Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65304	A. BUILDING: _____ B. WING _____	C 10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINTER HAVEN HEALTH AND REHABILITATION CEN	202 AVE O NE WINTER HAVEN, FL 33880

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N 000	INITIAL COMMENTS A Re-licensure survey was conducted in conjunction with a Complaint for complaint numbers 2021006390, 2021006950, and 2021010279, at Winter Haven Health and Rehabilitation on to . The facility had deficiencies at the time of the visit. Complaint number 2021006390 had no deficiencies Complaint number 2021006950 had no deficiencies Complaint number 2021010279 had no deficiencies	N 000		
N 042 SS=E	400.1183 FS Resident Grievances and Complaints (1) Every nursing home must have a grievance procedure available to its residents and their families. The grievance procedure must include: (a) An explanation of how to pursue redress of a grievance. (b) The names, job titles, and telephone numbers of the employees responsible for implementing the facility's grievance procedure. The list must include the address and the toll-free telephone numbers of the ombudsman and the agency. (c) A simple description of the process through which a resident may, at any time, contact the toll-free telephone hotline of the ombudsman or the agency to report the unresolved grievance. (d) A procedure for providing assistance to residents who cannot prepare a written grievance without help. (2) Each nursing home facility shall maintain records of all grievances and a report, subject to agency inspection, of the total number of grievances handled, a categorization of the cases underlying the grievances, and the final	N 042		

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N 042	Continued From page 1 disposition of the grievances. (3) Each facility must respond to the grievance within a reasonable time after its submission. (4) The agency may investigate any grievance at any time. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to resolve grievances related to . . . food for five (Residents #46, #102, #23, #70, and #62) out of fifty-seven sampled residents. Findings included: A review of the Activities Resident Council Minutes dated , revealed that Resident #46 verbalized that the food was . . . The resolution revealed that the Dietary Manager explained that it might be related to the distance from the kitchen to the location of Resident #46's room. She verbalized that she would conduct a test run to make improvements with the food temperature. A review of the Activities Resident Council Minutes dated , revealed that the majority of the meeting was spent on dietary related issues such as chicken served too often and food over or under cooked. The solution indicated that the Dietary Manager explained to the residents that she would review the menu and check with corporate about changes to the menu. She also told the residents that she would let them know what type of changes to the menu were allowed. She informed the residents that she would monitor the food temperatures and timing of when the residents received their meals. A review of the Grievance/Concern Log for and , did not reflect	N 042	1. Residents #46, #102, #23, #70 and #62 were interviewed related to their grievances. Grievances were filed based on their interviews for complete follow through with the grievance process. 2. Current residents were interviewed for any concerns by the concierge assigned to the resident to identify any unresolved grievances. Grievances were filed based on the interviews for follow up. The Administrator initiated the All . . . Dining Program to ensure delivery of meals from the kitchen at the correct temperatures to maintain food safety & resident satisfaction. 3. The Activities Coordinator was educated by the Administrator on escalation of grievances from the Resident Counsel meeting immediately following the meeting. The IDT was educated by the Administrator on the Grievance Program & All . . . Dining Program with dining assistance assignments established. Clinical Staff were educated by the SDC/Designee on the grievance program & importance of residents receiving meals in a timely fashion once delivered to the individual units. 4. The Administrator will monitor the	

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N 042	Continued From page 2 grievances voiced by the Resident Council related to food. On starting at 10:00 a.m., a Resident Council Meeting was conducted in the Activities Room. Five (Resident #46, #102, #23, #70, and #62) of the ten residents that attended the meeting reported that the food was always . Resident #46 stated that he did not eat because the food was . Resident #62 stated that the eggs were rubbery, and the french toast was so hard that you could crumble it. The residents reported that when they report the concerns to staff, they just shrug it off and nothing was done. A record review of the Admission Record for Resident #46 indicated that the resident was admitted into the facility on with a primary diagnosis of , and following . Section C- Patterns of the annual Minimum Data Set (MDS) dated , revealed that the resident had a ( ) score of 15 out of 15 indicating that he was . A record review of the Admission Record for Resident #102 indicated that the resident was admitted into the facility on with a primary diagnosis of wasting and atrophy. Section C- Patterns of the quarterly MDS dated , revealed that the resident had a score of 15 out of 15 indicating that she was . A record review of the Admission Record for Resident #23 indicated that the resident was admitted into the facility on with a primary diagnosis of wasting and atrophy. Section C- Patterns of the quarterly	N 042	timeliness of grievance management and completion of the process through resolution weekly for 1 month and then randomly for 2 months. The RD/Dietary Manager will complete test trays 3 times a week for 1 month and then randomly for 2 months. The audits will be presented to the QA&A committee by the SSD & RD/Dietary Manager for 3 months or until substantial compliance is achieved.	

