STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355053	A. BUILDING _____ B. WING _____	C 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNIFE RIVER CARE CENTER	**118 22ND ST NE BEULAH, ND 58523**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 12/18/23 and concluded 12/21/23.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		1/25/24

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

Electronically Signed | 01/19/2024

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, review of resident council meeting minutes, and resident interviews, the facility failed to respect each resident's dignity and individuality and care for residents in a manner and an environment that promotes, maintains, or enhances the quality of life for 2 of 21 sampled residents (Residents C and E) and 2 supplemental residents (Residents A and D). Failure to provide cares in a respectful manner and respect personal property does not preserve the residents' personal dignity or enhance their quality of life. Findings include: Review of the policy titled, "Promoting/Maintaining Resident Dignity" occurred on 12/21/23. This policy, dated December 2022, stated, ". . . All staff members are involved in providing care to residents to promote and maintain dignity and respect resident rights. . . . Respect the resident's living space and personal possessions. . . ." Review of Resident Council meeting minutes occurred on 12/20/23. August 2023 Resident Council meeting minutes stated, "It was mentioned by [Resident name] that CNAs should	F 550	1. What corrective action will be accomplished for those residents affected by the deficient practice: a. Correction to the deficiency will include education to all staff on KRCC's cell phone policy, code of conduct, promoting/maintaining resident dignity policy, call light policy, and resident rights policy. Resident dignity and cell phone use will be added as standing topics to the resident council agenda. Manager rounding audits will have additional questions added regarding dignity and respect, and cell phone use. For continuing education on these topics, resident rights will be added to education for all staff yearly, and a minimum of bi-monthly (every other month) departmental meetings will be held with an agenda submitted to the administrator for approval prior to meeting. Departmental meetings will include different focus areas around resident rights, cell phones, code of conduct, promoting/maintaining resident dignity, and call lights, each will not have all of them but will have a focus on one or more 2. How will you identify other residents	

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F 550	Continued From page 2 be limited to the amount of time they spend on their cell phones." September 2023 Resident Council meeting minutes stated, "Cell phones-[Resident name] feels they should only be used on break. [Resident name] said she doesn't know if staff are talking to them or their phones." During confidential interviews, residents reported the following: * 12/18/23 at 12:13 p.m., Resident E stated, "Staff are on their cell phones when in my room." * 12/18/23 at 12:40 p.m., in regards to call lights, Resident A stated "my call light will be on and they [staff] just walk by." Resident A also stated, "I feel like a second class citizen." * 12/18/23 at 1:17 p.m., Resident C stated, "Last week when I had my bath the gal [CNA] grabbed onto both sides of my skin, you know my love handles to hold me up because I couldn't do it myself. The staff make fun of me and laugh at me." * 12/20/23 at 8:01 a.m., Resident C stated, "I'm third class to them, they act like they are deaf when I talk to them. They holler at me like I'm a dog, I feel so mistreated. They threw a card I had got from my niece's family with a picture and when I asked her why she threw it she said it was old. That's my stuff not theirs." * 12/20/23 at 11:18 a.m. identified Resident D felt cell phone use in resident rooms and halls is still an issue. During an interview on 12/21/21 at 1:20 p.m. an administrative staff member (#13) stated he	F 550	having the potential to be affected by the same deficient practice? a. All residents in the facility have the potential to be affected. 3. How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed, if a new system is necessary or if a system does not exist and must be developed. a. Correction to the deficiency will include education to all staff on KRCC's cell phone policy, code of conduct, promoting/maintaining resident dignity policy, call light policy, and resident rights policy. Resident dignity and cell phone use will be added as standing topics to the resident council agenda. Manager rounding audits will have additional questions added regarding dignity and respect, and cell phone use. For continuing education on these topics, resident rights will be added to Relias for all staff yearly, and a minimum of bi-monthly departmental meetings will be held with an agenda submitted to the administrator prior to meeting. Departmental meetings will include different focus areas around resident rights, cell phones, code of conduct, promoting/maintaining resident dignity, and call lights, each will not have all of them but will have a focus on one or more	

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F 550	Continued From page 3 expects staff to treat all residents with respect and dignity and are not allowed to have cell phones in resident care areas.	F 550	4. How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? a. Social services and the administrator will continue to monitor the resident satisfaction surveys through Pinnacle Quality Insights and implement interventions as needed. Pinnacle Quality Insight surveys will be monitored monthly. The activities director will review the manager rounding audits, and assure action is taken on area identified as opportunities. These audits will be reviewed monthly. Pinnacle sends surveys to 7 residents/month, 19 residents are visited with for manager rounding audits/month. 5. When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (12/22/2023). Or a maximum of 35 days after the date of the exit conference, so this would be 1/25/2024 before the end of day. a. 1/25/2024	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and	F 558		1/25/24

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F 558	Continued From page 4 preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation and review of the facility policy, the facility failed to provide reasonable accommodation of needs regarding call lights for 3 supplemental residents (Residents #26, #45 and #50). Failure to ensure the resident can reach/access the call light may result in unmet needs and the inability to call for help. Findings include: Review of the facility policy titled "Call Lights: Accessibility and Timely Response" occurred on 12/21/23. This policy, revised 01/20/23, stated, ". . .Staff will ensure the call light is within reach of the resident and secured. . ." - Observation on 12/18/23 at 12:39 p.m. showed Resident #45 in the recliner, and the call light located on the floor under the end of the bed out of reach of the resident. - Observation on 12/20/23 at 8:45 a.m. showed Resident #26 in the recliner, and the call light attached to the bed. Observations on all days of the survey showed the call light not within the resident's reach. - Observation on 12/20/23 at 3:28 p.m. showed Resident #50 in a wheelchair, and the call light located across the bed next to the wall out of reach of the resident. During an interview on 12/21/23 at 12:55 p.m., an	F 558	1. What corrective action will be accomplished for those residents affected by the deficient practice: a. Education provided to nursing staff for residents # 45, #26, and #50 need to have their call light be placed within reach. 2. How will you identify other residents having the potential to be affected by the same deficient practice? a. The facility has determined that all residents have the potential to be affected. 3. How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed if a new system is necessary or if a system does not exist and must be developed. a. Education provided to all staff on importance of call light being within reach. Education provided on policy “call lights: accessibility and timely response” to all staff. 4. How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the	

