STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355108	A. BUILDING _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMP HEALTH - MARYHILL	110 HILLCREST DR ENDERLIN, ND 58027

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 09/12/22 and concluded 09/15/22.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, staff and resident interview, the facility failed to ensure the interdisciplinary team assessed the appropriateness to self-administer medications (SAM) for 1 of 1 sampled resident (Resident #13) with medications observed in the resident's room. Failure to determine whether SAM is a safe practice has the potential to limit a resident's right to SAM or result in a medication error and/or harm to a resident. Findings include: Review of the facility policy titled "Medication Self-Administration" occurred on 09/14/22. This policy, dated 07/2015, stated, ". . . Policy: Resident's who desire to and are assessed capable may self-administer their medications. . . .Upon completion of the BIMS [Brief Interview for Mental Status], with a score 13 or greater, the physician will be contacted for the appropriateness of self-administration and an order obtained. An individualized care plan will be developed for the implementation of the self-administration program based on the	F 554	1. Inhaler was removed from Resident #13 room temporarily and provider notified. Orders received that resident could keep inhaler in room at bedside. Staff were educated that medications cannot be left with Resident #13 without an order. 2. All residents who have medications ordered and administered have the potential to be affected by this practice. All residents wishing to keep meds at bedside will be evaluated by the IDT and have a SAM assessment to ensure appropriateness. 3. Education was provided on Oct 6, 2022, related to medication administration expectations. This included when it is appropriate to leave medication with resident and when it is not. Informed all staff that SAM assessment is required before medications can be left with the resident at bedside. Assessments are in the resident's chart and care planned	10/18/22

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

Electronically Signed | 10/10/2022

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F 554	Continued From page 1 resident's abilities. . . ." Observation on 09/13/22 at 9:22 a.m. showed a medication cup containing multiple pills and a plastic cup containing white powder located on the table in front of Resident #13. The resident reported she was waiting for her breakfast to arrive. During an interview on 09/13/22 at 9:22 a.m., Resident #13 stated she had an inhaler to use for her asthma symptoms. When asked where she keeps the inhaler, she reported it is kept in her room, she then retrieved an Atrovent inhaler from her personal bag and stated, "I took it with to my appointment yesterday, I usually keep it on my night stand next to my phone." Observation on 09/14/22 at 12:20 p.m., showed the Atrovent inhaler located in Resident #13's room on the bedside stand. Review of Resident #13's medical record occurred on September 13-14, 2022. The record identified a BIMS score of 15 an indication of intact cognition. The record lacked a SAM assessment, a provider order, and documentation on the care plan indicating Resident #13 can safely self-administer medications. During an interview on 09/14/22 12:25 p.m., an administrative nurse (#1) confirmed staff failed to complete the SAM for Resident #13.	F 554	appropriately. During the admission process, will ask the resident/family is there are any medication on their personal belonging. If so, will assess for appropriateness via the SAM assessment to ensure this does not recur. 4. Audits observing medication administration to follow policy to only have medication left in the room if the team has assessed and SAM assessment completed per resident. The nursing department will complete audits weekly for two weeks, biweekly for two weeks, monthly for 2 months and as determined by the Quality Assurance program thereafter. All audits will be submitted to DON and presented to the Quality Assurance program to ensure compliance. 5. 10/18/22	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		10/18/22

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F 641	Continued From page 2 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17.1), the facility failed to complete a Minimum Data Set (MDS) that accurately reflected the resident's status for 1 of 2 sampled residents (Resident #27) reviewed for weight loss. Failure to accurately code the MDS may negatively affect the development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2019, page K-5 to K-6 stated, ". . . K0300: Weight loss . . . compare the resident's weight in the current observation period to his or her weight in the observation period 30 days ago. If the current weight is less than the weight in the observation period 30 days ago, calculate the percentage of weight loss . . . compare the resident's weight in the current observation period to his or her weight 180 days ago. If the current weight is less than the weight in the observation period 180 days ago, calculate the percentage of weight loss. Coding Instructions . . . Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days . . . Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days . . ."	F 641	1. Resident #27 weight calculated and correction to MDS completed 2. All residents who have an MDS completed have the potential to be affected by this practice. All MDSs completed in the past quarter for accurate coding of weight loss/gain and corrections were made if indicated. 3. Dietary Manger was in-serviced 10/13/2022 on procedure for completion of Section K of the MDS, including assessment of significant weight gain or loss. 4. Registered Dietitian will conduct quality monitoring of completion of Section K of the MDS, including assessment of significant weight gain or loss weekly for three months and quarterly thereafter, to ensure accuracy of Section K. All audits will be presented to the Quality Assurance program to ensure compliance. 5. 10/18/22	

