STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	C 09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY LIVING AND REHABILITATION CENTER	1000 S DOUGLAS HWY GILLETTE, WY 82716

(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 A complaint survey was conducted by Healthcare Licensing and Surveys on 9/19/23 through 9/22/23. The survey was prompted by complaint intakes WY000003665, WY000003668, WY000003670, WY000003673, and WY000003675. In addition, a COVID-19 focused infection control survey, which included a review of emergency preparedness requirements, was conducted by Healthcare Licensing and surveys from 9/19/23 to 9/22/23. Based on the findings of the survey team, it was determined that no deficiencies were identified pertaining to the infection control survey. The following common abbreviations are used throughout this document: DON- Director of Nursing Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.	F 585		11/6/23

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

Electronically Signed | 10/16/2023

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F 585	Continued From page 1 §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations	F 585		

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by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than

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F 585	Continued From page 3 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, resident, resident representative, and staff interview, grievance review, and policy and procedure review, the facility failed to ensure prompt efforts were made to resolve grievances for 3 of 5 sample residents (#1, #2, #3) who submitted a grievance to the facility. The findings were: 1. Review of the quarterly MDS assessment dated 8/24/23 showed resident #1 had a brief interview for mental status (BIMS) score of 13 out of 15, which indicated s/he was cognitively intact, and diagnoses which included diabetes mellitus. Further review showed the resident was independent with set-up help for eating. The following concerns were identified: a. Review of a "Compliments/Complaints/Concerns Report" dated 8/26/23 showed the resident notified the facility related to meal trays "always" missing items, no snacks in the refrigerator, and the kitchen was "always" out of "something." The follow-up action showed the facility spoke with the resident and the nutrition team about menu cards. The nutrition team was to put all items on the tray which were marked on the cards and fill out the cards completely to prevent missing items. There was no evidence the facility resolved the concern or notified the resident. b. Review of a "Compliments/Complaints/Concerns Report" dated 8/29/23 showed the resident skipped lunch due to service being late and s/he did not want to miss Bingo. Further review showed follow-up action taken was nutrition team communication	F 585	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: By Oct 13th, Residents #1, #2, #3 received in-person updates from the Facility Director and the Director of Admissions & Community Relations regarding their grievances. The diet card for Resident #3 was updated on Sep 29th to reflect preferences. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Any residents/representatives who filed a grievance are at risk. To identify those who did not receive satisfactory follow-up and resolution, the NHA reviewed last 6 months (April 2023 to Oct 2023) of the grievance log and documentation with Director of Admissions and Community Relations. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Grievance forms are available throughout the community for staff and residents/families to utilize. Once a form is filled out it will be taken to morning meetings to discuss as a team and add to log. Each day the grievance will be discussed until resolution is complete. The NHA will review and sign off on each	

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F 585	Continued From page 4 about setting up the tray line sooner and working to start a new communal dining process. There was no evidence the facility resolved the concern or notified the resident. c. Review of a "Compliments/Complaints/Concerns Report" dated 4/12/23 showed the resident notified staff s/he was "very upset" and had not received lunch by 1 PM. Review of the follow-up action showed on 5/9/23 the resident reported the concerns had not been corrected. The resident reported at 12:50 PM, on that day, s/he went to his/her hair appointment without eating due to the meal tray not being served by 12:50 PM. There was no evidence the facility resolved the concern or notified the resident. d. Interview with the resident on 9/19/23 at 3 PM confirmed s/he had voiced concerns about the meals and meal service; however, the only response s/he had received was "I'm sorry" for the last 3 months and the issues continued to happen. e. Interview with the resident representative for resident #1 on 9/20/23 at 10:26 AM revealed she had reported several concerns to the facility and did not receive any communication of resolution. The representative indicated concerns were related to meals, meal service, and staff's treatment of the resident. The resident representative revealed she reported a concern about a nurse telling the resident "I have more things to do than come take your blood pressure" when the resident requested his/her blood pressure to be obtained. Further interview revealed the facility's response to everything was "We're doing the best we can and you need to be patient." Review of a "Compliments/Complaints/Concerns Report" dated 6/12/23 showed a concern was made	F 585	grievance. The NHA/Designee will audit 100% of grievances weekly x 4 weeks and monthly x 2 months to ensure that grievances are resolved and communicated to resident and/or representative. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The NHA/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and take corrective action as needed.	

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regarding the nurse to resident interaction; however, the resident representative was not listed as the reporting person. Further review showed no evidence the resident's representative was notified of resolution of the concern.

f. Observation of meal service on 9/20/23 at 5:35 PM showed the resident's meal card indicated the resident ordered a chef salad with turkey and ham. Observation of the salad provided to the resident, at that time, showed no ham or turkey was on the salad. Nursing staff reported other residents had meat on their salads and the resident requested ham and turkey to dietary staff member #1, who responded "It's all I have." Interview with the resident on 9/20/23 at 5:40 PM revealed after the salad was delivered, staff said the facility did not have ham and turkey. Further interview revealed the resident did not understand why meal delivery took so long for a salad and revealed the facility staff did not offer an alternative meal.

g. Interview with dietary staff member #1 on 9/20/23 at 5:52 PM revealed the resident's salad did not have meat because, she brought 2 salads with meat and 2 salads without meat to the unit for meal service. When she began getting the resident's meal ready for service, only salads without meat were left.

h. Interview with the facilities director on 9/21/23 10:18 AM revealed there was ham and turkey available in the kitchen and staff should have called down to the kitchen to get some for the resident's salad.

