page 14 written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and facility policy review the facility failed to respect the dignity of a resident as evidenced by not completely covering the resident's naked body while transporting the resident to the shower for one (1) of 67 resident's observed, Resident #33 Findings Include: Record review of the facility policy titled, "Dignity and Respect" with no revision date revealed under "Procedure...#4 Privacy of a resident's body shall be maintained during toileting, bathing, and other activities of personal hygiene, except when staff assistance is needed for the resident's safety." An observation on 05/17/23 at 3:36 PM, revealed	F 583	1. On 5/17/23, Resident #33 was covered on his return trip from the shower by CNA#2. On 5/17/23, CNA #2 was in-serviced by DON on ensuring privacy of a resident□s body shall be maintained during toileting, bathing, and other activities of personal hygiene, except when staff assistance is needed for the resident□s safety. 2. This alleged deficient practice has the potential to affect all residents. 3. On 05/17/23, in-service began with nursing staff on resident□s rights including ensuring privacy of a resident□s body shall be maintained during toileting, bathing, and other activities of personal hygiene, except when staff assistance is	

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F 583	Continued From page 15 Certified Nurse Assistant (CNA) #2 pushing Resident #33 down the hall in a shower chair covered in the front with a white facility blanket and no covering over his bare buttocks, which were visible from the back side of the chair as he was being pushed down the hallway. An interview on 5/17/23 at 3:38 PM, with CNA #2 revealed she did not realize that Resident #33 was not covered in the back but knows they should be because that is an invasion of the resident's privacy, and she has been taught by the staff that she should make sure they are completely covered. An interview on 5/17/23 at 3:41 PM, with Licensed Practical Nurse (LPN) #3 confirmed that a resident should be completely covered when they are taken to the shower. She stated, "Please tell me you did not see that on this hall, because we just talked about that with the staff." When the State Agent (SA) confirmed that she had seen a resident's bare buttocks in a shower chair going down the hall, she confirmed that was a dignity issue and should not have happened. An interview on 5/17/23 at 4:00 PM, with the Administrator confirmed that the resident's bare buttocks being exposed while being taken to the shower in a shower chair is not respecting the resident's dignity. An interview on 5/18/23 at 8:40 AM, with Resident #33 revealed he was not aware until a couple of days ago that he was not completely covered when they took him to the shower. Record review revealed the facility had an in-service titled "Dignity and Respect" on 3/30/23	F 583	needed for the resident□s safety. Room Rounds initiated on 06/16/23. Medical Director also made aware of all findings. 4. Beginning on 5/17/23, DON will observe during walking rounds 5 days per week x 4 weeks, then monthly x 2 months to ensure residents are covered appropriately during care. Any issues will be immediately corrected. Director of Nursing will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months starting 06/22/2023 and as needed for review/revision.	

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F 583	Continued From page 16 and CNA #2 had attended. Record review of Resident #33's Admission Record revealed the resident was admitted to the facility on 10/31/21 with medical diagnoses that included Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris. Record review of Resident #33's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/15/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident is cognitively intact.	F 583		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and	F 644	1. On 06/14/23, a PASARR Level 2 was	6/22/23

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F 644	Continued From page 17 review of the statement regarding the facility's policy, the facility failed to submit a change in status for a Level II PASARR (Pre Admission Screening and Resident Review) referral for one (1) of four (4) residents reviewed. Resident # 46. Findings Include: Record review of facility policy titled, "Admission Criteria", dated 4/25/23, revealed, "Our facility admits only residents who's medical and nursing care needs can be met." The policy also revealed, "All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. Record review of the signed Administrator's note on facility letterhead dated 5/17/23 revealed, "(Proper name of facility) follows state regulations regarding Pre-Admission Screening and Resident Review Level II submissions and resubmissions. The facility does not have a separate policy". An interview with the Licensed Social Worker (LSW) on 5/17/23 at 2:00 PM, revealed Resident #46 was admitted to the facility on 6/18/19. She stated she had a Preadmission Screen dated 6/19/19 and at that time it was determined that she was appropriate for nursing facility placement. The LSW confirmed that Resident #46 was diagnosed with Paranoid Personality Disorder and Delusional Disorder in November 2021, a significant status change form should have been submitted for a Level II, but it was not. She stated she was responsible for submitting these and this one "Fell through the cracks" and she failed to submit it. She stated the purpose of	F 644	submitted for Resident #46 by Social Worker. On 6/14/23 the social services initiated a PASARR audit on all current residents to identify any needs for level 2 PASARR. 2. This alleged deficient practice has the potential to affect all residents. PASARR audit initiated on 06/16/23. 3. On 6/13/23 In-service with Social Services Director and MDS was performed by Administrator on PASARR policy, including, ensuring when a resident has a newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment is submitted. Any identification of needs for a level 2 PASARR will be completed and submitted by 6/22/2023. 4. The administrator will monitor all new admissions as well as for any new diagnosis of current residents that would trigger the need for a new PASARR Level 2 to be submitted weekly X 4 weeks and monthly x 2 thereafter to ensure compliance. Any issues will be immediately corrected. The Administrator will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months starting 06/22/2023 and as needed for review/revision.	