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F 558	Continued From page 5 administrative staff member (#3) stated she expected call lights to be within the resident's reach.	F 558	correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? a. The facility plans to monitor its performance to make sure solutions are sustained by assigning the unit managers, and/or designee to monitor by using random audits that will ensure call lights are within reach. These random audits will be completed on 9 residents weekly for 12 weeks and then on 9 residents monthly for 3 months. If during the audit process mistakes are identified education will be provided to the staff member. Each unit manager and/or designee will report audit results to the QA team with corrective action implemented, as deemed necessary. 5. When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (12/22/2023). Or a maximum of 35 days after the date of the exit conference, so this would be 1/25/2024 before the end of day. a. 1/25/2024	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.	F 561		1/25/24

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F 561	Continued From page 6 §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and resident interview, the facility failed to honor resident choices for 1 of 19 sampled residents (Resident #10) who use incontinence products. Failure to honor Resident #10's choice to choose an incontinence product does not respect their autonomy or right to determine what is significant to their care and well-being. Findings include: A Guide to Your Rights as a Resident of a Nursing Facility In North Dakota, from the Long-Term Care Ombudsman, updated 03/21/23, page	F 561	1. What corrective action will be accomplished for those residents affected by the deficient practice: a. Education provided to nursing staff that Resident #10 was provided with incontinence products, pads and pullups, to use per her request. 2. How will you identify other residents having the potential to be affected by the same deficient practice? a. The facility has determined that all residents have the potential to be affected. 3. How the deficiency will be corrected? Include how the facility will correct the	

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F 561	Continued From page 7 17, stated, ". . . You can make choices about how you want to live your life that are significant to you. This includes deciding how you want to spend your time, what you would like your daily schedule and routine to be and what your health care wishes are that are consistent with your personal beliefs, values, interests, as well as assessments and plans of care. . ." In an interview on 12/18/23 at 1:25 p.m., Resident #10 reported that the facility staff discontinued the resident's use of a pad with a pullup due to the increased risk for infection if the pad were to stay on too long. Resident #10 reported she was independent with toileting and currently wore a pullup. Resident #10 reported she stayed "wet" in just a pullup for a longer amount of time because she relied on staff for assistance to remove the pullup and the wait times can be "long." Resident #10 reported she was able to remove the pad on her own and would like to use a pad with a pullup to maintain her independence. Review of Resident #10's medical record occurred on all days of survey and revealed a Brief Interview for Mental Status (BIMS) score of 15 from a Minimum Data Set (MDS) dated 11/11/23. The resident's care plan, updated 08/22/23, stated, "TOILET USE: The resident is able to: toilet herself but sometimes needs x1 [of one] staff assistance." A Communication progress note, dated 10/27/23, stated, "Resident stated to this writer that she was upset. When asked why resident stated she would like to a have a Tena [incontinence product brand] pad in her brief because she 'dribbles' and	F 561	existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed if a new system is necessary or if a system does not exist and must be developed. a. Implementation of policy Promoting/Maintaining resident self □ determination. Education provided to nursing staff on policy implemented. The topic honoring choices is added to the resident council monthly agenda. 4. How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? a. The facility plans to monitor its performance to make sure solutions are sustained by assigning the social service designee and/or other designee to monitor by using random audits that will ensure self-determination through support of resident choice. These random audits will be completed on 6 residents weekly for 12 weeks and then 6 residents monthly for 3 months. If during audit process mistakes are identified education will be provided to the staff member. The social service designee and/or other designee will report audit results to the	

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F 561	Continued From page 8 would prefer to throw away the pad opposed to the brief. This writer stated understanding and that she would note the conversation." An Alert Note, dated 12/02/23, stated, "Resident stated to this writer that she would like to be allowed the addition of an incontinence pad in her brief. Resident stated that she does not want to wear more absorbent briefs . . . Resident is alert and oriented to person, place, time and situation. Resident stated she wanted everyone to know and except [sic] that she would like to use a pad. This writer stated understanding. . ." A Physician Visit Note, dated 12/20/23, stated, ". . . Booster [absorbent product without a waterproof backing] pads with pullup would help." The facility failed to acknowledge the resident's choice and preference for incontinence products.	F 561	QA team with corrective action implemented, as deemed necessary. 5. When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (12/22/2023). Or a maximum of 35 days after the date of the exit conference, so this would be 1/25/2024 before the end of day. a. 1/25/2024	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		1/25/24

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F 584	Continued From page 9 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure a safe, clean, comfortable, and homelike environment for 2 of 6 units (Golden Grain and Fruit Blossom) in the facility and one resident room on Golden Grain observed during the survey. Failure to maintain a clean, comfortable, and sanitary environment does not provide a homelike living area for residents and fails to promote quality of life. Findings include:	F 584	1. What corrective action will be accomplished for those residents affected by the deficient practice: a. Golden Grain, Fruit Blossom and resident rooms (on these units) will be inspected and cleaned. Housekeeping staff were educated on the expectation related to providing a safe, clean, comfortable, and homelike environment. 2. How will you identify other residents having the potential to be affected by the same deficient practice?	