2. Review of the quarterly MDS assessment dated 7/14/23 showed resident #2 had a BIMS score of 15 out of 15, which indicated s/he was cognitively intact, and diagnoses which included Asthma, COPD or chronic lung disease,

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respiratory failure, and tracheostomy. Further review showed the resident was independent with eating. The following concerns were identified:

a. Review of a "Compliments/Complaints/Concerns Report" dated 8/7/23 showed "Another report on 8/9 that is attached to this grievance." Review of a progress note dated 8/5/23 and timed 1:14 PM, which was attached to the report, showed "During lunch, this nurse received a phone call from [staff name] in kitchen asking if resident had received [his/her] lunch tray and that the Butterscotch pudding had yellow dye in it, which is one of this residents [sic] allergies. Resident had begun to eat [his/her] meal; as this nurse approached, another kitchen staff had already taken the resident's lunch tray, but the container of butterscotch pudding was left with resident. This nurse explained situation to resident, who immediately stopped eating and [s/he] said [s/he] had only had 2 bites of it. Resident declined to have the rest of tray brought back up to finish. Later, [staff name] from kitchen came up to speak directly with resident regarding incident and asked this nurse to accompany her during discussion. Kitchen staff apologized to resident for mistake and offered to bring a meal up if [s/he] was still hungry. Resident declined and also expressed [his/her] frustration and how upset [s/he] was at the incident and allergies can be serious." Review of a progress note dated 8/9/23 and timed 2:41 PM, which was attached to the report, showed "This resident approached nurses station to report to this nurse [s/he] had been served "black pepper" on [his/her] meat on [his/her] lunch tray. Nutrition staff were already alerted and aware of what had occurred. Resident reported "[s/he] felt as though [his/her] tongue was swelling." No tongue, throat, mouth,

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etc. swelling noted upon visual exam. Discussed doing [his/her] breathing treatments in [his/her] room and perhaps trying a Benadryl. On call provider called and received a one time order for 50 mg of Benadryl. Given at 1330. Checked on resident at 1430 and resident reports [s/he] feels "ok", the tongue swelling sensation is still there, but [his/her] breathing is ok and [s/he] will alert staff for any other needs or symptoms." There was no evidence the facility resolved the concern or notified the resident.

b. Review of a "Compliments/Complaints/Concerns Report" dated 8/10/23 showed the resident reported s/he had tongue swelling due to items received which s/he was allergic to. The follow up action showed "spoke with resident on changes coming. Spoke with nutrition supervisor on changing the swarm technique to several eyes on plates to look for allerigies [sic] before the [sic] send it. Spoke with supervisor of the importance of allergies." There was no evidence the facility resolved the concern.

c. Review of a "Compliments/Complaints/Concerns Report" dated 8/21/23 showed the resident reported concerns of allergens being served on his/her meals on 8/12/23, 8/16/23, and 8/20/23. The resident reported having hives in his/her mouth, tongue swelling, and trouble breathing. The resident indicated s/he had reported concerns previously; however, s/he did not feel it was resolved as it continued to happen. The follow-up action taken showed an allergy action plan was created and the facility spoke with the resident about a plan moving forward. Further review showed each station in nutrition has allergy cards and "call-outs" were being conducted on the tray line. There was no evidence the facility resolved the concern.

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d. Review of a "Compliments/Complaints/Concerns Report" dated 8/30/23 showed the resident was served a lemon poppy seed muffin and the resident was allergic to lemon. Further review showed the follow-up action taken was communication with the nutrition team about serving the resident citrus, communication with the resident about gluten free options, and ordering new gluten free options for the week of September 4th. There was no evidence the facility resolved the concern.

e. Interview with the resident on 9/20/23 at 11:20 AM confirmed s/he had voiced concerns related to meals and receiving items s/he was allergic to. The resident revealed s/he was "tired of hearing I'm sorry" and feels staff think s/he is "old and stupid." Further interview confirmed the resident had allergic reactions to meals on 8/16/23 and 8/20/23.

3. Review of a "Compliments/Complaints/Concerns Report" dated 9/6/23 showed the representative for resident #3 reported the resident received a "very dry hamburger" on 9/5/23. The representative said the hamburger was difficult to cut and the resident received a piece of bread to eat as an alternative. The representative indicated on 9/6/23 the resident received a plate with mashed potatoes and gravy, a side of cold diced potatoes, and roast beef. The representative indicated the resident requested no gravy and did not eat any of the meal. Further review showed no response, follow-up action taken, or resolution by the facility and there was no evidence the facility resolved the concern or notified the resident representative.

4. Interview with the grievance official on 9/21/23

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at 10:27 AM revealed when a resident voiced a concern staff were to notify their supervisor who would interview the resident and document the concern. The supervisor should attempt to resolve the concern. Anyone who completes a concern can drop it in the grievance box where it would be forwarded to the appropriate supervisor. The grievance official revealed concerns were reviewed in a morning meeting and supervisors had 5 days to return the concern to her to for resolution. Further interview revealed all concerns should have documented resolution, resolution should be communicated to the individual who reported it, and the concerns should be resolved within 10 days of the grievance.