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F 644	Continued From page 18	F 644		

submitting these changes accurately was to ensure the resident was appropriate for nursing home placement and for the resident to receive recommended services.

An interview with the Administrator on 5/17/23 at 4:00 PM, revealed the significant status change for the determination of a Level II was required but it was not done. She stated each time a resident had a new mental illness diagnosis, a status change should be submitted. She confirmed the facility failed to submit the status change for a Level II, and therefore, the resident was not reassessed for being appropriate for nursing home placement or for interventions recommended for the resident's mental health.

Record review of the Preadmission Screening revealed this was done on 6/19/19 and revealed active medical conditions of Anxiety disorder and Depression.

Record review of the Notice of Negative Level 1 Screen Outcome dated 6/8/2020 revealed "...nursing facility placement is appropriate for you".

Record review of the Admission Record revealed the resident was admitted to the facility on 6/18/19. Diagnoses included Paranoid Personality Disorder (diagnosed on 11/16/21), Recurrent Depressive Disorders, Anxiety Disorder, and Delusional Disorders (diagnosed on 11/18/21).

Record review of Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 2/8/23, revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated the resident

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F 644	Continued From page 19 was cognitively intact.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		6/22/23

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F 656	Continued From page 20 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and policy review the facility failed to develop a care plan for cardio-pulmonary resuscitation code status (Resident #30 and Resident #51) and implement a care plan by failing to change a humidifier bottle and tubing, and ensuring a resident received humidified oxygen (Resident # 17) for three (3) of 24 resident reviewed. Findings include: A review of the facility policy titled, "Care Plan-Comprehensive," revealed Policy Statement: "It is the policy of the facility to develop comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychosocial needs" ... Findings Include: Resident #30 A review of Resident #30's care plan titled, "I am A CPR status" with a review date of 3/27/23 revealed, Goals "I will receive all measures of comfort care, and life sustaining treatment	F 656	1. On 05/17/23, Clinical Educator Updated the care plan for Resident #30 and Resident #51 to include a plan for cardio-pulmonary resuscitation code status. On 5/17/23, Clinical Educator reviewed all current resident care plans to ensure they contained the appropriate cardio-pulmonary resuscitation code status. On 5/16/23, the humidifier bottle and oxygen tubing was replaced by Director of Nursing (DON(For Resident #17. On 5/16/23, the DON reviewed all other residents on oxygen to ensure their humidifier bottle was not empty and was dated along with the oxygen tubing being appropriately dated. 2. This alleged deficient practice has the potential to affect all residents. Audit of code status was conducted on 5/17/23 to ensure code status and care plans were consistent, any issues corrected immediately. Audit by DON on 5/16/23 to ensure oxygen tubing, humidifier bottles, and nebulizer tubing was dated and appropriately working.	