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F 584	Continued From page 10 Review of the facility policy titled "HOUSEKEEPING POLICY" occurred on 12/21/23. This policy, dated May 2022, stated, ". . . Clean, sanitary, and pleasant environment, are essential to the care of the residents and staff. . . . Resident care areas, . . . dining areas, . . . and living areas require a high quality of sanitation to be maintained." Review of the facility's Housekeeping/Laundry Daily checklist occurred on 12/21/23. This checklist showed staff complete daily housekeeping in resident rooms and lounge areas. Observations during survey showed the following: * 12/18/23 at 11:54 a.m., Fruit Blossom hallway tissues, and other unidentified items of garbage on the floor. * 12/18/23 at 12:13 p.m., resident room (Golden Grain) several broken toothpicks, pieces of food, and tissues on the floor. * 12/19/23 at 8:48 a.m., resident room (Golden Grain) several broken toothpicks, pieces of food, and tissues remained on the floor from the previous day. * 12/21/23 at 8:15 a.m., Golden Grain dayroom food on the floor. * 12/21/23 at 8:15 a.m., Golden Grain hallway food and pieces of tissue on floor. During an interview on 12/21/23 at 9:32 a.m., a housekeeping supervisor (#9) stated staff should clean resident rooms, hallways, and lounge areas daily.	F 584	a. The facility recognizes that all residents have the potential to be affected. 3. How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed if a new system is necessary or if a system does not exist and must be developed. a. Education provided to housekeeping staff in regard to Safe and Homelike Environment, and Housekeeping Policy. These policies contain expectations for facility cleanliness in a homelike, clean, comfortable and safe environment. 4. How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? a. The facility plans to monitor its performance to make sure solutions are sustained by assigning the Housekeeping Supervisor, Safety Director and/or designee to monitor by using random audits that will ensure safe, clean, comfortable, and homelike environment. These audits will be conducted at a minimum of 6 Environment Inspection	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 11	F 584	Audit weekly for 12 weeks and then 6 monthly for 3 months. Audits will be monitored by the Housekeeping Supervisor/Safety Director and results reported to the QAPI committee. 5. When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (12/22/2023). Or a maximum of 35 days after the date of the exit conference, so this would be 1/25/2024 before the end of day. a. 1/25/2024	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		1/25/24

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	355053	A. BUILDING _____ B. WING _____	C 12/21/2023

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F 657	Continued From page 12 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident and staff interview, the facility failed to review and revise comprehensive care plans to reflect the residents' current status for 2 of 21 sampled residents (Resident #15 and #27). Failure to review and revise the care plan limited staff's ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy,"CARE PLAN POLICY", occurred on 12/21/23. This policy, dated 12/01/23, stated, ". . . 5. Review of care plans by individual members is expected to occur at the time of the quarterly care conference and on an ongoing basis as the resident's condition changes so that additions or deletions can be made . . ." - Review of Resident #15's medical record occurred on all days of survey. Resident #15's care plan, reviewed on the morning of 12/19/23, identified the following: ". . . The resident has open area of the left great toe r/t [related to] fragile skin and pressure on toe. . . ." Review of a "Wound - Weekly Observation Tool", dated 11/29/23, stated, "Pressure injury to tip of left great toe has heled [sic] at this time. There is [sic] no open areas noted. . . ."	F 657	1. What corrective action will be accomplished for those residents affected by the deficient practice: a. Care plans for resident's #15 and #27 are updated to reflect the resident's current status. 2. How will you identify other residents having the potential to be affected by the same deficient practice? a. The facility has determined that all residents have the potential to be affected. 3. How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed if a new system is necessary or if a system does not exist and must be developed. a. Education provided to the MDS nurses and nurse managers on "Care Plan Revisions Upon Status Change" policy. The nurse managers will review 3 care plans weekly with direct care staff. 4. How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance	

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F 657	Continued From page 13 During an interview on the morning of 12/19/23, a supervisory nurse (#6) stated Resident #15's left toe is "no longer open." - Review of Resident #27's medical record occurred on all days of survey. The Resident's care plan stated, ". . . The resident has oral/dental health problems . . . She has an upper denture for her top teeth . . ." A progress note, dated 02/14/23, stated, "CNA (Certified Nurse Aide) [CNA's name] reported to the nurse the res. [resident] is missing her dentures - the CNA looked all over the res.'s [resident's] room as well. . . ." During an interview on 12/20/23 at 8:01 a.m., Resident #27 stated, "My dentures have been lost for a long time now." The facility failed to review and revise Resident #27's care plan to reflect her current dental status.	F 657	process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? a. The facility plans to monitor its performance to make sure solutions are sustained by assigning the unit managers, MDS nurses, and/or designee to monitor by using random audits that will ensure if a resident experiences a change in status that the care plan is updated to include new or modified intervention. These random audits will be completed on 6 residents weekly for 12 weeks and then 6 residents monthly for 3 months. If during the audit process mistakes are identified education will be provided to the staff member. Each unit manager and/or designee will report audit results to the QA team with corrective action implemented, as deemed necessary. 5. When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (12/22/2023). Or a maximum of 35 days after the date of the exit conference, so this would be 1/25/2024 before the end of day. a. 1/25/2024	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686		1/25/24

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F 686	Continued From page 14 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to provide care and services to aid the healing or to prevent the development of pressure ulcers for 1 of 1 supplemental resident (Resident #26) with pressure ulcers. Failure to apply the blue pressure relief boot may result in worsening and/or the development of pressure ulcers. Findings include: Review of Resident #26's medical record occurred on all days of survey. Diagnoses included pressure ulcer of right heel, stage 2. Current physician's orders included, "Blue pressure relief boot at all times to R [right] foot." The December treatment administration record showed from 12/18/23 to 12/21/23 staff initialed the application of the blue pressure relieving boot. Observations on 12/18/23 to 12/21/23 showed Resident #26 without the blue pressure relieving boot to the right foot.	F 686	1. What corrective action will be accomplished for those residents affected by the deficient practice: a. Order for blue pressure relieving boot discontinued for Resident #26 as order was no longer current. 2. How will you identify other residents having the potential to be affected by the same deficient practice? a. Identification of other residents that utilize pressure relieving boots. Chart review completed by unit managers. Education provided to nursing staff in regard to “Pressure Injury Prevention and Management Policy”. 3. How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed if a new system is necessary or if a system does not exist	