5. Review of the policy titled "Subject: Grievance-Legacy" last reviewed on 9/25/22 showed "...Upon receipt of a Grievance and Complaint Report or Complaint Concern form, the Social Services Director or designee will begin an exploration into the allegations/concerns. The appropriate department director will be notified of the nature of the complaint and that follow up is necessary. The investigation and report will include, as each may apply: A. The date and time the incident took place B. The circumstances surrounding the incident C. Where the incident took place D. The names of any witnesses and their account of the incident E. The resident's account of the incident F. The employee's account of the incident G. Accounts of any individual involved (i.e., employee's supervisor, etc.) H. Recommendations for corrective action if not already remedied...The Grievance and Complaint Investigation Report must be filed with the administrator within five (5) working days of the receipt of the grievance or complaint form...The resident, or person acting on behalf of

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F 585	Continued From page 10 the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within ten (10) working days of the filing of the grievance or complaint..."	F 585		
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident, resident representative and staff interview, medical record review, and policy and procedure review, the facility failed to ensure sufficient food was available that was nourishing, palatable, and well balanced with consideration for preferences for 4 of 6 sample residents (#1, #2, #3, #4) who had reported food and meal service concerns. The findings were: 1. Review of the quarterly MDS assessment dated 8/24/23 showed resident #1 had a brief interview for mental status (BIMS) score of 13 out of 15, which indicated s/he was cognitively intact, and diagnoses which included diabetes mellitus. Further review showed the resident was independent with set up help for eating. The following concerns were identified: a. Review of a "Compliments/Complaints/Concerns Report" dated 8/26/23 showed the resident notified the facility related to meal trays "always" missing items, no snacks in the refrigerator, and the	F 800	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On Sept 21st, the Facility Director posted recipe for chef salads in cold prep area of kitchen (Resident #1). Oven performance assessed and two ovens were repaired the week of Sept 25th (Residents #2, #3). Integrated nursing department into formal meal service process to improve quality and experience of meal service. This was implemented on Birch neighborhood on Oct 6th; implementation on Spruce neighborhood will begin on Oct 16th (Residents #1, #2, #3, #4). Nutrition supervisor at time of survey was found to be noncompliant with kitchen processes and put on a plan for performance improvement. This supervisor opted to resign; two new supervisors hired from within for their demonstrated adherence to kitchen and	11/6/23

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F 800	Continued From page 11 kitchen was "always" out of "something." The follow-up action showed the facility spoke with the resident and the nutrition team about menu cards. The nutrition team was to put all items on the tray which were marked on the cards and fill out the cards completely to prevent missing items. b. Review of a "Compliments/Complaints/Concerns Report" dated 9/12/23 showed the resident reported when s/he received his/her meal, it was not what s/he had on the menu and was "not fit to eat." c. Review of a "Compliments/Complaints/Concerns Report" dated 5/10/23 showed the resident was "carrying around a piece of meat to show staff how it was not edible." Review of a note attached to concern showed "I inspected the product [s/he] stated was inedible, apologized and asked if we could make another meal for [him/her]. [S/he] declined any other meal options at that time. Upon further discussion and inspection of the food [s/he] received, I determined that [his/her] main protein was overcooked. I apologized, and explained the scenarios that could have led to this..." d. Interview with the resident on 9/19/23 at 3 PM confirmed s/he had voiced concerns about the meals and meal service; however, the only response s/he had received was "I'm sorry" for the last 3 months and the issues continued to happen. Further interview revealed the hot foods were often served cold and s/he did not receive all items s/he had indicated on the meal card. e. Interview with the resident representative for resident #1 on 9/20/23 at 10:26 AM revealed she felt there was a disconnect in food service which began 8 months earlier. The representative indicated food was served lukewarm and staff did not want to deliver trays to resident rooms.	F 800	meal service expectations. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Assumed that all residents are potentially affected by survey concerns. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Integration of nursing into meal service optimizes current staff in ways that mitigate shortages and improve the quality of meal service through the following: - "Expediting: one staff member reading resident meal card out loud to the staff member plating the food in order to limit distractions and ensure there are no missing items or inappropriate foods served. - Once plated, staff member who read the card will cover the food to maintain temperature and deliver the meal. - Nursing staff being trained in: temperature control, portion sizes, infection prevention, identifying special diets and/or requests, offering alternative meals if resident is not pleased with their meal. Training of current nursing staff will be completed by November 6th, to include visual and written aides. This training will be incorporated into onboarding and annual competencies. - Nutrition supervisor, NHA/designee, Facility Director/designee will audit quality of meal service via in-person observation and resident interview during meal times. In-person observation will include portion	