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F 656	Continued From page 21 through each review during nursing home stay." A review of the Advance Health Care Directive signed 6/29/2016 by Resident #30 revealed Part one (1)- Power of Attorney of Health Care: I designate the following individual as my agent to make decisions for me naming (Proper Name) the sister. Part two (2)-Instructions for Health Care: (6) End-Of-Life Decisions: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (a) Choice Not to prolong Life. A review of the Advance Directive with Social Services staff on 5/17/23 at 9:10 AM confirmed the Advance Directives stated that Resident #30 does not wish to prolong life, and confirmed the facility failed to develop the appropriate Code Status Care plan revealing Resident #30's care plan should read Do Not Resuscitate (DNR). A review of the Advance Directive and care plan for Resident #30 with the Administrator on 5/17/23 at 9:36 AM confirmed the Advance Directive did not match the care plan and revealed Resident #30 should be care planned as a DNR. An interview with LPN #1 on 5/17/23 at 11:14 AM revealed the purpose of the comprehensive care plan is to direct staff on the type of individualized care a resident need. An interview with the Director of Nursing (DON) on 5/18/23 at 9:56 AM, revealed the physician's orders, and the care plan should match and confirmed the care plan directs the type of care the resident may need.	F 656	3. On 5/22/23, The RNC in-serviced the DON and MDS on ensuring all current residents have a care plan with the appropriate cardio-pulmonary resuscitation code status. On 5/17/23, the Clinical Educator in-serviced licensed nurses on policy for ensuring humidified oxygen and tubing are changed and dated appropriately. 4. Starting 5/16/23 DON will monitor weekly x 4 weekly, bi-weekly x 2, then monthly x 1 to ensure humidified oxygen and tubing are changed and dated appropriately and Advance Directive Care Plans. Any issue will be corrected immediately. Director of Nursing will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months starting 06/22/2023 and as needed for review/revision.	

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Record review of the Admission Record revealed that the facility admitted Resident #30 to the facility on 8/11/2016 with diagnoses of Cerebral Palsy.

Record review of the MDS Section C with an ARD of 3/29/23, revealed that Resident #30 had a BIMS score of 10 which indicated that the resident was moderately cognitively impaired.

Resident #51

Record review of Resident #51's care plan revealed a care plan initiated 12/8/22 for DNR status.

Record review of the Advance Health-Care Directive dated 12/8/22 and signed by Resident #51 revealed the instructions for health care which indicated the resident's wishes for "choice to prolong life. I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards". This copy indicated this choice to prolong life was changed to choice not to prolong life. This was the copy that was changed when State Agency was in the facility requesting the Advance Directive for this resident.

During an interview with the Medical Record's Licensed Practical Nurse on 5/17/23 at 12:05 PM, she stated there was a mistake in the documentation for this resident and the Code Status form and order did not match the resident's wishes according to the Advance Directive she signed. She confirmed that Resident #51 chose to have CPR performed and

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this was not indicated on her orders, Code Status form, or care plan and this could have led to her wishes not being honored.

An interview with Resident #51 on 5/17/23 at 3:20 PM, revealed the staff discussed the Advance Directive with her on admission and today. She stated if something happens to her, she wants a full code. She stated, "I would hope they would do something to help me live. I hope they wouldn't just turn around and walk out the door and leave me there."

An interview with the Administrator on 5/17/23 at 4:00 PM, revealed she verified with the resident what her preference was for her Advance Directive and the resident wanted CPR performed as indicated on the Advance Directive signed by the resident on admission. She confirmed the care plan failed to indicate the resident's preference for CPR since it stated resident had a DNR status. She confirmed the importance of the care plan reflecting the resident's preferences for care and the facility failed to ensure an accurate care plan for this resident.

Record review of the Admission Record revealed Resident #51was admitted to the facility on 12/8/22 with diagnoses that included Hypertensive Heart Disease with Heart Failure, Type 2 Diabetes Mellitus, Heart Failure, and Stage 3 Chronic Kidney Disease.

Record review of admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/15/22 revealed resident with a Brief Interview for Mental Status (BIMS) of 11 which indicated moderate cognitive impairment. Record review of the most recent quarterly MDS with

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ARD of 3/8/23 revealed a BIMS of 8 which indicated moderate cognitive impairment.

Resident #17

An observation of Resident #17 on 5/15/23 at 11:00 AM, revealed the oxygen (O2) humidifier bottle dated 4/18/23 with no date on tubing connected to the humidifier.

An observation of Resident #17 on 5/16/23 at 2:08 PM, revealed an empty O2 Humidifier bottle with date of 4/18/23 and no date to tubing connected to the humidifier bottle.