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F 686	Continued From page 15 During an interview on 12/21/23 at 12:55 p.m., an administrative staff member (#3) stated she expected staff to follow physician orders.	F 686	and must be developed. a. Education provided to nursing staff on "Pressure Injury Prevention and Management Policy". Education provided to charge nurses to ensure order is carried out if signing it off in the TAR. 4. How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? a. The facility plans to monitor its performance to make sure solutions are sustained by assigning the nurse managers, and/or designee to monitor by conducting a random audit of 3 residents that will assure interventions to prevent pressure injuries were followed and random audit of 3 residents that their physician orders are current. These random audits will be completed for 6 residents weekly for 12 weeks and then 6 residents monthly for 3 months. If during the audit process mistakes are identified, education will be provided to the staff member. Unit Managers and/or designee will report audit results to the QA team with corrective action implemented, as deemed necessary. 5. When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (12/22/2023). Or a maximum of 35 days after the date of the exit conference, so	

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F 686	Continued From page 16	F 686	this would be 1/25/2024 before the end of day. a. 1/25/2024	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		1/25/24

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F 690	Continued From page 17 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, and staff interview, the facility failed to provide appropriate services and assistance to maintain bowel/bladder continence for 1 of 12 sampled residents (Resident #23) who required toileting assistance/incontinence care. Failure to provide toileting assistance may result in unnecessary incontinence and a loss of dignity. Findings include: Review of the facility's "Incontinence Policy" occurred on 12/21/23. This policy, dated 11/03/23, stated, ". . . Policy Statement: Based on the resident's assessment, all residents that are incontinent will receive appropriate treatment and services. . . ." Review of Resident #23's medical record occurred on all days of survey and included a diagnosis of dementia. The resident's current Minimum Data Set (MDS), dated 11/04/23, identified frequently incontinent of bladder and continent of bowel. Resident #23's care plan stated, ". . . TOILET USE: The resident requires supervision as he allows. . . .The resident has urinary and bowel incontinence. . . . INCONTINENT: Check resident as needed for incontinence. . . . Change clothing PRN [as needed] after incontinence episodes. . . ." A bowel and bladder assessment, dated 11/01/23, stated, ". . . Good candidate for retraining . . ."	F 690	1. What corrective action will be accomplished for those residents affected by the deficient practice: a. Education provided to nursing staff to provide assistance for toileting and incontinence care for resident #23 and document refusals. 2. How will you identify other residents having the potential to be affected by the same deficient practice? a. The facility has determined that all residents have the potential to be affected. 3. How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed if a new system is necessary or if a system does not exist and must be developed. a. Education provided to nursing staff on “Incontinence Policy” and to provide assistance for toileting and incontinence care. Education provided to nursing staff to document refusals of toileting and/or incontinence care in the behavior and toileting tasks if refusal of care occurs. 4. How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance	

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F 690	Continued From page 18 Observations during survey showed the following: * 12/19/23 at 9:43 a.m. Resident #23 asleep in his bed, a soaker pad on the resident's recliner soiled with feces, soiled clothes on the floor by the recliner and in the bathroom. The resident's room and hallway had a strong odor. * 12/19/23 at 11:41 a.m. Resident #23 struggled and moaned as he ambulated into the bathroom by himself. The back of his pants and his bedspread were soiled with feces. * 12/19/23 at 11:51 a.m. Resident #23 seated on the side of the bed as he attempted to put his pants on. The resident's room and hallway had a strong odor. * 12/19/23 at 11:58 a.m. Resident #23 stood by the closet and naked from the waist down. When the resident saw this surveyor he pointed to the bathroom. The surveyor summoned a facility staff member to the resident's room. * 12/19/23 at 4:37 p.m. Resident #23 sat in his recliner with his pants soiled with feces. * 12/20/23 at 7:56 a.m. Resident #23 sat on the edge of the bed naked and a strong odor was noted in the room. The surveyor informed a staff member the resident needed assistance and the CNA (certified nurse aide) (#14) stated she would notify another CNA. During an interview on 12/20/23 at 8:50 a.m., when asked about Resident #23's toileting and frequent bowel incontinence observed on 12/19/23, an administrative nurse (#5) stated the resident often refuses toileting. Resident #23's toileting and behavior task record for 12/19/23 - failed to show the resident refused toileting and/or incontinence cares.	F 690	process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? a. The facility plans to monitor its performance to make sure solutions are sustained by assigning the unit managers, and/or designee to monitor by using random audits that will ensure toileting/incontinence care is offered and refusals are charted in POC if a refusal occurs. These random audits will be completed on 9 residents weekly for 12 weeks and then 9 residents monthly for 3 months. If during audit process mistakes are identified education will be provided to the staff member. Each unit manager and/or designee will report audit results to the QA team with corrective action implemented, as deemed necessary. 5. When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (12/22/2023). Or a maximum of 35 days after the date of the exit conference, so this would be 1/25/2024 before the end of day. a. 1/25/2024	

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F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, facility staff failed to offer fluids to 1 of 21 sampled residents (Resident #63) and 1 supplemental resident (Resident #43) during cares who required staff assistance for fluid intake and failed to provide water consistently for 4 of 21 sampled residents (Resident #6, #23, #27 and #67) and 2 supplemental residents (Resident #13, and #66). Failure to provide water to all residents consistently and provide assistance with fluid intake may result in dehydration, constipation, and urinary tract infections (UTIs).	F 692	1. What corrective action will be accomplished for those residents affected by the deficient practice: a. Education provided to staff to offer fluid with every interaction for resident #63 and #43. Education provided to nursing staff to have fluid available consistently for resident #6, #23, #27, #67, #13, and #66. 2. How will you identify other residents having the potential to be affected by the same deficient practice? a. The facility has determined that all	1/25/24