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F 800	Continued From page 12 Further interview revealed on the weekends, she had to order food from outside the facility for the resident because, food was served cold or no food was provided. f. Observation of meal service on 9/20/23 at 5:35 PM showed the resident's meal card indicated the resident ordered a chef salad with turkey and ham. Observation of the salad provided to the resident, at that time, showed no ham or turkey was on the salad. Nursing staff reported other residents had meat on their salads and the resident requested ham and turkey to dietary staff member #1, who responded "It's all I have." Interview with the resident on 9/20/23 at 5:40 PM revealed after the salad was delivered, staff said the facility did not have ham and turkey. Further interview revealed the resident did not understand why meal delivery took so long for a salad and revealed the facility staff did not offer an alternative meal. g. Interview with dietary staff member #1 on 9/20/23 at 5:52 PM revealed the resident's salad did not have meat because she brought 2 salads with meat and 2 salads without meat to the unit for meal service. When she began getting the resident's meal ready for service, only salads without meat were left. h. Interview with the facilities director on 9/21/23 10:18 AM revealed there was ham and turkey available in the kitchen and staff should have called down to the kitchen to get some for the resident's salad. 2. Review of an admission MDS assessment dated 8/23/23 showed resident #4 had a BIMS score of 15 out 15, which indicated s/he was cognitively intact, and diagnoses which included diabetes mellitus and muscle wasting and atrophy. Further review showed the resident was	F 800	control, infection prevention practices, temperature control, and fidelity to the meal card. Resident interview will include questions on temperature, taste, if they received the food/condiments requested, if they were offered an alternative if they were not satisfied with any of the items. Audit will consist of 10% of residents weekly x 4 weeks then monthly x 2 months. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The NHA/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and take corrective action as needed.	

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independent with set up help for eating. The following concerns were identified:

a. Review of a "Compliments/Complaints/Concerns Report" dated 6/27/23 showed the resident reported s/he did not receive dinner on 6/25/23. Review of a "Compliments/Complaints/Concerns Report" dated 6/25/23, which was attached to the 6/27/23 concern, showed the resident reported bread is never toasted, the facility did not send condiments, and not everything is served to residents.

b. Interview with the resident on 9/20/23 at 11:36 AM revealed at times s/he received trays with no food, only fluids. The resident revealed the food was served cold and s/he seldom received food s/he ordered. The resident revealed s/he once ordered a hot dog and when it came, there was no bun or condiments and for breakfast s/he received two sausage links and nothing else. The resident confirmed s/he had filed grievances; however, s/he felt nothing got done. The resident revealed the facility's response was "Be patient, it's going to get better." Further interview revealed when staff attempted to call the kitchen for additional items, nobody in the kitchen would answer the phone.

c. Interview with the resident on 9/20/23 at 6:10 PM revealed the pizza served for dinner was burnt and no alternative meal was offered. Observation at that time showed the resident had difficulty folding the pizza crust and when s/he did, the crust crumbled. Further observation showed the crust was dark brown in color.

3. Review of the quarterly MDS assessment dated 7/14/23 showed resident #2 had a BIMS score of 15 out of 15, which indicated s/he was cognitively intact, and diagnoses which included

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Asthma, COPD or chronic lung disease, respiratory failure, and tracheostomy. Further review showed the resident was independent with eating. The following concerns were identified:

a. Interview with resident #2 on 9/20/23 at 11 AM revealed the meat served at the facility was dry and created a choking hazard for him/her and food was either burnt or raw when it was served. The resident revealed the facility recently had door dash deliver food for residents at 9 PM. Further interview revealed sometimes residents received alternative meals and sometimes they did not.

b. Interview with the resident on 9/20/23 at 6:10 PM revealed the pizza s/he had received had a good flavor; however, it was cold.

4. Review of the admission MDS assessment dated 8/1/23 showed resident #3 had a BIMS score of 5 out 15, which indicated severe cognitive impairment, and diagnoses which included malnutrition and endocrine nutritional and metabolic disease. Further review showed the resident required supervision of 1 person for eating. The following concerns were identified:

a. Review of a "Compliments/Complaints/Concerns Report," completed by a staff member, dated 8/25/23 showed resident #3 reported s/he got "the worst food" and his/her food was "always cold." Further review showed "this nurse did assess resident's burger that [s/he] saved and it did appear to be very burnt. Resident's daughter asked if she could put a microwave in [his/her] room to solve [his/her] cold food issues."

b. Review of a "Compliments/Complaints/Concerns Report" dated 9/6/23 showed the representative for resident #3 reported the resident received a "very

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dry hamburger" on 9/5/23. The representative said the hamburger was difficult to cut and the resident received a piece of bread to eat as an alternative. The representative indicated on 9/6/23 the resident received a plate with mashed potatoes and gravy, a side of cold diced potatoes, and roast beef. The representative indicated the resident requested no gravy and did not eat any of the meal.

5. Interview with the administrator and facilities director on 9/21/23 at 10:18 AM revealed they expected meals to be served with the right food, at the right time, with the right items, the right quality, and to be palatable. They revealed staff should offer residents an alternative meal if the resident did not like the meal or did not eat the meal and if the requested item was not available. Further interview confirmed on 9/10/23 the facilities manager was working in the kitchen during the morning and he left because he was ill. As a result, the lunch meal was late and the DON had to door dash meals for 4 residents.

6. Review of policy titled "Subject: Meal Preparation" last revised on 4/2022 showed "Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; food that is palatable, attractive, and at the proper temperature...5. Cold food may be prepared in bulk but distributed or served in batches for appropriate cold (temperature) retention...7. Meal service is timed for tray/cart delivery within reasonable time limits to preserve temperature and quality food...Optimal Conditions...2. Food is held in appropriate heat and service equipment, not on a steam table or held for more than 30 minutes..."