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F 641	Continued From page 3 Review of Resident #27's medical record occurred on all days of survey. A quarterly MDS, dated 07/30/22, identified section K0300 coded for weight loss. Review of Resident #27's weight documentation identified the following: * 01/28/22 weight 126 lbs (pounds) * 06/27/22 122 lbs * 07/28/22 117 lbs (4% weight loss in 30 days and 7% in 180 days) The facility staff failed to accurately code the quarterly MDS as "0" indicating Resident #27 did not have a 5% weight loss in 30 days or a 10% weight loss in 180 days.	F 641		
F 657 SS=E	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	F 657		10/18/22

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F 657	Continued From page 4 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 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON 07/22/21 Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise comprehensive care plans to reflect the status for 6 of 15 sampled residents (Residents #9, #11, #20, #21, #24, and #28). Failure to review and revise the care plan limited staffs' ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Comprehensive Care Plans" occurred on 09/14/22. This policy, revised September 2022, stated, ". . . The care planning process will begin upon admission and ongoing with changes . . . The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS [Minimum Data Set] assessment. . . . The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. . . ."	F 657	1. Corrective action was taken for the following residents: a. #9 Care plan was updated and therapy orders to eval and treat for transfer status. b. #20 Accucheck/parameter orders clarified, and updated care plan to match orders. c. #24 Updated PCC Care plan and ADL sheet to reflect most recent interventions which was documented from the latest process note. d. #11 Care plan unresolved and updated to reflect current interventions for falls. e. #28 Fall care plan initiated. f. #21 Wandering care plan was in place, added that she specifically goes into other residents' rooms. Interventions were added for other residents to not disturb them by #21 (locked keypad, childproof door handles, and stop warning signs). #21 wandering has improved, and verbal aggressive behaviors have	

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F 657	Continued From page 5 - Observation on 09/13/22 at 11:04 a.m. showed a certified nursing assistant (CNA) (#2) and a nurse (#3) pivot transferred Resident #9 from the bed to the recliner. One CNA (#2) stated ". . . resident should be reassessed for transfer." Review of Resident #9's medical record occurred on all days of survey. The quarterly MDS, dated 06/24/22, indicated extensive assistance of two or more staff for transfers. A "Stop and Watch" progress note, dated 05/23/22, stated, ". . . it was very difficult transferring resident with 2 assist from her bed to wheel chair, wheel chair to toilet and then getting her off the toilet, resident had no strength and went limp, . . . Action: . . . transferred with pal [mechanical sit-to-stand] lift with assist of 2 . . ." The care plan stated "ADLS [activities of daily living]: I have, limited physical mobility r/t [related to] Disease Process . . . Refer to ADL sheet . . ." The ADL sheet, dated 09/13/22, stated, "Transfers . . . A1 [assist with one]". The care plan and/or ADL sheet did not accurately reflect Resident #9's transfer needs. During an interview on 09/15/22 at 12:36 p.m., an administrative nurse (#1) confirmed Resident #9's care plan and/or ADL sheet failed to reflect current transfer needs. - Review of Resident #20's medical record occurred on all days of survey. A physician's order, dated 12/21/21, stated, "Accucheck qid [four times a day] and 2am BS [blood sugar] < [less than] 60 or > [greater than] 500, if BS consistency over 400, notify physician . . ." The	F 657	been improved since being monitored by the psychologist. 2. All residents care plans will be reviewed and updated for accuracy by DON and MDS coordinator by 10/18/2022. 3. Education provided on the expectations of updating care plans timely and assuring that information is consistent between different areas of the chart, such as the PCC care plan and the ADL sheet, which is an extension of the electronic care plan. Education on the expectation of updating care plans with significant changes, reviewed during care plan meetings, new orders, with CAA's and most importantly at the point the risk is identified such as with the fall assessment and elopement assessment. 4. Audits specifically looking at care plans after fall events, oxygen administration, diabetics with parameters, transfer assistance, behaviors and wandering into other residents' room will be completed by the nursing department weekly for two weeks, biweekly for two weeks, monthly for 2 months and as determined by the Quality Assurance program thereafter. All audits will be submitted to DON and presented to the Quality Assurance program to ensure compliance. 5. 10/18/22	

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F 657	Continued From page 6	F 657		

care plan, dated 08/02/22, stated, "BS's [sic] as ordered. Report to MD [medical doctor] BS's [sic] <40 and >600." The care plan failed to accurately reflect the physician's order.