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F 692	Continued From page 20 Findings include: - Review of Resident #63's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 11/02/23, identified Resident #63 required substantial/maximal assistance with eating, in which the helper does more than half the effort. A dietary note, dated 11/21/23, stated, ". . . Staff assist resident with intake - green mug with handle is used to aid in self-feeding - staff report occasionally resident will give himself a drink. . . ." Resident #63's current care plan identified the following: "The resident has dehydration or potential fluid deficit r/t [related to] Diuretic use, use/side effects of medication . . . Ensure the resident has access to water whenever possible. . . ." Observation of a staff member providing cares for Resident #63 occurred on 12/20/23 at 10:50 a.m. The CNA (certified nurse aide) (#7) checked Resident #63's brief and then transferred the resident from the bed to the wheelchair. The CNA (#7) failed to offer water or other fluids to the resident. - Review of Resident #43's medical record occurred on all days of survey and included a diagnosis of dementia. The care plan identified the following: ". . . The resident requires assistance by . . . staff for locomotion using W/C [wheelchair] . . . Encourage . . . fluid intake . . ." Observation of a staff member providing cares for	F 692	residents have the potential to be affected. 3. How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed if a new system is necessary or if a system does not exist and must be developed. a. Education provided to nursing and dietary staff on the implementation of “Hydration” Policy. Education provided to nursing staff to offer fluids with every interaction. 4. How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? a. The facility plans to monitor its performance to make sure solutions are sustained by assigning the unit managers, QAPI nurse, and/or designee to monitor by using random audits that will ensure that water is passed, and fluid is offered with every interaction. These random audits will be completed on 9 residents weekly for 12 weeks and then 9 residents monthly for 3 months. If during audit process mistakes are identified	

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F 692	Continued From page 21 Resident #43 occurred on 12/18/23 at 2:15 p.m. The CNA (#14) failed to offer water or other fluids to the resident. Observations during survey included the following: * 12/20/23 at 8:25 a.m. Resident #23's water pitcher was empty. * 12/20/23 at 8:01 a.m. Resident #27's water pitcher was empty. The resident stated, "They didn't bring water to me all afternoon yesterday." * 12/20/23 at 8:28 a.m. Resident #66's water pitcher was empty and the resident stated, "Every once in awhile they bring fresh ice water." * 12/20/23 at 8:26 a.m. Resident #67's water pitcher was empty. During an interview on 12/19/23 at 9:35 a.m., Resident #6 stated, "The only time I get my water refilled is a when the water girl is here a few days a week." During an interview on 12/20/23 at 11:18 a.m. Resident #13 reported when there is not a designated staff person to fill water pitchers, the resident has to request water or the pitchers do not get refilled. Resident #13 reported the facility does not have staff to fill water pitchers in the resident's rooms on the weekends. During an interview on 12/21/23 at 4:40 p.m., an administrative nurse (#15) agreed staff providing fresh water to all residents has been an ongoing issue.	F 692	education will be provided to the staff member. Each unit manager and/or designee will report audit results to the QA team with corrective action implemented, as deemed necessary. 5. When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (12/22/2023). Or a maximum of 35 days after the date of the exit conference, so this would be 1/25/2024 before the end of day. a. 1/25/2024	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		1/25/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 22 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, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services for 1 of 3 sampled residents (Resident #130) receiving oxygen. Failure of maintain respiratory supplies by routinely changing and documenting the replacement of the cannula/tubing may compromise the integrity of the cannula/tubing and could result in adverse effects for the resident. Findings include: Review of the facility policy titled "Oxygen Concentrator Procedure" occurred on 12/21/23. This policy, dated 12/01/23, stated, ". . . 10. Cannulas . . . should be changed weekly. . . . " Observation on all days of survey showed Resident #130 with continuous oxygen administered at 2 liters per nasal cannula either by an oxygen concentrator in the resident's room or a portable oxygen unit on the back of the resident's chair. The oxygen concentrator and the portable unit each had separate nasal cannula and tubing. Review of Resident #130's medical record lacked	F 695	1. What corrective action will be accomplished for those residents affected by the deficient practice: a. Education provided to nursing staff that resident #130 is to have order on TAR to change oxygen tubing weekly. Order was added to TAR to change oxygen tubing weekly. 2. How will you identify other residents having the potential to be affected by the same deficient practice? a. A chart review was completed by the unit managers to identify other residents that utilize oxygen. 3. How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed if a new system is necessary or if a system does not exist and must be developed. a. Education provided to nurses on “Oxygen Concentrator Policy”, “Liquid Oxygen Filling and Use Procedure”, and	

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F 695	Continued From page 23 an order to change the oxygen tubing and cannula. During an interview on 12/20/23 at 5:14 p.m., a supervisory nurse (#6) stated oxygen tubing is changed every Sunday and staff document this in the Treatment Administration Record (TAR), however, review of the TAR failed to identify staff documentation of cannula/tubing changes. The nurse confirmed the record lacked documentation of staff changing the tubing weekly.	F 695	to change oxygen tubing weekly with an order entered in the TAR. Verified that residents who currently use oxygen have an order in the TAR to change tubing weekly. 4. How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? a. The facility plans to monitor its performance to make sure solutions are sustained by assigning the nurse managers, and/or designee to monitor by conducting a random audit of 3 residents that will assure orders are in the TAR to change oxygen tubing weekly. These random audits will be completed on 3 residents weekly for 12 weeks and then 3 residents monthly for 3 months. If during the audit process mistakes are identified, education will be provided to the staff member. Unit Managers and/or designee will report audit results to the QA team with corrective action implemented, as deemed necessary. 5. When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (12/22/2023). Or a maximum of 35 days after the date of the exit conference, so this would be 1/25/2024 before the end of day. a. 1/25/2024	