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N 042	Continued From page 3 MDS dated . . . . . , revealed that the resident had a score of 13 out of 15 indicating that he was . . . . . . A record review of the Admission Record for Resident #70 indicated that the resident was admitted into the facility on . . . . . with a primary diagnosis of . . . . . Section C- . . . . . Patterns of the quarterly MDS dated , revealed that the resident had a . . . score of 14 out of 15 indicating that he was . . . . A record review of the Admission Record for Resident #62 indicated that the resident was admitted into the facility on with a primary diagnosis of . . . . wasting and atrophy. Section C- Patterns of the admission MDS dated . . . . . , revealed that the resident had a . score of 11 out of 15 indicating that she was moderately . . . . On . . . at 2:49 p.m., the Activities Director reported that the concerns related to food was brought up in the Resident Council Meeting multiple times. He stated that the Dietary Manager attended the meeting when concerns were mentioned. On at 3:09 p.m., the Dietary Manager stated she only had one complaint related to . . . food from Resident #46. She stated that test trays were done once per month as a part of their monthly audits. The Dietary Manager stated that this process was in place prior to receiving the complaints related to food. She stated when they do the test tray, they follow the cart to the floor. The test tray is placed behind the resident's tray that had the complaint to see if there was a drop in the temperature. There were no concerns	N 042		

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N 042	Continued From page 4 when the audits were conducted. She confirmed that concerns were brought up in the Resident Council Meetings related to . . . food during the meetings she attended. She confirmed that she had only done audits in an attempt to resolve the concern. On at 4:01 p.m., the Social Services Director (SSD) confirmed that she had not received any grievances from the Resident Council. She stated that after a concern was voiced, a grievance should be filed, and a follow up should be done. She stated that a grievance should be resolved within five days. The policy and procedure "Grievance/Concern Management" effective . . . . . revealed that the following: "12. Complete a concern report investigation with summary and conclusion." Class III	N 042		
N 052 SS=D	59A-4.107(3), FAC Physician Orders (3) Verbal orders, including telephone orders, must be immediately recorded, dated, and signed by the person receiving the order. All verbal treatment orders must be countersigned by the physician or other health care professional on the next visit to the facility. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility did not ensure that physician orders were followed for two (Residents #63 and #35) of five residents observed during medication pass observations.	N 052	1. Resident #35 had no adverse effects from the medication error on . The physician/RR was notified by DON on & a medication error report was filed. Resident # 35 had no adverse	

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N 052	Continued From page 5 Findings included: On at 9:00 a.m. medication administration was observed with Staff A, RN with Resident #63. The resident had an order for [brand name] . Patch 4% apply to , one time a day for non-acute . The nurse applied the patch to the residents lower . On at 9:13 a.m. Staff A, RN passed medications to Resident #35. The resident had current orders for and was given the following medications: give 30 mg (milligrams) by one time a day for nutritional support 325 mg give 1 tablet by one time a day for nutritional supplementation Tablet give 40 mg by one time a day for tablet 10 mg give 1 tablet by three times a day for ( ) The resident had the following order, but only received a half dose (6.25 mg): tablet ( ) give 12.5 mg by two times a day for The resident had current orders for the following medications, that were not distributed, but marked as given: give 1000 units by one time a day for nutritional supplementation Tablet give 25 mg by one time a day for hold for (-top number) <110 DBP (diastolic -bottom number) <60 HR (rate) <60 Voltaren gel 1% ( ) Apply to both	N 052	effects from the medication errors on . The physician/RR was notified, and a medication error was filed. Staff member A was educated immediately by SDC on concerning safe administration of medications and following physician orders. 2. During the morning Clinical Meeting 5 days a week, the DON will identify discontinued medications and verify removal of the medications from the medication cart. The Unit Managers will audit the medication carts to ensure the current medications ordered are available on the medication cart for administration twice a week for 1 month and randomly for 2 months. 3. Staff was educated on following physician orders as written, verifying correct medication, dose, route, frequency, and other considerations such as proper placement before administration to resident. Nurses were educated by the SDC/Designee on safe & accurate medication administration & following physician orders as written. 4. The DON /designee is completing medication administration competencies with nurses to ensure safe medication administration, including following physician orders 3 times a week for 1 month and randomly for 2 months. The results of medication cart audits will be presented to the QA&A Committee for 3 months for further recommendations or until substantial compliance is achieved. The nurse medication administration competencies will be presented and reviewed by the QA&A committee for 3	