During an interview on 09/14/22 at 08:49 a.m., an administrative nurse (#1) confirmed staff failed to update Resident #20's care plan to coincide with the physician's orders.

- Review of Resident #24's medical record occurred on all days of survey. The progress notes from 06/19/22 to 09/12/22 showed nine falls. During the timeframe, the falls precautions in place included a call light within reach, frequent rounding, the bed in a low position, the room free of clutter, and if the resident recently toileted.

The care plan, dated 07/27/22, stated, ". . . TRANSFER: I use assist of one for transfers. I do not always call for assistance. . . . Be sure my call light is within reach and encourage me to use it for assistance as needed. It is noted that I may not always call for assistance when needed. . . ." The ADL sheet, dated 09/13/22, stated, "Fall Prevention . . . BL [bed in lowest position when in bed]." The care plan and/or ADL sheet did not identify the documented interventions to decrease the risk of falls in the progress notes related to the resident's falls.

During an interview on 09/15/22 at 1:45 p.m., an administrative nurse (#1) confirmed the care plan and/or ADL sheet failed to include the additional interventions identified in the progress notes related to Resident #24's fall risk.

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F 657	Continued From page 7	F 657		

- Review of Resident #11's medical record occurred on all days of survey. The quarterly MDS, dated 06/18/22, identified one fall without injury and one fall with injury. The progress notes showed the resident fell while ambulating independently in her room, once in May requiring neurological checks due to hitting her head on the wall and once in June without injury.

The care plan stated, ". . . I may have an ADL Self Care Performance Deficit r/t Dementia. I have a hx [history] of hip and pelvic fracture. I like to be independent and often refuse staff assistance. . . ." The care plan failed to have a problem, goals, and interventions to address the resident's fall risk.

During an interview on 09/13/22 at 4:43 p.m., an administrative nurse (#1) stated Resident #11 had a prior falls care plan, was unsure why it was deleted, and agreed the resident's current care plan should address falls.

- Review of Resident #21's medical record occurred on all days of survey.

Review of Resident #21's January 1 through September 13, 2022 progress notes showed behavior entries related to wandering into other resident rooms and verbal and/or physical aggression towards residents and staff.

Resident #21's care plan lacked problems, goals, and interventions to address these behaviors.

- Review of Resident #28's medical record occurred on all days of survey. The record showed Resident #28 experienced four falls

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F 657	Continued From page 8 06/10/22 through 08/26/22. Resident #28's care plan lacked a problem, goals, and interventions to address the falls.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of professional literature, and staff interview, the facility failed to follow professional standards of practice for 2 of 2 sampled residents (Resident #1 and #15) who received insulin during medication pass. Failure to disinfect the rubber seal of insulin pens increases risk of infection to residents and failure to indicate an open date and/or expiration date on insulin pens may result in reduced efficacy of the insulin. Findings include: Review of the facility policy titled "Insulin Pen" occurred on 09/15/22. This policy, revised February 2022, stated, "Insulin pens must be clearly labeled with the . . . expiration date. . . . Insulin pens should be disposed of after 28 days or according to manufacturer's recommendation. . . " Review of information found at https://pi.lilly.com/us/humalog-kwikpen-um.pdf, stated, ". . . HUMALOG KwikPen . . . Preparing	F 658	A. Insulin pens being outdated 1. The outdated insulin pen was disposed of immediately and a new one taken from fridge and dated. 2. All Residents requiring insulin have the potential to be affected by this practice. Checked all the open insulin pens to ensure they were dated, and if not, they were disposed. 3. Education provided on 10/6/22 outlining the expectation to date insulin pens when removed from the refrigerator and put into the medication cart. 4. MDS/infection control coordinator will complete audits looking at insulin pens to ensure that they are dated which will be done weekly for two weeks, biweekly for two weeks, monthly for 2 months and as determined by the Quality Assurance program thereafter. All audits will be submitted to DON and presented to the	10/18/22