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F 800	Continued From page 16 7. Review of a policy titled "Subject: Meal Substitutions" last revised 4/2022 showed "Each resident receives and the facility provides substitutions offered of similar nutritive value to residents who refuse food served...1. Alternative entrees or always available foods/meals are available for resident's selection...4. If a meal component is refused, a similar alternative is offered. If consistently refused, the RD is notified to assure nutritional status is not affected...6. Food dislikes are detailed and listed in resident's tray card and in office files for reference..." 8. Review of the policy titled "Subject: Meal Service Standards" last revised on 4/2022 showed "...Residents should be served within 30 minutes of arrival in the dining room...30 minutes from the start of mealtimes, residents should have a meal...Keys to meeting this requirement: 1. Act upon reasonable requests from our residents...3. Serve residents quickly to assure hot food is hot and cold food does not warm excessively. 4. Offer reasonable alternatives and accommodation for residents...14. Never deny food or beverage to a resident for any reason. If food is unavailable, explain and try to offer a reasonable substitute	F 800		
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population	F 802		11/6/23

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F 802	Continued From page 17 in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, resident, resident representative, and staff interview, email review, and policy and procedure review, the facility failed to ensure adequate staffing in 1 of 1 kitchen (main kitchen). The census was 106. The findings were: 1. Observation of the 5 PM scheduled meal on 9/20/23 showed dietary staff member #1 arrived on the Birch unit with the steam table at 5:07 PM and began setting up for the meal. Continued observation showed the dietary staff member began meal service at 5:18 PM while 5 nursing staff members waited to pass resident trays. At 5:40 PM, a chef salad without the meat, was served to resident #1. Interview with the resident at that time revealed s/he did not understand why it took so long to deliver a salad which was prepared incorrectly. Meal service was completed on the Birch unit at 6:01 PM. 2. Review of a "Compliments/Complaints/Concerns Report" dated 4/12/23 showed resident #1 notified staff s/he was "very upset" and had not received lunch	F 802	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Initiated the inclusion of the nursing department into the meal service process to offset effects of staffing shortage in Nutrition. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Assumed that all residents are potentially affected by survey concerns. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: At time of survey, the Director had been covering all shifts as needed, and a hiring team for Nutrition focused on recruitment. Since survey, an ineffective supervisor vacated their position and two new supervisors were hired and are currently being trained. Also hired since survey: two	

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by 1 PM. Review of the follow-up action taken showed on 5/9/23 the resident reported the concerns had not been corrected. The resident reported at 12:50 PM, on that day, s/he went to her hair appointment without eating due to the meal tray not being served by 12:50 PM. Further review showed no actions taken to resolve the concern.

3. Review of a "Compliments/Complaints/Concerns Report" dated 8/16/23 showed the resident representative for resident #6 reported the resident was unhappy with the food and "on Sunday" the resident did not get a dinner tray. When the resident inquired about a dinner tray, s/he was told the kitchen thought s/he was out of the building. Further review showed the follow up action did not include any response related to the resident not getting a meal tray except "...called [representative's name] and expressed to him my apologies..."

4. Review of a "Compliments/Complaints/Concerns Report" dated 8/25/23 showed resident #3 reported s/he got "the worst food" and his/her food was "always cold." Further review showed the follow-up action included "Spoke with nutrition team about monitoring quality of food. Working on communal dining process to help eliminate food sitting for a length of time in a cart."

5. Review of a "Compliments/Complaints/Concerns Report" dated 8/29/23 showed resident #1 skipped lunch due to service being late and s/he did not want to miss Bingo. Further review showed follow-up action taken was nutrition team communication

cooks (there was only one at time of survey), five food service workers/dishwashers, and four temporary staff obtained via local agency.
Integrating nursing staff into meal service (1) eliminates dependence on labor-intensive kitchen tray line, (2) allows current Nutrition staff to improve their processes surrounding meal service, such as stocking, preparations, and cleaning, and (3) optimizes the function of available nursing staff.
Beecan-Vivage, Legacy operations manager, will be on-site the week of Oct 23rd to assist in development of standardized processes and expectations of quality. These processes will be kept in a location easily accessed by non-Nutrition leadership in the event of significant call-offs or other event that necessitates non-Nutrition staff to prepare and deliver food. To prevent failures in quality when the Director is absent, by November 6th, 2023, the three supervisors (two are new) will be trained and demonstrate competencies in kitchen processes, quality expectations, and safe/timely provision and storage of food.
Facility Director/designee will review schedule for sufficient staff at a minimum of once a week ongoing. If there are gaps in the schedule that cannot be covered from within the department, the Director/designee will work with the NHA/designee to close gaps with staff from another department as well as ensure the necessary resources for those staff (such as availability and/or review of written processes, finding opportunity for

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F 802	Continued From page 19 about setting up the tray line sooner and working to start a new communal dining process. 6. Review of a "Compliments/Complaints/Concerns Report" dated 9/10/23 showed the representative for resident #1 reported "Lunch not served by time of call (1355 [1:55 PM]) on Sunday 9/10. No explanation, no idea what time meal will be served..." Further review showed the follow up action included "On 9/10/23 meals went out at 12:04 PM. We have since implemented communal dining which improves residents [sic] satisfaction and meal times. Resident chooses to remain in [his/her] room. Timing of nutrition staff was prolonged due to staffing shortages." 7. Review of a "Compliments/Complaints/Concerns Report" dated 9/12/23 showed resident #1 reported his/her lunch wasn't what s/he had on the menu and was "not fit to eat." When asked if the resident wanted to fill out a concern form, s/he stated "it doesn't do any good anyway" and no one has followed up with me about any of my concern forms." Further review showed the follow-up action included "I, [staff name], have followed up with resident any time I know of concern. On 9/12/23 we implemented a menudo [sic] to staffing shortages. (With approval), we followed recipes and timing provided. We provided resident with the main meal." 8. Interview with resident #1 on 9/19/23 at 3 PM confirmed meals were often late and the resident did not get all items s/he indicated on the meal card. 9. Interview with the resident representative for	F 802	hands-on training prior to filling the gap). If needed, NHA/designee will also request staff from local staffing agency. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The NHA/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and take corrective action as needed.	