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N 052	Continued From page 6 , two times a day for . The resident was administered the following medication, which was not on their current order set: , 75 mg On at 2:21 p.m., in an interview with Staff A, RN, she said that creams and patches are usually treatments, but if they are on the MAR (medication administration record), then they are considered medications. "I will ask the DON (director of nursing) to make sure, but that is what I think it is." If I make a medication error or give a medication that doesn't belong to a resident, then I would fill out an incident report, call the physician, call the family, tell the resident, and then monitor them for any side effects. When I pass medications, I pull the medication, compare it to the computer, make sure that the resident is the right resident, you know, make sure of the 5-rights of passing medications." On at 2:22 p.m., the DON confirmed that if a medication is on the MAR it is considered a medication. On at 10:44 a.m., in an interview with the DON, she said, "I'm going to do some training and education with the nurses. I'm going to do some spontaneous medication passes. I expect the nurses to follow current physician orders and notify them if a medication is missing and unable to be given. When giving a wrong medication, they (the nurses) must do a medication error report and observe the resident for possible side effects. If a medication is not ordered, they shouldn't give it. We have to call the physician and let them know what happened as soon as the error is discovered."	N 052	months for further recommendations or until substantial compliance is achieved.	

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N 052	Continued From page 7 On at 3:15 p.m., an interview with the facility's Consultant Pharmacist was obtained my phone. She said that it was her expectation that the nurse followed the current physician orders when passing medications. Class III	N 052		
N 110 SS=E	400.141(1)(h) FS; 59A-4.122(1) FAC Physical Environment - Safe, Clean, Homelike 400.141(1)(h) FS Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner. 59A-4.122(1) FAC The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible This Statute or Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure an adequate supply of linens (towels) for eight (Residents #46, #102, #23, #70, #62, #2, #29, and #107) out of the sampled fifty-seven residents. Findings included: 1. On , starting at 10:00 a.m., a Resident Council Meeting was conducted in the Activities Room. Five (Residents #46, #102, #23, #70, and	N 110	1) Residents #46, #102, #23, #70, #62, #2, #29 and #107 were supplied towels when the facility dryer completed the next cycle. 2) Housekeeping Manager and Administrator completed a check of all remaining residents by asking room to room if towels were needed. No other residents were found to be affected. 3) A distribution schedule was	

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N	Continued From page 8 #62) of the ten residents that attended the meeting reported that they were always running out of towels. They reported that sometimes they were given pillowcases and sheets to dry off with after a shower or bed bath. The residents reported that the washing machines and dryers were always broken. The residents stated that the Certified Nursing Assistants (CNAs) were always going from room to room looking for towels. A record review of the Admission Record for Resident #46 indicated that the resident was admitted into the facility on [redacted] with a primary diagnosis of [redacted] and [redacted] following [redacted]. Section C- [redacted] Patterns of the annual Minimum Data Set (MDS) dated [redacted] revealed that the resident had a [redacted] ([redacted]) score of 15 out of 15 indicating that he was [redacted]. A record review of the Admission Record for Resident #102 indicated that the resident was admitted into the facility on [redacted] with a primary diagnosis of [redacted] wasting and atrophy. Section C- [redacted] Patterns of the quarterly MDS dated [redacted] revealed that the resident had a [redacted] score of 15 out of 15 indicating that she was [redacted]. A record review of the Admission Record for Resident #23 indicated that the resident was admitted into the facility on [redacted] with a primary diagnosis of [redacted] wasting and atrophy. Section C- [redacted] Patterns of the quarterly MDS dated [redacted] revealed that the resident had a [redacted] score of 13 out of 15 indicating that he was [redacted]. A record review of the Admission Record for	N 110	implemented, by the Housekeeping Manager, in conjunction with a par level required for each unit. Housekeeping Manager will audit the delivery times for compliance. 4) Administrator or designee will audit the delivery times three times per week for 1 month and randomly for 2 months for compliance. Results of the audits will be presented and reviewed by the Quality Assurance Committee for 3 months or until substantial compliance is achieved.	

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N 110	Continued From page 9 Resident #70 indicated that the resident was admitted into the facility on with a primary diagnosis of . Section C- Patterns of the quarterly MDS dated revealed that the resident had a score of 14 out of 15 indicating that he was . A record review of the Admission Record for Resident #62 indicated that the resident was admitted into the facility on with a primary diagnosis of wasting and atrophy. Section C- Patterns of the admission MDS dated revealed that the resident had a score of 11 out of 15 indicating that she was moderately . On at 1:50 p.m., Staff J, CNA, stated they were always running out of towels. She stated that this had been an issue for four or five months. She stated that when she could not find towels on the unit, she would go to laundry to look, or she would have to wait to do care. On at 1:50 p.m., Staff I, Laundry Aide/Housekeeper, reported that one of the two washers was not working last month. On at 2:49 p.m., the Activities Director reported that the residents had voiced concerns about running out of towels maybe once or twice, but he did not recall the concern being mentioned in the Resident Council Meetings. He stated about a month and a half ago, the washer was broken but it was working now. On at 5:09 p.m., the Administrator reported that they did not have a policy related to ordering supplies or inventory.	N 110		