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F 658	Continued From page 9 your Pen . . . Wipe the Rubber Seal with an alcohol swab. . . ." Review of information found at https://www.lantus.com/dam/jcr:817aed9c-a677-4cd6-a6b3-d93d8aba629a/lantus-solostar-pen-guide.pdf, stated, ". . . HOW TO STORE YOUR OPENED LANTUS SOLOSTAR PEN . . . after 28 days, throw your opened Lantus pen away . . ." Review of information found at https://uspl.lilly.com/basaglar/basaglar.html#ug0, stated, ". . . BASAGLAR KwikPen . . . Do not use your Pen . . . for more than 28 days after you first start using the Pen. . . ." Observation on 09/14/22 at 9:24 a.m. showed a medication aide (#4) prepared Resident #15's Humalog insulin pen. The aide failed to disinfect the rubber seal on the pen prior to attaching the needle. Observation during review of the north medication cart on 09/14/22 at 9:37 a.m. showed Resident #1's Basaglar insulin pen and Resident #15's Lantus insulin pen showed both pens lacked an open and/or expiration date. During an interview on 09/14/22 at 2:35 p.m. an administrative nurse (#1) stated she expected staff to label insulin pens with expiration dates.	F 658	Quality Assurance program to ensure compliance. 5. 10/18/22 B. Insulin pens not being wiped off with an alcohol swab prior to putting the needle in place 1. Education provided immediately to staff directly involved. Education provided through the Communication tab in PCC to all staff who administer insulin using the pen. 2. All Residents requiring insulin have the potential to be affected by this practice. 3. Education provided on 10/6/22 specifically addressing how to wipe off the pen prior to placing the needle and giving the insulin. 4. The nursing department will complete audits looking at insulin pens to assure that they are wiped off prior to putting the needle on will be done weekly for two weeks, biweekly for two weeks, monthly for 2 months and as determined by the Quality Assurance program thereafter. All audits will be submitted to DON and presented to the Quality Assurance program to ensure compliance. 5. 10/18/22	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		10/18/22

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F 689	Continued From page 10 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and professional reference review, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 4 sampled residents (Resident #9) observed during gait belt transfers. Failure to properly use a gait belt during transfer placed the resident at risk of accidents and/or injury. Findings include: Review of the facility policy titled "Resident Handling/Transfers" occurred on 09/15/22. This policy, dated February 2022, stated, "It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury . . . Handling aids may include gait belts . . . Staff members are expected to maintain compliance with safe handling/transfer practices. . . ." Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 1126, stated, "Assisting a Client to Ambulate . . . If the client is a low safety risk . . . use a gait/transfer belt for standby assist as needed and assistive devices as needed . . . and 1-2 caregivers. Make sure the belt is pulled	F 689	1. Resident #9 immediately assess and care plan updated per nurse to reflect requiring a full body lift. Therapy did an eval 9-19-2022 which confirmed full body lift to be most appropriate transfer method. 2. All residents who have the potential to fluctuate in transfer ability have the potential to be affected. 3. Education, including demonstration was provided on Oct 6, 2022, on proper use of a gait belt transfer. Education also addressed steps to take if further evaluation is necessary. 4. Audits will be completed by the nursing department on gait belt transfers weekly for two weeks, biweekly for two weeks, monthly for 2 months and as determined by the Quality Assurance program thereafter. All audits will be submitted to DON and presented to the Quality Assurance program to ensure compliance. 5. 10/18/22	

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F 689	Continued From page 11 snugly around the client's waist and fastened securely. Grasp the belt at the client's back . . ." Review of Resident #9's medical record occurred on all days of survey. Diagnoses included repeated falls and abnormalities of gait and mobility. The care plan stated, "ADLS [activities of daily living]: I have, limited physical mobility r/t [related to] Disease Process . . . Refer to ADL sheet . . ." The ADL sheet, dated 09/13/22, stated, "Transfers . . . A1 [assist with one]." Refer to F657. Observation on 09/13/22 at 11:04 a.m. showed a certified nurse aide (CNA) (#2) and a nurse (#3) applied a gait belt loosely under Resident #9's breasts and assisted the resident to stand by pulling up with the gait belt with one hand and under the resident's axilla with the other hand. The gait belt slid upward over the resident's chest to the level of her neck. The staff members physically turned the resident and sat her in the recliner because she could not pivot her feet. The staff failed to tighten or readjust the gait belt with the transfer.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F 758		10/18/22

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F 758	Continued From page 12 (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced	F 758		