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resident #1 on 9/20/23 at 10:26 AM revealed she felt there was a disconnect in food service which began 8 months earlier. The representative indicated food was served lukewarm and staff did not want to deliver trays to resident rooms. Further interview revealed on the weekends she had to order food from outside the facility for the resident because, food was served cold or no food was provided.

10. Interview with resident #4 on 9/20/23 at 11:36 AM confirmed food was delivered cold and at times there was no food served to him/her until s/he asked staff about it.

11. Interview with resident #5 on 9/20/23 at 11:54 AM confirmed meals were late at times.

12. Interview with resident #2 on 9/20/23 at 12:05 PM revealed the facility recently had to use door dash to deliver food for residents at 9 PM.

13. Review of an email from the administrator to the ombudsman dated 9/19/23 and timed 7:55 PM showed "...Thank you for reaching out about concerns with our nutrition department. We have several items we are working on regarding that service, and it involves several domains. Situation: Resident meals have not met expectations in timing, taste, temperature..." Further review showed "...Assessment of Issue with Description of interventions: Understaffing is the primary root cause, cascading into other vulnerabilities. We have 57% of required staff. One is out with a significant medical issue. Two will be going on FMLA shortly. We also have a COVID outbreak that includes one Nutrition staff. This puts us having 38% of required staff. Manager working 16-20 hours a day to cover

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vacancies, having only 2 days off since his start date of July 24th...On Sept 10th, leader worked in the morning but left before lunch due to fatigue which turned out to be illness. His absence in context of massive shortage resulted in lunch and dinner being late..."

14. Interview with the administrator on 9/20/23 at 6:30 PM confirmed the facility had insufficient staffing in the kitchen.

15. Interview with the administrator and facilities director on 9/21/23 at 10:18 AM confirmed scheduled meal start times were 7 AM, 11 AM, and 5 PM. They revealed they expected meals to be served with the right food, at the right time, with the right items, the right quality, and to be palatable. They revealed the facility had been unable to provide all the resources dietary staff need. They confirmed that on 9/10/23 the facilities manager was working in the kitchen during the morning and he left because he was ill. As a result, the lunch meal was late and the DON had to door dash meals for 4 residents. They revealed they are using an agency to find staff due to 43% of their dietary staff positions were open; however, the agency has been unsuccessful in recruiting staff.

16. Review of the policy titled "Subject: Sufficient Staff" last revised on 4/2022 showed "...The facility must employ sufficient support personnel competently to carry out the functions of the dietary department...Staff are scheduled and available during all hours of operation of the dietary department...1. Staff schedules are written in advance with ample hours for appropriate food preparation and service at all meals..."

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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 802	Continued From page 22 17. Review of the policy titled "Subject: Meal Service Standards" last revised on 4/2022 showed "...Residents should be served within 30 minutes of arrival in the dining room...30 minutes from the start of mealtimes, residents should have a meal...Keys to meeting this requirement: 1. Act upon reasonable requests from our residents...3. Serve residents quickly to assure hot food is hot and cold food does not warm excessively. 4. Offer reasonable alternatives and accommodation for residents...14. Never deny food or beverage to a resident for any reason. If food is unavailable, explain and try to offer a reasonable substitute.	F 802		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and policy and procedure review, the facility failed to ensure palatable food was served to 4 of 6 residents (#1, #2, #3, #4) reviewed with food related concerns. The census was 106. The findings were: 1. Review of the quarterly MDS assessment dated 8/24/23 showed resident #1 had a brief interview for mental status (BIMS) score of 13 out	F 804	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Kitchen ovens assessed the week of September 25th and found in need of repairs; repairs completed. Two experienced cooks hired since survey. At time of survey, only one cook was employed and was having significant	11/6/23

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	535022	A. BUILDING _____ B. WING _____	C 09/22/2023