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N 110	Continued From page 10 2. A tour of the building and resident wings was conducted on beginning at 9:30 a.m. At 10:10 a.m., Resident # 29 reported that there had been no towels for the aides to use when providing morning care or to provide to residents so they could perform their morning care. Resident #29 reported that it had happened before and usually meant that a laundry aide had called off and it took a long time to get someone to fill in for her. Resident #29 reported that the aide handed her a pillow case to "dry her butt with " that morning. Resident #29 had an quarterly Minimum Data Assessment conducted on which identified her as having a ( ) score of 15 indicating no . She was assessed as needing help with bathing as she was bed bound. At 10:40 a.m. on , Resident # 2 confirmed that there were mornings when there were no towels available. When asked what had happened that morning, the resident responded that she had not yet received any towels - she was still waiting. The resident had an Admission MDS conducted on which assessed her as having no with a of 15. The resident was assessed as requiring one staff for with personal hygiene needs. At 11:45 a.m. on , an aide (Staff H) was observed unlocking and entering the linen closet on the 100 unit. The rack of linen supplies contained two bath towels and a short stack of wash cloths that may have contained five or six cloths. While the aide was in the closet obtaining supplies for resident care, a resident was observed to self propel in her wheelchair up to the closet and ask the aide for towels. The aide	N 110		

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N 110	Continued From page 11 gave the resident the two bath towels and a few washcloths. At 11:50 a.m., two CNAs were observed walking up to the linen closet on the 100 hall . They opened the closet and were asked what they were going to do about the availability of towels. Staff G reported that having no towels had happened before and they had heard that a laundry aide had called off. They reported that it must have taken time to replace her as it took time to get someone to start the laundry. The CNAs reported that they came in at 7:00 a.m. and they need supplies to get started. The CNAs reported that they usually check other units for supplies or ask other aides if they had some stashed that they can have. At 12:45 p.m. on [redacted], Resident # 107 confirmed that on occasion there were no supplies. She confirmed that yes this morning they had no towels. She reported that the CNAs were saying that someone called off and she wasn't replaced until almost 9:00 a.m., which put everything [redacted]. Resident #107 was assessed on her quarterly MDS completed on [redacted] as having a [redacted] of 15 indicating no [redacted]. Resident #107 was assessed as needing two staff to provide [redacted] with her personal hygiene needs. On [redacted] at 9:40 a.m., Staff K CNA was observed leaving the linen closet on the 100 hall. The storage rack inside of the closet was observed to have no towels. When asked what she did in that situation, when there are no supplies, she reported that she would go to the laundry room as maybe the towels were ready and had not been brought out to the units.	N 110		

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N 110	Continued From page 12 At 10:20 a.m. the linen closet on the 100 hall was noted with 10 wash cloths and 5 bath towels. Resident # 29 confirmed at that time, she was just receiving her morning care. An interview was conducted with Staff F at 11:40 a.m. on . . . . . She confirmed that she was the day shift laundry aide. She reported that she delivered clean linens to each unit several times a shift. She also reported that if the linen closets were empty, the aides know they could enter the clean laundry anytime and pick up their own supplies. Staff F confirmed she called off a few days earlier and heard that a housekeeper was pulled from her assignment to do the laundry that day. An interview was conducted with the Housekeeping Manager on . . . . beginning at 11:50 a.m. He confirmed that his day laundry aide had called off on . . . . . By the time he was able to respond and get someone to do the laundry, it was several hours into the shift. He confirmed that there was a shortage of linens as many had to be tossed out as they were either torn or stained. He reported that he had a monthly inventory that he documented and when supplies were below the par level, the administrator would place the order. The housekeeping manager confirmed there were multiple deliveries to the units of linens and reported that he estimated each unit received 30 towels and 45-60 wash cloths during each delivery. The manager provided his inventory, which he reported was due by the 15th of each month. The inventory count indicated there were 563 wash cloths when the inventory was conducted the previous month. The total	N 110		

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	65304	A. BUILDING: _____ B. WING _____	C 10/22/2021

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N 110	Continued From page 13 wash cloths needed, or the par level, was 250 . At the time of the inventory, there were 170 wash cloths in the building with 393 having been disposed of. The inventory of the bath towels showed the previous total was 202 with the par level of 189. At the time of the inventory, there were 231 bath towels in the facility with 43 towels having been disposed of. The inventory showed there were 78 wash cloths in resident rooms and 56 bath towels in resident rooms. The manager's supervisor joined the discussion and reported that wash cloths and bath towels were not supposed to be kept in the resident rooms. The supervisor and the manager both reported they were not aware that residents did not have towels the morning of . . . . . . When asked what the plan was for staff call offs, the manager reported that he had other staff that could fill in for the laundry aide. The supervisor agreed that there needed to be a plan for call offs so the replacement would be more timely. A review was conducted of the Facility's Assessment which included a section entitled "Facility Resources needed to provide competent support and care for our resident population every day and during emergencies." Under the section for Physical Environment and building/plant needs, the guidelines included "describe your processes to ensure adequate supplies and to ensure equipment is maintained to protect and promote the health and safety of residents." Under the Physical Resource Category of Non-medical supplies , bed and bath linens was included. The documented process was "Contract with medical supply vendors to ensure items as needed." Continued in this	N 110		