An interview with the Director of Nursing (DON) on 5/16/23 2:12 at PM confirmed "Absolutely" the oxygen humidifier bottle and tubing for Resident #17 should have been changed every week and more if needed and confirmed with the date 4/18/23 on the humidifier bottle that there was no way it had been changed. The DON went on to say possible complications from failing to change the humidifier bottle and tubing is possible respiratory infections. The DON reviewed the oxygen care plan and confirmed the staff was not following the care plan.

Record review of Resident # 17's care plan titled, "I use oxygen therapy r/t (related to) shortness of breath," with a review date of 4/18/23, revealed Interventions: Change Humidifier bottle and tubing weekly and prn (as needed) ...Oxygen settings: O2 via nasal prongs at 2 liters continuous. Humidified ..."

An interview with LPN #1 on 5/17/23 at 11:14 AM, she revealed the purpose of the comprehensive care plan is to direct staff on the type of

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individualized care a resident's needs and confirmed staff were not following Resident #17's oxygen care plan.

Record review of the Admission Record revealed that the facility admitted Resident #17 to the facility on 3/27/2013 with diagnoses of Chronic Obstructive pulmonary disease and sleep disorder.

Resident #30

Record review of Resident #30's Care Plan Detail dated 3/27/2023, revealed "I am a CPR status ... Goals "I will receive all measures of comfort care, and life sustaining treatment through each review during nursing home stay ..."

A review of the Advance Health Care Directive signed 6/29/2016 by Resident #30 revealed Part one (1)- Power of Attorney of Health Care: I designate the following individual as my agent to make decisions for me naming (Proper Name) the sister. Part two (2)-Instructions for Health Care: (6) End-Of-Life Decisions: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (a) Choice Not to prolong Life.

A phone interview with Resident #30's sister who is the designated Durable Power of Attorney (POA) on 5/17/23 at 6:00 PM, she confirmed she was the POA and confirmed her brother's Living Will states he does not want CPR. She went on to say her brother has been chronically ill for a long time with Cerebral Palsy and she confirmed she has made no changes to his code status.

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Record review of the Advance Directive with Social Services staff on 5/17/23 at 9:10 AM, confirmed the Advance Directives stated that Resident #30 does not wish to prolong life, and confirmed the facility failed to develop the appropriate Code Status Care plan revealing Resident #30's care plan should read Do Not Resuscitate (DNR).

Record review of the Advance Directive and care plan for Resident #30 with the Administrator on 5/17/23 at 9:36 AM, confirmed the Advance Directive did not match the care plan and revealed Resident #30 should be care planned as a DNR. The Administrator went on to reveal concerns of failing to identify and follow Resident #30's Advance Directives if the facility was not following his wishes and staff would have performed CPR.

An interview with LPN #1 on 5/17/23 at 11:14 AM, revealed the purpose of the comprehensive care plan is to direct staff on the type of individualized care a resident need.

An interview with the DON on 5/18/23 at 9:56 AM, revealed the physician's orders, and the care plan should match and confirmed the care plan directs the type of care the resident may need.

Record review of the Admission Record revealed that the facility admitted Resident #30 to the facility on 8/11/2016 with diagnoses of Cerebral Palsy.

Record review of the MDS Section C with an ARD of 3/29/23, revealed that Resident #30 had a BIMS score of 10 which indicated that the resident was moderately cognitively impaired.

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F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review the facility failed to change an oxygen (O2) humidifier bottle and tubing weekly as ordered for one (1) of four (4) residents reviewed for oxygen therapy. Resident #17 Findings include: Record review of the facility policy titled, "Oxygen Education," with a date of September 12, 2013, revealed ... "Important facts: All tubing is changed once a week and clearly marked with the days date..." Record review of the facility policy titled, "Oxygen Administration," with a Procedure revised date of August 25, 2014, revealed ... "Steps in the Procedure ... 9 ... Be sure there is water in the humidifying jar (if used) and that the water level is high enough that the water bubbles as oxygen flows through ...11. Periodically re-check the water level in the humidifying jar ..." An observation of Resident #17 on 5/15/23 at	F 695	1. On 5/16/23, the humidifier bottle and oxygen tubing was replaced by Director of Nursing (DON) For Resident #17. The alleged deficient practice has the potential to affect all residents on oxygen. DON completed audit on 05/16/23 of all residents requiring oxygen therapy. 2. Residents who require respiratory equipment have the potential to be affected by the alleged deficient practice. 3. On 5/16/23, the DON reviewed all other residents on oxygen to ensure their humidifier bottle was not empty and was dated along with the oxygen tubing being appropriately dated. On 5/17/2023, the clinical educator In-service began with nurses on policy for ensuring humidified oxygen and tubing are changed and dated appropriately. 4. Starting 05/16/2023 DON will monitor weekly x 4, then monthly x 2 to ensure humidified oxygen and tubing are changed and dated appropriately. Any	6/22/23