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F 804	Continued From page 23 of 15, which indicated s/he was cognitively intact, and diagnoses which included diabetes mellitus. Further review showed the resident was independent with set up help for eating. The following concerns were identified: a. Review of a "Compliments/Complaints/Concerns Report" dated 5/10/23 showed the resident was "carrying around a piece of meat to show staff how it was not edible." Review of a note attached to concern showed "I inspected the product [s/he] stated was inedible, apologized and asked if we could make another meal for [him/her]. [S/he] declined any other meal options at that time. Upon further discussion and inspection of the food [s/he] received, I determined that [his/her main protein was overcooked. I apologized, and explained the scenarios that could have led to this..." b. Review of a "Compliments/Complaints/Concerns Report" dated 9/12/23 showed the resident reported when s/he received his/her meal, it was not what s/he had on the menu and was "not fit to eat." c. Interview with the resident on 9/19/23 at 3 PM confirmed s/he had voiced concerns about the meals and meal service; however, the only response s/he had received was "I'm sorry" for the last 3 months and the issues continued to happen. Further interview revealed the hot foods were often served cold. 2. Review of an admission MDS assessment dated 8/23/23 showed resident #4 had a BIMS score of 15 out 15, which indicates s/he was cognitively intact, and diagnoses which included diabetes mellitus and muscle wasting and atrophy. Further review showed the resident was independent with set up help for eating. The following concerns were identified:	F 804	health issues. Addition of two experienced cooks facilitates the provision of palatable food. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Assumed that all residents are potentially affected by survey concerns. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: - Nursing staff being trained in: temperature control, portion sizes, infection prevention, identifying special diets and/or requests, offering alternative meals if resident is not pleased with their meal. Training of current nursing staff will be completed by November 6th, to include visual and written aides. This training will be incorporated into onboarding and annual competencies. - Nutrition supervisor, NHA/designee, Facility Director/designee will audit quality of meal service via in-person observation and resident interview during meal times.In-person observation will include portion control, infection prevention practices, temperature control, and fidelity to the meal card. Resident interview will include questions on temperature, taste, if they received the food/condiments requested, if they were offered an alternative if they were not satisfied with any of the items. Audit will consist of 10% of residents weekly x 4 weeks then monthly x 2 months. - Facility Director/designee will assess	

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F 804	Continued From page 24 a. Interview with the resident on 9/20/23 at 6:10 PM revealed the pizza served for dinner was burnt and no alternative meal was offered. Observation at that time showed the resident had difficulty folding the pizza crust and when s/he did, the crust crumbled. Further observation showed the crust was dark brown in color. 3. Review of the quarterly MDS assessment dated 7/14/23 showed resident #2 had a BIMS score of 15 out of 15, which indicated she was cognitively intact, and diagnoses which included Asthma, COPD or chronic lung disease, respiratory failure, and tracheostomy. Further review showed the resident was independent with eating. The following concerns were identified: a. Interview with resident #2 on 9/20/23 at 11 AM revealed the meat served at the facility was dry and created a choking hazard for him/her and food was either burnt or raw when it was served. Further interview revealed sometimes residents received alternative meals and sometimes they did not. b. Interview with the resident on 9/20/23 at 6:10 PM revealed the pizza s/he had received had a good flavor; however, it was cold. 4. Review of the admission MDS assessment dated 8/1/23 showed resident #3 had a BIMS score of 5 out 15, which indicated severe cognitive impairment, and diagnoses which included malnutrition and endocrine nutritional and metabolic disease. Further review showed the resident required supervision of 1 person for eating. The following concerns were identified: a. Review of a "Compliments/Complaints/Concerns Report," completed by a staff member, dated 8/25/23 showed resident #3 reported s/he got "the worst	F 804	palatability via audit of meal trays. One meal tray will be audited weekly x 4 weeks, then monthly x2 months. Audit will include time meal left kitchen to time it reaches resident and the temperature of food items when resident receives it. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The NHA/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and take corrective action as needed.	

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F 804	Continued From page 25	F 804		

food" and his/her food was "always cold." Further review showed "this nurse did assess resident's burger that [s/he] save and it did appear to be very burnt. Resident's daughter asked if she could put a microwave in [his/her] room to solve [his/her] cold food issues."

b. Review of a "Compliments/Complaints/Concerns Report" dated 9/6/23 showed the representative for resident #3 reported the resident received a "very dry hamburger" on 9/5/23. The representative said the hamburger was difficult to cut and the resident received a piece of bread to eat as an alternative. The representative indicated on 9/6/23 the resident received a plate with mashed potatoes and gravy, a side of cold dice potatoes, and roast beef. The representative indicated the resident requested no gravy and did not eat any of the meal.

5. Interview with the administrator and facilities director on 9/21/23 at 10:18 AM revealed they expected meals to be served with the right food, at the right time, with the right items, the right quality, and to be palatable. Further interview revealed staff should offer residents an alternative meal if the resident did not like the meal or did not eat the meal and if the requested item was not available.

6. Review of policy titled "Subject: Meal Preparation" last revised on 4/2022 showed "Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; food that is palatable, attractive, and at the proper temperature...5. Cold food may be prepared in bulk but distributed or served in batches for appropriate cold (temperature) retention...7. Meal

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F 804	Continued From page 26 service is timed for tray/cart delivery within reasonable time limits to preserve temperature and quality food...Optimal Conditions...2. Food is held in appropriate heat and service equipment, not on a steam table or held for more than 30 minutes..."	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interview, and policy and procedure review, the facility failed to ensure food was served which accommodated resident allergies for 1 of 3 sample residents (#2). The findings were: 1. Review of the quarterly MDS assessment dated 7/14/23 showed resident #2 had a BIMS score of 15 out of 15, which indicated she was cognitively intact, and diagnoses which included Asthma, COPD or chronic lung disease, respiratory failure, and tracheostomy. Further review showed the resident was independent with eating. Review of the nutritional problem care plan last revised on 9/15/23 showed the resident had food allergies which included Gluten (not celiac), black & white pepper, all peppers,	F 806	I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Identified that the Nutrition supervisor was not adhering to the 3-person verification process to ensure allergens are not being served. This supervisor opted to resign in lieu of a performance improvement plan. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Assumed that all residents with food allergies or sensitivities are potentially affected by survey concerns. III. MEASURES OR SYSTEMIC	11/6/23