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N 110	Continued From page 14 section was the process for overseeing the services and how the services would meet the residents' needs. The assessment included the guidance, "facility has contracts/agreements with transport, medical supply, food/water, hospice agencies and medical professionals to meet the needs." The assessment did not address the staffing component of providing linen services, only the physical aspect of the linens. On . . . . . beginning at approximately 4:30 p.m. an interview was conducted with the Administrator on the subject of lack of supplies and staff to provide those supplies. The Administrator reviewed the process he had with the housekeeping manager related to the inventory count and purchasing new linens. He confirmed every month they were purchasing supplies that included linens and towels. Related to the concern with replacing the staff who call off, he replied that there were other staff who could fill in when needed. He confirmed that there was no other plan except for trying to get others to fill in when needed. Class III	N 110		

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F 000	INITIAL COMMENTS A recertification survey was conducted in conjunction with a Complaint for complaint numbers 2021006390, 2021006050, and 2021010279 on to at Winter Haven Health and Rehabilitation. The facility was not in compliance with 42 CFR, Part 483, Requirements for Long Term Care Facilities. Complaint number 2021006390 had no deficiencies Complaint number 2021006950 had no deficiencies Complaint number 2021010279 had no deficiencies	F 000		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to have an adequate supply of personal care supplies ( ) for one (Resident #46) out of twenty-seven sampled residents. Findings included: On starting at 10:00 a.m., a Resident Council Meeting was conducted in the Activities Room. During the meeting, the residents were	F 558	1) The Administrator purchased on . . . . and dispensed them to all residents in need and re-stocked the central supply room. 2) A resident census form was printed, all male patients were identified and provided a , if needed by the Administrator. Staff were in-serviced by the Staff Development Coordinator to communicate if patient care items were	

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

Electronically Signed /2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 558	Continued From page 1 asked if they had any concerns. Resident #46 stated that they were always running out of . . . . He stated that housekeeping would clean the and return the to him and that was unsanitary. A record review of the Admission Record for Resident #46 indicated that the resident was admitted into the facility on . . . . . with a primary diagnosis of , and , following . . . . . Section C- . . . Patterns of the annual Minimum Data Set (MDS) dated . . . . . , revealed that the resident had a ( ) score of 15 out of 15 indicating that he was . . . . . On at 1:45 p.m., the Administrator reported that he ordered supplies on Wednesdays and Fridays and received shipments on Thursdays and Mondays. He stated he placed an order today, , but did not order any . . . . The Administrator reported that he did not have an inventory list for supplies and that it was a work in progress. At 1:55 p.m., all the supply closets in the facility were observed with the Administrator. There were no . . . . observed in the supply closets of the . . . room, the 100 unit, the 200 unit, or the 300 unit. He stated that no one had reported to him that they were out of . . . . The Administrator reported that employees were asked if they needed any supplies during the morning meetings. There was a list posted in the supply closets to write down supplies that they were out of. He stated that he also went around asking employees if they needed anything prior to placing orders.	F 558	depleted. Facility implemented a central supply policy and a par-level for resident care items. A supply form was implemented to identify patient care items that need to be ordered. 3) Staff were in-serviced by the Staff Development Coordinator to escalate to a supervisor immediately, if resident care items are unable to be located. 4) An audit of resident care supplies will be conducted by Administrator and/or designee twice weekly for a period of 1 month to monitor adequate levels of resident care items. Policy and results of the audits will be presented by Administrator or designee and reviewed by the Quality Assurance Committee for recommendations for 3 months or until substantial compliance is achieved.	

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F 558	Continued From page 2 On . . . . . at 4:23 p.m., the Administrator reported that they had someone doing the ordering, but that person had turned in a resignation and he took over the ordering about three weeks ago. On . . . . . at 5:09 p.m., the Administrator reported that they did not have a policy related to ordering supplies or inventory.	F 558		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		

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F 584	Continued From page 3 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)( ); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after , must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure an adequate supply of linens (towels) for eight (Residents #46, #102, #23, #70, #62, #2, #29, and #107) out of the sampled fifty-seven residents. Findings included: 1. On , starting at 10:00 a.m., a Resident Council Meeting was conducted in the Activities Room. Five (Residents #46, #102, #23, #70, and #62) of the ten residents that attended the meeting reported that they were always running out of towels. They reported that sometimes they were given pillowcases and sheets to dry off with after a shower or bed bath. The residents reported that the washing machines and dryers were always broken. The residents stated that the Certified Nursing Assistants (CNAs) were always going from room to room looking for towels. A record review of the Admission Record for Resident #46 indicated that the resident was	F 584	1) The Housekeeping Manager stocked all three carts/rooms with towels when the next wash/dry cycle completed. Direct care staff were notified that towels had been replenished and to disperse if any residents were in need. No other residents were found to be affected. 2) The Administrator educated the Housekeeping Manager on cross training all housekeeping staff to the laundry. A delivery schedule has been implemented to include a par level for towels and washcloths for each of the three resident areas. Each unit will receive three deliveries, 7am, 3pm and 10pm daily to meet resident needs. Housekeeping Manager will replace any laundry personnel call-offs immediately with present staff that are cross-trained to meet delivery schedules on-time. Housekeeping Manager and Administrator will meet monthly to place linen order for needed or disposed of laundry items. No	