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F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to ensure safe and secure storage of medicated shampoo in 1 of 5 medication carts (memory unit). Failure to store the medicated shampoo properly may result in unauthorized access and has the potential to cause resident harm. Findings include:	F 761	1. What corrective action will be accomplished for those residents affected by the deficient practice: a. Education provided to nursing staff that medicated shampoo for resident #229 needs to be locked in the medication cart or medication room when not in use. 2. How will you identify other residents	1/25/24

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F 761	Continued From page 25 Review of the facility policy titled "Medication System Procedure" occurred on 12/21/23. This policy dated December 2023 stated, ". . . I. Medications set-up for dispensing must remain in nurse/CMA Certified[medication aide] possession or line of sight . . ." Observations of the memory unit on 12/20/23 at 8:45 a.m., showed a bottle of medicated shampoo sitting on a bedside table in the hallway. Two residents sat near the medicated shampoo without a nurse/CMA in line of sight. During an interview on 12/21/23 at 12:55 p.m., an administrative staff member (#3) confirmed that the medicated shampoo should be stored in the medication cart until it is needed.	F 761	having the potential to be affected by the same deficient practice? a. A chart review was completed by the unit managers to identify other residents that use medicated shampoo. Education provided to nursing staff on "pharmaceutical services" policy that medicated shampoo needs to be stored in the medication cart or medication room and dispensed on bath days in a medication cup. 3. How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed if a new system is necessary or if a system does not exist and must be developed. a. Education provided to nursing staff on "pharmaceutical services" policy and that medicated shampoo must be stored in the medication room or medication cart. 4. How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? a. The facility plans to monitor its performance to make sure solutions are sustained by assigning the unit	

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F 761	Continued From page 26	F 761	managers, and/or designee to monitor by using random audits that will ensure medicated shampoos are stored in the medication room or medication cart. These random audits will be completed on 3 residents weekly for 12 weeks and then 3 residents monthly for 3 months. If during audit process mistakes are identified education will be provided to the staff member. Each unit manager and/or designee will report audit results to the QA team with corrective action implemented, as deemed necessary. 5. When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (12/22/2023). Or a maximum of 35 days after the date of the exit conference, so this would be 1/25/2024 before the end of day. a. 1/25/2024	
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident	F 790		1/25/24

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F 790	Continued From page 27 an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, and resident and staff interviews, the facility failed to assist with obtaining dental services to meet the needs of 1 of 1 sampled resident (Resident #27) with lost dentures. Failure to assist the resident in making an appointment may have resulted in chewing and/or eating difficulties, weight loss, delayed dental care and/or dental complications. Findings include:	F 790	1. What corrective action will be accomplished for those residents affected by the deficient practice: a. Resident #27 will be offered a referral to see the dentist for new dentures. Family will be updated regarding referral. Management staff and charge nurses will be educated about the dental services policy. 2. How will you identify other residents having the potential to be affected by the same deficient practice?	

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F 790	Continued From page 28 Review of the facility policy titled "DENTAL SERVICES POLICY" occurred on 12/21/23. This policy, dated April 2023, stated, ". . . For residents with lost or damaged dentures, the facility will refer the resident for dental services within three days . . ." During an interview on 12/20/23 at 8:01 a.m., Resident #27 stated, "My dentures have been lost for a long time now." Observation on all days of survey showed Resident #27 without an upper denture. Review of Resident #27's medical record occurred on all days of survey. The medical record included the following progress notes: * 02/14/23 at 5:26 p.m., ". . . CNA [Certified Nurse Aide] [CNA's name] reported to the nurse the res. [resident] is missing her dentures - the CNA looked all over the res.'s [resident's] room as well. Left a message with social services on their voice mail to follow up. . . ." * 03/07/23 stated, ". . . Followed up with daughter in law [daughter-in- law's name] regarding missing dentures. . . ." During an interview on 12/21/23 an administrative staff member, (#13) confirmed the facility failed to offer and/or assist Resident #27 with scheduling a dental appointment within 3 days following the loss of her dentures.	F 790	a. Any resident's of KRCC who have dentures have the potential to be affected. 3. How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed if a new system is necessary or if a system does not exist and must be developed. a. KRCC's dental Services policy will be reviewed by social services. Education will be provided by social services to all managers and charge nurses. 4. How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? a. The facility plans to monitor its performance to make sure solutions are sustained by assigning Social Services and/or designee to monitor by using random audits that will ensure the Dental Services policy is being followed. The audit will assess a resident for dentures, whether dentures are in place or not, if dentures are not in place, audit will include if follow-up and documentation was done, and if gaps are identified, what	

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F 790	Continued From page 29	F 790	education/training was provided to staff, and if resident was offered dental services within 3 days of notification of lost or damaged dentures. Social services will complete and review the audits. Three audits will be completed at a frequency of weekly for 12 weeks, and the three audits, monthly for 3 months thereafter. If gaps are identified processes will be changed and audits will continue. 5. When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (12/22/2023). Or a maximum of 35 days after the date of the exit conference, so this would be 1/25/2024 before the end of day. a. 1/25/2024	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §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;	F 803		1/25/24