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F 806	Continued From page 27 pineapple, oranges, lemon, lime, whole eggs, all artificial sweeteners, yellow dye, and spices. Further review showed the resident had intolerances of gravies, onions, spicy foods, cucumber, radish, tea, cinnamon, nutmeg, all spice, ginger, and cloves. The following concerns were identified: a. Review of a "Compliments/Complaints/Concerns Report" dated 8/7/23 showed "Another report on 8/9 that is attached to this grievance." Review of a progress note dated 8/5/23 and timed 1:14 PM, which was attached to the report, showed "During lunch, this nurse received a phone call from [staff name] in kitchen asking if resident had received [his/her] lunch tray and that the Butterscotch pudding had yellow dye in it, which is one of this residents [sic] allergies. Resident had begun to eat [his/her] meal; as this nurse approached, another kitchen staff had already taken the resident's lunch tray, but the container of butterscotch pudding was left with resident. This nurse explained situation to resident, who immediately stopped eating and [s/he] said [s/he] had only had 2 bites of it. Resident declined to have the rest of tray brought back up to finish. Later, [staff name] from kitchen came up to speak directly with resident regarding incident and asked this nurse to accompany her during discussion. Kitchen staff apologized to resident for mistake and offered to bring a meal up if she was still hungry. Resident declined and also expressed her frustration and how upset [s/he] was at the incident and allergies can be serious." Review of a progress note dated 8/9/23 and timed 2:41 PM, which was attached to the report, showed "This resident approached nurses station to report to this nurse [s/he] had been served "black pepper" on [his/her] meat on [his/her] lunch	F 806	CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Three-person verification process monitored by Facility Director/designee. Monitoring includes visual observation of process and confirmation of a clearly labeled, allergen-free meal. This will be done for at least one meal daily (variety of breakfast, lunch, dinner) until 30 days have passed with no allergens served and no near-misses (not caught in verification process but did not reach resident). Once 30 days have past successfully, monitoring to decrease to 3 times a week (different days and different meals) for 8 weeks. Any near miss or allergen served restores daily monitoring until 30 days of success. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: The NHA/designee will report findings from the audits to the QAPI Committee monthly for 90 days. The QAPI committee will identify any trends and take corrective action as needed.	

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F 806	Continued From page 28	F 806		

tray. Nutrition staff were already alerted and aware of what had occurred. Resident reported "[s/he] felt as though [his/her] tongue was swelling." No tongue, throat, mouth, etc. swelling noted upon visual exam. Discussed doing [his/her] breathing treatments in [his/her] room and perhaps trying a Benadryl. On call provider called and received a one time order for 50 mg of Benadryl. Given at 1330. Checked on resident at 1430 and resident reports [s/he] feels "ok", the tongue swelling sensation is still there, but [his/her] breathing is ok and [s/he] will alert staff for any other needs or symptoms." There was no evidence the facility resolved the concern or notified the resident.

b. Review of the medication administration record for August 2023 showed the resident received two Benadryl allergy oral capsules, 25 mg each, on 8/9/23 at 1:55 PM.

c. Review of a "Compliments/Complaints/Concerns Report" dated 8/10/23 showed the resident reported s/he had tongue swelling due to items received which s/he was allergic to.

d. Review of a "Compliments/Complaints/Concerns Report" dated 8/21/23 showed the resident reported concerns of allergens being served on his/her meals on 8/12/23, 8/16/23, and 8/20/23. The resident reported having hives in his/her mouth, tongue swelling, and trouble breathing. The resident indicated s/he had reported concerns previously; however, s/he did not feel it was resolved as it continued to happen.

e. Review of a "Compliments/Complaints/Concerns Report" dated 8/30/23 showed the resident was served a lemon poppy seed muffin and the resident was allergic to lemon.

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f. Interview with the resident on 9/20/23 at 11:20 AM confirmed s/he had voiced concerns related to meals and receiving items s/he was allergic to. The resident revealed s/he was "tired of hearing I'm sorry" and feels staff thought s/he was "old and stupid." Further interview confirmed the resident had allergic reactions to meals on 8/16/23 and 8/20/23.

2. Interview with the administrator and facilities director on 9/21/23 at 10:18 AM confirmed the resident had received and consumed items which were listed on his/her allergies list and received medication intervention following one instance. They revealed the facility implemented tray cards, 1 used by the cook and 1 used on the tray line. They revealed the registered dietitian and the DON performed staff education related to resident allergies; however, the training was done in huddles without a sign in sheet and there was no evidence the education was completed. Further interview revealed the facility implemented a 3 person verification where 3 staff members review the plate and allergies in an effort to prevent residents from receiving and ingesting known food allergies; however, there was no evidence ongoing monitoring or audits were conducted.

3. Review of the policy titled "Subject: Therapeutic Diets" last revised on 4/2022 showed "...Allergies and intolerances are noted in the medical record...4. Allergies and intolerances are noted and there may be varying levels of tolerance noted. This may be reflected in the medical record and in nutrition notes..."