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F 584	Continued From page 4 admitted into the facility on . . . . . with a primary diagnosis of , and , following . . . . . Section C- . . . Patterns of the annual Minimum Data Set (MDS) dated . . . . . revealed that the resident had a ( ) score of 15 out of 15 indicating that he was . . . . A record review of the Admission Record for Resident #102 indicated that the resident was admitted into the facility on with a primary diagnosis of . . . . wasting and atrophy. Section C- Patterns of the quarterly MDS dated . . . . . revealed that the resident had a . score of 15 out of 15 indicating that she was . . . . . A record review of the Admission Record for Resident #23 indicated that the resident was admitted into the facility on . . . . . with a primary diagnosis of wasting and atrophy. Section C- . . . Patterns of the quarterly MDS dated revealed that the resident had a . . score of 13 out of 15 indicating that he was . . . A record review of the Admission Record for Resident #70 indicated that the resident was admitted into the facility on with a primary diagnosis of . . . . . , . Section C- Patterns of the quarterly MDS dated . . . . . revealed that the resident had a score of 14 out of 15 indicating that he was . . . . . A record review of the Admission Record for Resident #62 indicated that the resident was admitted into the facility on . . . . . with a	F 584	other residents were found to be affected by this deficiency. 3) Housekeeping employees were educated to replace laundry personnel if there is a call off in the laundry and notify the supervisor. Housekeeping manager educated the housekeeping staff on the linen delivery schedule. 4) Administrator and/or designee will audit delivery times and par level supplies of linen for 1 month, twice daily and for two months randomly thereafter. The audits will be presented to the QA&A by the Housekeeping Manager with results being reviewed by the Quality Assurance Committee for 3 months or until substantial compliance is achieved.	

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F 584	Continued From page 5	F 584		

primary diagnosis of [redacted] wasting and atrophy. Section C- [redacted] Patterns of the admission MDS dated [redacted] revealed that the resident had a [redacted] score of 11 out of 15 indicating that she was moderately [redacted].

On [redacted] at 1:50 p.m., Staff J, CNA, stated they were always running out of towels. She stated that this had been an issue for four or five months. She stated that when she could not find towels on the unit, she would go to laundry to look, or she would have to wait to do care.

On [redacted] at 1:50 p.m., Staff I, Laundry Aide/Housekeeper, reported that one of the two washers was not working last month.

On [redacted] at 2:49 p.m., the Activities Director reported that the residents had voiced concerns about running out of towels maybe once or twice, but he did not recall the concern being mentioned in the Resident Council Meetings. He stated about a month and a half ago, the washer was broken but it was working now.

On [redacted] at 5:09 p.m., the Administrator reported that they did not have a policy related to ordering supplies or inventory.

2. A tour of the building and resident wings was conducted on [redacted] beginning at 9:30 a.m. At 10:10 a.m., Resident # 29 reported that there had been no towels for the aides to use when providing morning care or to provide to residents so they could perform their morning care. Resident #29 reported that it had happened before and usually meant that a laundry aide had called off and it took a long time to get someone to fill in for her. Resident #29 reported that the

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F 584	Continued From page 6	F 584		

aide handed her a pillow case to "dry her butt with " that morning. Resident #29 had an quarterly Minimum Data Assessment conducted on which identified her as having a (..) score of 15 indicating no . She was assessed as needing help with bathing as she was bed bound.

At 10:40 a.m. on , Resident # 2 confirmed that there were mornings when there were no towels available. When asked what had happened that morning, the resident responded that she had not yet received any towels - she was still waiting. The resident had an Admission MDS conducted on which assessed her as having no with a of 15. The resident was assessed as requiring one staff for with personal hygiene needs.

At 11:45 a.m. on , an aide (Staff H) was observed unlocking and entering the linen closet on the 100 unit. The rack of linen supplies contained two bath towels and a short stack of wash cloths that may have contained five or six cloths. While the aide was in the closet obtaining supplies for resident care, a resident was observed to self propel in her wheelchair up to the closet and ask the aide for towels. The aide gave the resident the two bath towels and a few washcloths.