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F 758	Continued From page 13 by: Based on record review, facility policy review, and staff interview, the facility failed to ensure orders for as needed (PRN) psychotropic drugs were limited to 14 days for 1 of 5 sampled residents (Resident #21) reviewed for unnecessary medications. Failure to ensure the physician renewed the PRN order after 14 days may result in the resident receiving an unnecessary medication. Findings include: Review of the facility titled "PSYCHOTROPIC MEDICATION POLICY" occurred on 09/15/22. This policy, revised December 2021, stated, ". . . Psychotropic medications include: anti-anxiety, hypnotic, antipsychotic and antidepressant classes of drugs. . . . If a PRN antianxiety or antipsychotic medication is ordered, nursing staff will monitor the effects/side effects of the medication and observe frequency and time of day that the medication is given over a 1-2 week period. The physician should be notified at that time to schedule antianxiety medications or antipsychotic medications if needed. . . ." Review of Resident #21's medical record occurred on all days of survey. Diagnoses included dementia with Lewy bodies, psychotic disorder with delusions, and anxiety. Physician's orders included the following: * Start date 07/03/22, "Ativan Tablet 0.5 MG (LORazepam) [antianxiety] Give 0.5 mg [milligrams] by mouth every 8 hours as needed for agitation . . ." * Start date 07/15/22, "ZyPREXA Tablet (OLANZapine) [antipsychotic] Give 5 mg by	F 758	1. Unnecessary PRN psychotropic medication was discontinued for Resident # 21. The necessary PRN Zyprexa was evaluated by the provider in person on Oct 11th and was determined per provider on appropriateness to prevent resident from unnecessary ER trips and hospitalizations. PRN order remained in place and documented in the resident's chart. 2. All residents who have PRN psychotropic medications ordered have the potential to be affected by this practice. All residents who have PRN psychotropics were reviewed and providers were contacted for evaluation. 3. Education was provided on Oct 6, 2022, related to expectations of PRN psychotropic medication that isn't necessary to all staff. Ensure providers were updated on 10-11-2022 that all PRN psychotropic medication needs to continue to be reevaluated. If a PRN psychotropic medication is not appropriate after the initial 14 days, will update the provider and discontinue. If PRN order is necessary will work with provider to reevaluate to renew for an additional 14 days and document the providers evaluation on appropriateness. For PRN psychotropic medication will put in discontinue dates with the Point Click Care (EMR) to remove the option in the Medication Administration Record (MAR) to ensure the problem does not continue	

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F 758	Continued From page 14 mouth every 8 hours as needed for behaviors related to DEMENTIA WITH LEWY BODIES . . ." Resident #21's medical record lacked evidence the attending physician or prescribing practitioner evaluated the resident for the appropriateness of the medications after 14 days.	F 758	to recur. 4. Audits specifically focusing on unnecessary PRN psychotropic medications will be completed by the nursing department weekly for two weeks, biweekly for two weeks, monthly for 2 months and as determined by the Quality Assurance program thereafter. All audits will be submitted to DON and presented to the Quality Assurance program to ensure compliance. 5. 10/18/22	
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; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition	F 803		10/18/22

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F 803	Continued From page 15 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, policy review, review of menus, and staff interview, the facility failed to serve food according to prepared menus during 1 of 1 observation of tray line (noon meal on 09/14/22). Failure to serve food according to menus may result in inadequate nutrition and weight loss. Findings include: Review of the facility policy titled "Altered Portions" occurred on 09/15/22. This undated policy stated, ". . . Altered portion sizes will be served upon request however, small or double portions require a physician's order. . . . . Small portions are planned on the menu to meet nutritional needs. . . ." Observation of the noon meal tray-line on 09/14/22 showed the following portion sizes served to residents and what the menu required: * Regular diet - Wax beans: 3 ounce (3/8 cup). Staff served less than the menu's required amount of 1/2 cup. * Small diet - Roast beef: 1/2 slice (about 1.5 ounces). Staff served less than the menu's required amount of 2 ounces. During an interview on 09/14/22 during the noon	F 803	1. Education provided immediately to dietary cooks. Education provided face to face and through the Communication tab in PCC to all staff. 2. All residents have the potential to be affected by this practice. 3. Education was provided October 6th, 2022, on policy and procedures. Registered Dietitian provided specialize training on 10/13/2022 for dietary staff on portion control, including portion control on menu, correct portioning equipment, scoops, ladles, and scales. 4. Dietary manager and/or registered dietitian will conduct quality monitoring weekly for one month and monthly thereafter, to ensure that policy and procedures for portion control are maintained. All audits will be submitted to the Quality Assurance program to ensure compliance. 5. 10/18/22	