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F 803	Continued From page 30 §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, review of menus, and staff and resident interviews, the facility failed to serve food according to prepared menus for 3 of 3 units observed (Shady Lane, Harvest Lane, and Whispering Winds) during meals. Failure to serve food according to the portion sizes listed on the menu may result in inadequate nutrition and either weight loss or gain. Findings include: During a interview on 12/18/23 in the afternoon, (Resident B) stated, "My only concern is portion sizes of meals are not enough." Observation of Shady Lane's breakfast tray line on 12/19/23 showed the following portion sizes served to residents and what the menu required: - Oatmeal #8 scoop, 1/2 cup (Menu: #6 scoop, 2/3 cup) - Cream of Wheat cereal #8 scoop, 1/2 cup (Menu: #6 scoop, 2/3 cup) Observation of Harvest Lane's lunch tray line on 12/19/23 showed the following portion sizes served to residents and what the menu required: - Chicken Fajita #16 scoop, 2 ounces (Menu: 3	F 803	1. What corrective action will be accomplished for those residents affected by the deficient practice: a. Portion sizes of all foods on the facility menus have been re-evaluated by the Registered Dietitian and the Certified Dietary Manager to assure accuracy and adequacy of planned menus. Foods are being served using proper serving and scoop sizes for the accurate delivery of portion sizes. 2. How will you identify other residents having the potential to be affected by the same deficient practice? a. The facility recognizes that all residents have the potential to be affected. 3. How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed if a new system is necessary or if a system does not exist	

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F 803	Continued From page 31 ounces) - Pureed Chicken #12 scoop, 1/3 cup (Menu: #8 scoop, 1/2 cup) - Mechanical soft burger #16 scoop, 2 ounces (Menu: #10 scoop 3 1/3 ounces) - Pickled Beets 3-ounce ladle (Menu: #8 scoop, 1/2 cup) - Pureed Pickled Beets #12 scoop, 1/3 cup (Menu: #8 scoop, 1/2 cup) - Pureed Apple Crisp #12 scoop, 1/3 cup (Menu: #8 scoop, 1/2 cup) Observation of Shady Lane's lunch tray line on 12/19/23 showed the following portion sizes served to residents and what the menu required: - Chicken Fajita #16 scoop, 2 ounces (Menu: 3 ounces) - Pickled Beets served with tongs (Menu: #8 scoop, 1/2 cup) - Pureed Beef #12 scoop, 3 ounces (Menu: #8 scoop, 4 ounces) - Pureed Chicken #16 scoop, 2 ounces (Menu: #8 scoop, 4 ounces) Observation of Whispering Winds's lunch tray line on 12/20/23 showed the following portion sizes served to residents and what the menu required: - Carrots 2-ounce ladle (Menu: #8 scoop, 1/2 cup) - Pureed Carrots #16 scoop, 1/4 cup (Menu: #10 scoop, 3/8 cup) - Pureed Chicken Pot Pie #16 scoop, 1/4 cup (Menu: #8 scoop 1/2 cup) - Sauerkraut #10 scoop, 3/8 cup (Menu: 1/2 cup) Observation of Harvest Lane's lunch tray line on 12/20/23 showed the following portion sizes	F 803	and must be developed. a. Education for all dietary staff has been completed by the Certified Dietary Manager in regard to facility guidelines for proper portion sizes as well as the Standardized Menu policy which discusses portion sizes. Observation of 3 consecutive meals for 4 consecutive days with compliance noted on each of these occurrences. 4. How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? a. The facility plans to monitor its performance to make sure solutions are sustained by assigning the Certified Dietary Manager and designee to monitor by using random audits that will ensure proper hand hygiene. The Certified Dietary Manager and designee will conduct, at a minimum, 6 food preparation and service audits weekly for 12 weeks and then 6 per month for 3 months thereafter. These audits will center around assuring the correct portion sizes are utilized at all meals. Audits will be reported to the QAPI committee for review. 5. When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (12/22/2023). Or a maximum of 35 days	

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F 803	Continued From page 32 served to residents and what the menu required: - Sauerkraut #16 scoop, 1/4 cup (Menu: 1/2 cup) - Pureed Chicken Pot Pie #16 scoop, 1/4 cup (Menu: #8 scoop, 1/2 cup) - Pureed Carrots #12 scoop, 1/3 cup (Menu: #10 scoop, 3/8 cup) Observation of Shady Lane's lunch tray line on 12/20/23 showed the following portion sizes served to residents and what the menu required: - Carrots 2-ounce scoop (Menu: #8 scoop, 1/2 cup) - Mashed potatoes #12 scoop, 1/3 cup (Menu: #8 scoop, 1/2 cup) During an interview the morning of 12/21/23, an administrative dietary staff member (#8) confirmed staff should use the portion sizes listed on the menu when serving food for meals.	F 803	after the date of the exit conference, so this would be 1/25/2024 before the end of day. a. 1/25/2024	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		1/25/24

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F 812	Continued From page 33 §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, review of facility policy, and staff interview, the facility failed to serve food in a sanitary manner for 2 of 3 kitchenettes (Shady Lane and Harvest Lane). Failure to change gloves when the type of food being handled has changed or after touching the face and prior to handling ready-to-eat food has the potential to result in cross-contamination and/or food borne illness. Findings include: Review of the facility policy, "Maintaining a Sanitary Tray Line" occurred on 12/21/23. This policy, dated 08/10/23, stated, "Policy: To provide an organized tray line that provides food . . . in a manner to prevent the spread of bacteria that may cause food borne illness. . . . Compliance Guidelines: . . . 3. During tray assembly, staff should: a. Use gloves when handling food items. b. Use utensils such as tongs, serving spoons, etc. to handle food as much as possible. c. Wear gloves when direct contact with the hands and food occur. d. Wear gloves before handling ready-to-eat foods such as salads, fruits, sandwiches, breads, etc. e. Wash hands before and after wearing or changing gloves . . . g. Change gloves when activities are changed, or when the type of food being handled is changed, or when leaving the work station. h. Change gloves after sneezing coughing or touching your face, hands, or hair with gloved hand. . . ."	F 812	1. What corrective action will be accomplished for those residents affected by the deficient practice: a. All dietary staff members have been educated on the proper procedures related to maintaining and sustaining a sanitary tray line while serving and hand washing guidelines for all dietary employees. Education involved both verbal/written as well as return demonstration from staff members. 2. How will you identify other residents having the potential to be affected by the same deficient practice? a. The facility recognizes that all residents have the potential to be affected. 3. How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed if a new system is necessary or if a system does not exist and must be developed. a. Education for all dietary staff members has been provided by the Certified Dietary Manager and Registered Dietician. Education involved educating	