At 11:50 a.m., two CNAs were observed walking up to the linen closet on the 100 hall . They opened the closet and were asked what they were going to do about the availability of towels. Staff G reported that having no towels had happened before and they had heard that a

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F 584	Continued From page 7	F 584		

laundry aide had called off. They reported that it must have taken time to replace her as it took time to get someone to start the laundry. The CNAs reported that they came in at 7:00 a.m. and they need supplies to get started. The CNAs reported that they usually check other units for supplies or ask other aides if they had some stashed that they can have.

At 12:45 p.m. on , Resident # 107 confirmed that on occasion there were no supplies. She confirmed that yes this morning they had no towels. She reported that the CNAs were saying that someone called off and she wasn't replaced until almost 9:00 a.m., which put everything . Resident #107 was assessed on her quarterly MDS completed on as having a of 15 indicating no . Resident #107 was assessed as needing two staff to provide with her personal hygiene needs.

On at 9:40 a.m., Staff K CNA was observed leaving the linen closet on the 100 hall. The storage rack inside of the closet was observed to have no towels. When asked what she did in that situation, when there are no supplies, she reported that she would go to the laundry room as maybe the towels were ready and had not been brought out to the units.

At 10:20 a.m. the linen closet on the 100 hall was noted with 10 wash cloths and 5 bath towels. Resident # 29 confirmed at that time, she was just receiving her morning care.

An interview was conducted with Staff F at 11:40 a.m. on . She confirmed that she was the day shift laundry aide. She reported that she

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F 584	Continued From page 8	F 584		

delivered clean linens to each unit several times a shift. She also reported that if the linen closets were empty, the aides know they could enter the clean laundry anytime and pick up their own supplies. Staff F confirmed she called off a few days earlier and heard that a housekeeper was pulled from her assignment to do the laundry that day.

An interview was conducted with the Housekeeping Manager on . . . . beginning at 11:50 a.m. He confirmed that his day laundry aide had called off on . . . . . By the time he was able to respond and get someone to do the laundry, it was several hours into the shift. He confirmed that there was a shortage of linens as many had to be tossed out as they were either torn or stained. He reported that he had a monthly inventory that he documented and when supplies were below the par level, the administrator would place the order. The housekeeping manager confirmed there were multiple deliveries to the units of linens and reported that he estimated each unit received 30 towels and 45-60 wash cloths during each delivery.

The manager provided his inventory, which he reported was due by the 15th of each month. The inventory count indicated there were 563 wash cloths when the inventory was conducted the previous month. The total wash cloths needed, or the par level, was 250 . At the time of the inventory, there were 170 wash cloths in the building with 393 having been disposed of.
The inventory of the bath towels showed the previous total was 202 with the par level of 189. At the time of the inventory, there were 231 bath

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F 584	Continued From page 9 towels in the facility with 43 towels having been disposed of. The inventory showed there were 78 wash cloths in resident rooms and 56 bath towels in resident rooms. The manager's supervisor joined the discussion and reported that wash cloths and bath towels were not supposed to be kept in the resident rooms. The supervisor and the manager both reported they were not aware that residents did not have towels the morning of . When asked what the plan was for staff call offs, the manager reported that he had other staff that could fill in for the laundry aide. The supervisor agreed that there needed to be a plan for call offs so the replacement would be more timely. A review was conducted of the Facility's Assessment which included a section entitled "Facility Resources needed to provide competent support and care for our resident population every day and during emergencies." Under the section for Physical Environment and building/plant needs, the guidelines included "describe your processes to ensure adequate supplies and to ensure equipment is maintained to protect and promote the health and safety of residents." Under the Physical Resource Category of Non-medical supplies , bed and bath linens was included. The documented process was "Contract with medical supply vendors to ensure items as needed." Continued in this section was the process for overseeing the services and how the services would meet the residents' needs. The assessment included the guidance, "facility has contracts/agreements with transport, medical supply, food/water, hospice agencies and medical professionals to meet the	F 584		

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F 584	Continued From page 10 needs." The assessment did not address the staffing component of providing linen services, only the physical aspect of the linens. On . . . . beginning at approximately 4:30 p.m. an interview was conducted with the Administrator on the subject of lack of supplies and staff to provide those supplies. The Administrator reviewed the process he had with the housekeeping manager related to the inventory count and purchasing new linens. He confirmed every month they were purchasing supplies that included linens and towels. Related to the concern with replacing the staff who call off, he replied that there were other staff who could fill in when needed. He confirmed that there was no other plan except for trying to get others to fill in when needed.	F 584		
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. §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	F 585		

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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 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

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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;
( ) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, , 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 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews, the