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F 695	Continued From page 28 11:00 AM, revealed the O2 humidifier bottle dated 4/18/23 with no date on tubing connected to the humidifier. An observation of Resident #17 on 5/16/23 at 2:08 PM, revealed an empty O2 humidifier bottle with date of 4/18/23 and no date to tubing connected to the humidifier bottle. An interview with Licensed Practical Nurse (LPN) #1 on 5/16/23 2:10 at PM, confirmed the oxygen humidifier bottle was empty with a date of 4/18/23 and confirmed there was no date on the oxygen tubing for Resident #17. LPN #1 revealed the humidifier bottle and tubing should be changed weekly and dated to prevent possible infections and to ensure moisturization of the oxygen to prevent drying and nasal discomfort and sores in the nose. An interview with the Director of Nursing (DON) on 5/16/23 2:12 at PM, she confirmed "Absolutely" the oxygen Humidifier bottle and tubing for Resident #17 should have been changed every week and more if needed. She revealed with the date 4/18/23 on the humidifier bottle there was no way it had been changed. The DON went on to say possible complications from failing to change the humidifier bottle and tubing is possible respiratory infections. Record review of the "Order Summary Report" with active orders as of 5/17/23 revealed an order dated 10/20/2019 "Change humidifier bottle and O2 tubing weekly and prn (as needed).. every night shift every Fri (Friday)." Record review of the Treatment Administration Record (TAR) for April 2023 and May 2023 for	F 695	issues will be immediately corrected. Director of Nursing will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly starting 6/22/23 x 3 months and as needed for review/revision.	

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F 695	Continued From page 29 Resident #17 revealed "Change humidifier bottle and O2 tubing weekly and prn (as needed).. every night shift every Fri (Friday)." The TAR was initialed and signed off as the humidifier bottles and O2 tubing as being changed every Friday night. Record review of the Admission Record revealed that the facility admitted Resident #17 to the facility on 3/27/2013 with diagnoses of Chronic Obstructive pulmonary disease and sleep disorder. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/26/23 revealed in Section C Resident #17 had a Brief Interview for Mental Status (BIMS) score of 99 indicating Resident #17 was unable to complete the interview.	F 695		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-	F 801		6/22/23

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(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national

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F 801	Continued From page 31 certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to ensure that the Dietary Manager (DM) had completed required training for dietary management after one year of full-time employment for four (4) or four (4) survey days observed. Findings include: Record review of the facility policy "Dietary Manager" with a revision date of June 1, 2000 revealed "Policy Statement: It is the policy of this facility that the day-to-day functions of the dietary department be under the supervision of a qualified dietary manager..."	F 801	1. On 5/18/23, Dietary Manager registered and paid for a course of study in Nutrition and Foodservice Professional Training through the University of Florida. The alleged deficient practice has the potential to affect all residents. On 5/17/23, Regional Director of Operations (RDO) in-serviced Dietary Manager regarding certification and regulatory compliance. 2. All residents have the possibility of being affected by the alleged deficient practice.	