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F 812	Continued From page 34 - Observation of tray line in the Harvest Lane kitchenette occurred on 12/19/23 at 11:36 a.m. A dietary staff member (#10) wore gloves while using utensils to dish food onto resident plates, handling diet sheets, and retrieving items from the refrigerator. Without changing gloves, the staff member (#10) reached into a bag to place bread on several residents' plates. The staff member failed to change gloves after touching various items and prior to handling ready-to-eat food. - Observation of tray line in the Shady Lane kitchenette occurred on 12/19/23 at 12:00 p.m. A dietary staff member (#11) wore gloves while using utensils to dish food onto residents' plates. Observation showed the staff member handling the diet sheets and touching his/her face. Without changing gloves, the staff member (#11) reached into a bag to place bread on several residents' plates. Later in the observation, the staff member used the same gloved hands to take a lettuce salad from a container and place it onto two plates. The staff member failed to change gloves after touching utensils and his/her face and prior to handling ready-to eat food. - Observation of tray line in the Harvest Lane kitchenette occurred on 12/20/23 at 11:46 a.m. A dietary staff member (#12) wore gloves while using utensils to dish food onto resident plates. Observation showed the staff member handling the diet sheets, retrieving items from the refrigerator, and then with the same gloved hands, reached into a bag for bread, placed a chocolate bar on a plate, and handled lettuce and cheese with the gloved hands to place on top of	F 812	on the maintaining and sustaining a sanitary tray line and Handwashing Guidelines for Dietary Employees policy as well as return demonstration from servers for the serving process. The CDM and/or designee observed 3 consecutive meals for 4 consecutive days with compliance noted on each of these occurrences. 4. How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT INDIVIDUAL NAME) that will monitor the corrective action? a. The facility plans to monitor its performance to make sure solutions are sustained by assigning the Certified Dietary Manager and designee to monitor by using random audits that will ensure a sanitary tray line. These random audits will be conducted, at a minimum, 6 audits weekly for 12 weeks and then 6 per month for 3 months thereafter. These audit results will be reported to the QAPI committee for review. 5. When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (12/22/2023). Or a maximum of 35 days after the date of the exit conference, so this would be 1/25/2024 before the end of day. a. 1/25/2024	

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F 812	Continued From page 35 the taco meat. (The containers with the lettuce and cheese did not have utensils in them). The staff member failed to change gloves after touching various items and prior to handling ready-to-eat food. During an interview on the morning of 12/21/23, an administrative dietary staff member (#8) confirmed staff should change gloves when changing tasks.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		1/25/24

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F 880	Continued From page 36 procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 37 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 1 of 10 sampled residents (Resident #64) observed during personal cares. Failure to practice infection control standards related to hand hygiene during personal cares has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Employee Hand Hygiene Procedure" occurred on 12/21/23. This policy, revised 08/11/23, stated, ". . .if your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. . . ." Observation on 12/18/23 at 12:25 p.m. showed a certified nurse aide (CNA) (#4) performed perineal cares for Resident #64. The CNA (#4) cleansed the resident's perineal area, discarded the wet incontinent product, removed his gloves, donned a new pair of gloves, and placed a clean incontinent product on the resident. The CNA (#4), without performing hand hygiene, opened a powder drink packet and the resident's water mug, then emptied the packet inside. The CNA (#4) handled the television remote and moved the resident's call button. The CNA failed to perform hand hygiene between glove changes and before completing other tasks. During an interview on 12/21/23 at 12:55 p.m., an	F 880	1. What corrective action will be accomplished for those residents affected by the deficient practice: a. Education provided to nursing staff on the “Employee Hand Hygiene Procedure”. 2. How will you identify other residents having the potential to be affected by the same deficient practice? a. The facility has determined that all residents have the potential to be affected. 3. How the deficiency will be corrected? Include how the facility will correct the existing deficiency. Identify what measures will be put into place and what systemic changes the facility will make to ensure the deficient practice does not recur. Example: Look at the system and determine if a change to the existing system is needed if a new system is necessary or if a system does not exist and must be developed. a. Education provided to nursing staff on the “Employee Hand Hygiene Procedure” and the importance of performing hand hygiene between glove changes and before completing other tasks. 4. How does the facility plan to monitor its performance to ensure solutions are permanent? What quality assurance process will be developed to ensure the correction is achieved and sustained? Identify the frequency of the monitoring and the staff person by job duty (NOT	

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F 880	Continued From page 38 administrative staff member (#3) confirmed he/she expected staff to follow hand hygiene practices.	F 880	INDIVIDUAL NAME) that will monitor the corrective action? a. The facility plans to monitor its performance to make sure solutions are sustained by assigning the Infection Preventionist and/or other designee to monitor by using random audits that will ensure hand hygiene is performed between glove changes and before completing other tasks. These random audits will be completed on 6 residents weekly for 12 weeks and then 6 residents monthly for 3 months. If during the audit process mistakes are identified education will be provided to the staff member. The Infection Preventionist and/or other designee will report audit results to the QA team with corrective action implemented, as deemed necessary. 5. When the deficiency will be corrected. The date of correction must be at least the day after the survey completion (12/22/2023). Or a maximum of 35 days after the date of the exit conference, so this would be 1/25/2024 before the end of day. a. 1/25/2024	