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F 803	Continued From page 16 meal, a dietary staff member (#5) stated for small portions she cuts the serving size in half. She stated the staff sliced the roast beef but didn't weigh the meat or know what a slice weighed. During an interview on 09/14/22 at 3:04 p.m., a dietary supervisor (#6) stated the staff should have weighed the meat slices to ensure a size of 3 ounces.	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure food is stored, prepared, and served in a sanitary manner for 2 of 2 kitchens (Main and Activity	F 812	1. Education provided immediately through the Communication tab in PCC to all staff.	10/18/22

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F 812	Continued From page 17 Room kitchen) and 2 of 2 nourishment stations (West and North). Failure to store food properly, maintain clean cooking/storage areas, use food by best by date, and label food may result in the spread of foodborne illness to residents, staff, and visitors. Findings include: Review of the following undated facility policies occurred on 09/15/22 and stated the following: * "Food Storage . . . Plastic container with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, . . . All containers must be legible and accurately labeled. . . . All refrigerator units are kept clean . . . All food should be covered, labeled and dated. All foods . . . will be consumed by their safe use by dates, or frozen (where applicable) or discarded. . . ." * "Cleaning Instructions: Ranges . . . The range will be cleaned after each use. Spills and food particles will be wiped up as they occur. . . ." * "Cleaning Instructions: Ovens . . . Ovens will be cleaned as needed and according to the cleaning schedule (at least once every two weeks). . . ." * "Cleaning Instructions: Microwave Oven . . . The microwave oven will be kept clean, sanitized and odor free. . . ." Observation of the main kitchen occurred on 09/12/22 at 11:20 a.m. and showed the following: - gas stove top and inner oven soiled with baked-on food and debris - counter/tray next to gas stove covered with food debris - three-door freezer with food debris/residue on inside floor	F 812	2. All residents have the potential to be affected. 3. Education was provided October 6th, 2022, on policy and procedures. Registered Dietitian provided specialize training on 10-13-2022: a. Staff will be in-serviced on policy and procedures for food storage, including sealing, labeling and dating, and discarding of outdated food. b. Dietary Staff will be in-serviced on policy and procedures for cleaning of kitchen equipment. The cleaning schedule will be updated by the dietary manager to insure daily, weekly and monthly cleaning and sanitation of kitchen, nourishment and activity areas. 4. Dietary manager and/or Registered Dietitian will conduct quality monitoring for food storage and cleaning of kitchen, nourishment, and activity areas weekly for one month, and monthly thereafter to ensure that policies and procedures for food storage, preparation, and service are maintained. All audits will be submitted to the Quality Assurance program to ensure compliance. 5. 10/18/2022	

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F 812	Continued From page 18 - one can of 50-ounce cream of chicken soup with a "Best By" date of 12/16/21 and five cans with "Best By" dates of 05/13/22, with one can dented on top seam - open/folded over bag of Spanish rice in a 36-ounce box with spilled rice covering the bottom of the box. The rice lacked an open date. - box with eight sprouted potatoes The dietary tour occurred on 09/14/22 at 3:04 p.m. with a dietary supervisor (#6). Observation showed the following: * Main Kitchen: - three-door freezer continued to have food debris/residue on the inside floor. The dietary supervisor stated she "might have missed" this pantry freezer when she updated the cleaning schedules. She later verified the cleaning list lacked this freezer. - gas stove top, oven, and counter/tray remained soiled - The dietary supervisor stated staff "do first in, first out" with new deliveries and wrote the date on the can when received. The cream of chicken cans with the Best By dates of 12/16/21 and 05/13/22 contained receipt dates of 01/30/22 and 06/18/22 respectively. The dietary supervisor was uncertain why staff accepted the cans as they would typically return outdated, broken or dented cans. - a precooked ham in the walk-in refrigerator lacked a date when taken from the freezer. * Activity Room kitchen: - undated and open unsealed bags of brown sugar, chocolate chips, white sugar, and box of baking soda - undated container of liquid butter alternative	F 812		

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F 812	Continued From page 19 - undated and unlabeled clear plastic container of white substance, identified by the dietary supervisor as sugar - expired jar of marshmallow cream, with date of 06/03/22 * West Nourishment station: - microwave soiled on inside - four containers of ready-to-eat jello with expiration dates of 08/29/21. * North Nourishment station: - microwave soiled and peeling paint on inside - bottom of oven soiled - two containers of ready-to-eat jello with expiration dates of 08/29/21. During an interview on 09/15/22 at 1:15 p.m., a dietary supervisor (#6) stated the facility had no policy on discarding potatoes and they are to use their best judgement. She confirmed the sprouting potatoes should have been discarded.	F 812		