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F 801	Continued From page 32 An interview on 5/17/23 at 2:20 PM, with the DM and the Registered Dietician (RD) revealed that the Dietary Manager had been in that position since 5/2022 and had not completed her DM certification course. The DM revealed that she was hired by another Administrator and when the new Administrator started, they discussed the need for her to get her certification, but nothing was ever done. The RD revealed she comes to the facility two times per month. The DM revealed she had one day of training at a sister facility with the Dietary Manager before she started working at this facility full time. The DM revealed that she had no prior experience in a nursing facility. An interview on 5/17/23 at 2:40 PM, with the Administrator revealed she had not been made aware when she started in August of 2022 that the Dietary Manager had not completed her DM certification course. She is not sure when or how she finally discovered that. She revealed that she sent the information to their corporate office around April of this year to get approval for funding to pay for the DM to take the certification course and confirmed that the DM will start her course sometime this month. An interview on 5/18/23 at 10:30 AM, with the Administrator confirmed that 12 months was too long to wait to get the DM signed up for her certification course. She revealed that she and the DM had discussed the certification course and that the DM had agreed to pay for it with her own personal credit card and get reimbursement back from the company later. She stated she failed to follow up with her and that was her responsibility.	F 801	3. On 5/17/23, the Regional Director of Operations and clinical educator in-serviced the Administrator and Dietary Manager on the requirement to meet the qualifications as listed in 483.60(a)(2). The dietary manager registered and paid for course of study in Nutrition and Foodservice Professional Training through the University of Florida. The Dietary Manager started courses on 6/12/23. 4. Starting 5/18/23, the Administrator will meet with Dietary Manager weekly to review progress toward completion of the Nutrition and Foodservice Professional Training Course until the course is completed no later than October 1, 2023. The course is preparation for the national Certifying Board for Dietary Managers Credentialing Exam. Any issues will be immediately addressed. The Administrator will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x 4 months starting 6/22/2023 and as needed for review/revision.	

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F 801	Continued From page 33 Record review revealed that the DM's hire date was 5/9/22.	F 801		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review the facility failed to store food in a manner that meets professional standards as evidenced by unlabeled and undated food in the refrigerator, dry food stored uncovered and resident nourishment refrigerators with resident snacks that were unlabeled or undated for two (2) of four (4) survey days. Findings include: Record review of the facility policy titled, "Food	F 812	1. On 5/15/23, Dietary Staff #3 was in-serviced on labeling and dating cold leftovers by Dietary Manager. On 5/15/23, the diced tomatoes were discarded by Dietary Manager. On 5/16/23, the bag of powdered sugar was discarded by Dietary Manager. On 5/16/23, the Dietary Manager was in-serviced on ensuring food is to be stored in an airtight container by Clinical Educator. On 5/17/23, all the food in the nutrition refrigerators was discarded by Dietary Manager.	6/22/23

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F 812	Continued From page 34 Storage" with a revision date of 8/18/11 revealed ... "Procedure ...2. All foods or food items not requiring refrigeration shall be stored above the floor, on shelves, racks, dollies, or other surfaces which facilitate thorough cleaning, in a ventilated room, not subject to sewage or wastewater backfill or contamination by condensation leakage, rodents, or vermin. All package food, canned foods or food items stored shall be kept clean and dry at all times ... 9. All leftover foods are to be stored in covered containers, dated, & labeled. Cooked leftovers are to be used reheating to 180 degrees Fahrenheit. If not used by the third (3rd) day, they are to be discarded. Cooked foods are to be reheated on (1) time only. Cold leftovers not used by the third (3rd) day are to be discarded..." Record review of a typed statement on facility letterhead, dated 5/18/2023, and signed by the Administrator revealed "(Proper Name of Facility) follows state and federal regulations regarding nourishment refrigerators and the dating of food for the resident. The facility does not have a separate policy." An observation and interview on 5/15/23 at 10:15 AM, during the initial tour of the kitchen revealed a plastic container of diced tomatoes in the refrigerator with no date or label on the container. Dietary Staff #3 confirmed that the unlabeled container was diced tomatoes, did not have a label or date, and should have. Dietary Staff #3 put a label on this container with a date for 5/18/23. When the State Agent (SA) asked the staff member if she put the tomatoes in that container in the refrigerator she stated, "No, I've not even used any tomatoes. I have no idea when they were put in the refrigerator." When the SA	F 812	2. All residents have the potential to be affected by the alleged deficient practice. 3. Dietary Manager audited kitchen for proper storage of food and expiration date and snacks with proper names and expiration dates on 5/16/23. On 5/16/23, the Clinical Educator in-serviced Dietary Manager on ensuring facility stores food in a manner that meets professional standards by labeling and dating food in the refrigerator and dry food and ensuring food is stored covered. On 5/15/23, the Dietary Manager in-serviced dietary staff/ on ensuring facility stores food in a manner that meets professional standards by labeling and dating food in the refrigerator and dry food, also on ensuring food is stored covered. On 6/13/23, clinical educator and Dietary Manager began in-servicing all nursing staff on only placing resident food that is labeled and dated into the nutrition refrigerators, including the time when each refrigerator is to be cleaned. 4. On 05/17/23, Assistant Director of Nursing (ADON) will monitor each refrigerator 5 times a week X 3 weeks and then monthly x 2 months during walking rounds to ensure food and snacks are labeled and stored properly. On 5/17/23, Dietary Manager will audit storage and labeling of foods 5 times a week x 3 weeks and then weekly x 8 weeks. Non-labeled food will be replaced and improper storage will corrected immediately. Director of Nursing will	

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F 812	Continued From page 35 asked what she was putting on the label, she stated, "They are good for 3 days" then confirmed she did not know when they were put in the refrigerator. She revealed that since she did not know when they were put in the refrigerator then she could not verify they were still good and if they were not and were served to the residents then that could make them sick. An observation on 5/16/23 at 10:00 AM, with the Dietary Manager (DM) revealed an opened 5-pound bag of powdered sugar that was more than half full being stored in an open cardboard box with one piece of lose plastic wrap laid over the top of the box. The DM revealed that the opened bag of powdered sugar stored in this manner could attract pests and rodents to the sugar. The DM confirmed the powdered sugar was not stored properly and should be stored in an airtight container. An interview on 5/17/23 at 2:20 PM, with the Dietary Manager (DM) confirmed that each meal cart included snacks for the residents and if they are not used and need refrigerated then they are put in the nutrition refrigerator near each nurse's station. She revealed as far as she knew the nursing staff were responsible for cleaning those refrigerators and throwing out expired foods and confirmed that the dietary department does not keep those refrigerators clean. An observation and interview with Certified Nursing Assistant (CNA) #1 on 5/17/23 at 2:50 PM, of the nutrition refrigerator for the 200 nurses station revealed there were nutrition shakes, salsa dip, an opened root beer can, a plastic bowl with food inside. None of the food items were labeled or dated. CNA #1 confirmed this was the	F 812	report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months starting 6/22/23 and as needed for review/revision	

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F 812	Continued From page 36	F 812		

refrigerator that held resident snacks. She confirmed that the refrigerator had both resident and staff food inside with no labels or dates. She stated that she is not sure, but thinks it is supposed to be only resident's food kept in this refrigerator and that the nightshift CNAs are responsible for cleaning the refrigerators.

An observation and interview on 5/17/23 at 3:00 PM, of the nutrition refrigerator on the 100-hall revealed three cold cut sandwiches with meat and cheese wrapped in plastic wrap with no date or label. One of the sandwiches was half eaten, a plastic bowl with food, a pitcher of water, a gallon jug of tea, and nutrition shakes with no labels, dates, or names. An interview with Licensed Practical Nurse (LPN) #3 confirmed that the nutrition refrigerators are supposed to only hold resident food and snacks. LPN #3 reported that the night shift CNAs are responsible for cleaning and checking the temperature. She stated that all staff are responsible for cleaning and labeling and removing any out-of-date food. She confirmed that there was both resident and staff food in the refrigerator with no labels or dates. She confirmed that if the cold cut sandwiches had been served to a resident with no date, then it could make them sick.

An interview on 5/17/23 at 3:10 PM, with the Administrator confirmed that resident food in the nutrition refrigerators on the halls should be labeled and dated and that if out of date food was served to a resident, then it could make them sick.

An interview on 5/17/23 at 3:30 PM, with the Director of Nurses (DON) confirmed that only resident food is supposed to be kept in the snack

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255127	A. BUILDING _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 37 refrigerators near each nurse's station. The DON stated that food should be dated and that night shift CNAs are supposed to clean the refrigerator and check temperatures. If out-of-date food were served to a resident then it could make them sick.	F 812		