1. Residents #46, #102, #23, #70 and

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F 585	Continued From page 13 facility failed to resolve grievances related to . . . . food for five (Residents #46, #102, #23, #70, and #62) out of fifty-seven sampled residents. Findings included: A review of the Activities Resident Council Minutes dated revealed that Resident #46 verbalized that the food was . . . . The resolution revealed that the Dietary Manager explained that it might be related to the distance from the kitchen to the location of Resident #46's room. She verbalized that she would conduct a test run to make improvements with the food temperature. A review of the Activities Resident Council Minutes dated , revealed that the majority of the meeting was spent on dietary related issues such as chicken served too often and food over or under cooked. The solution indicated that the Dietary Manager explained to the residents that she would review the menu and check with corporate about changes to the menu. She also told the residents that she would let them know what type of changes to the menu were allowed. She informed the residents that she would monitor the food temperatures and timing of when the residents received their meals. A review of the Grievance/Concern Log for and , did not reflect grievances voiced by the Resident Council related to food. On starting at 10:00 a.m., a Resident Council Meeting was conducted in the Activities Room. Five (Resident #46, #102, #23, #70, and #62) of the ten residents that attended the	F 585	#62 were interviewed related to their grievances. Grievances were filed based on their interviews for complete follow through with the grievance process. 2. Current residents were interviewed for any concerns by the concierge assigned to the resident to identify any unresolved grievances. Grievances were filed based on the interviews for follow up. The Administrator initiated the All Dining Program to ensure delivery of meals from the kitchen at the correct temperatures to maintain food safety & resident satisfaction. 3. The Activities Coordinator was educated by the Administrator on escalation of grievances from the Resident Counsel meeting immediately following the meeting. The IDT was educated by the Administrator on the Grievance Program & All . . . Dining Program with dining assistance assignments established. Clinical Staff were educated by the SDC/Designee on the grievance program & importance of residents receiving meals in a timely fashion once delivered to the individual units. 4. The Administrator will monitor the timeliness of grievance management and completion of the process through resolution weekly for 1 month and then randomly for 2 months. The RD/Dietary Manager will complete test trays 3 times a week for 1 month and then randomly for 2 months. The audits will be presented to the QA&A committee by the SSD & RD/Dietary Manager for 3 months or until substantial	

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F 585	Continued From page 14 meeting reported that the food was always . . . . . Resident #46 stated that he did not eat because the food was . . . . Resident #62 stated that the eggs were rubbery, and the french toast was so hard that you could crumble it. The residents reported that when they report the concerns to staff, they just shrug it off and nothing was done. A record review of the Admission Record for Resident #46 indicated that the resident was admitted into the facility on . . . . . with a primary diagnosis of , and , following . . . . . Section C- . . . Patterns of the annual Minimum Data Set (MDS) dated . . . . . revealed that the resident had a ( ) score of 15 out of 15 indicating that he was . . . . . A record review of the Admission Record for Resident #102 indicated that the resident was admitted into the facility on with a primary diagnosis of . . . . wasting and atrophy. Section C- Patterns of the quarterly MDS dated . . . . . revealed that the resident had a score of 15 out of 15 indicating that she was . . . . . A record review of the Admission Record for Resident #23 indicated that the resident was admitted into the facility on . . . . . with a primary diagnosis of wasting and atrophy. Section C- . . . Patterns of the quarterly MDS dated revealed that the resident had a . . score of 13 out of 15 indicating that he was . . . A record review of the Admission Record for Resident #70 indicated that the resident was	F 585	compliance is achieved.	

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F 585	Continued From page 15 admitted into the facility on . . . . . with a primary diagnosis of . . . . . Section C- . . . . Patterns of the quarterly MDS dated revealed that the resident had a . . score of 14 out of 15 indicating that he was . . . A record review of the Admission Record for Resident #62 indicated that the resident was admitted into the facility on with a primary diagnosis of . . . . wasting and atrophy. Section C- Patterns of the admission MDS dated . . . . revealed that the resident had a score of 11 out of 15 indicating that she was moderately . . . . On . . . . at 2:49 p.m., the Activities Director reported that the concerns related to food was brought up in the Resident Council Meeting multiple times. He stated that the Dietary Manager attended the meeting when concerns were mentioned. On at 3:09 p.m., the Dietary Manager stated she only had one complaint related to . . . food from Resident #46. She stated that test trays were done once per month as a part of their monthly audits. The Dietary Manager stated that this process was in place prior to receiving the complaints related to food. She stated when they do the test tray, they follow the cart to the floor. The test tray is placed behind the resident's tray that had the complaint to see if there was a drop in the temperature. There were no concerns when the audits were conducted. She confirmed that concerns were brought up in the Resident Council Meetings related to . . . food during the meetings she attended. She confirmed that she had only done audits in an attempt to resolve the	F 585		

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F 585	Continued From page 16 concern. On [redacted] at 4:01 p.m., the Social Services Director (SSD) confirmed that she had not received any grievances from the Resident Council. She stated that after a concern was voiced, a grievance should be filed, and a follow up should be done. She stated that a grievance should be resolved within five days. The policy and procedure "Grievance/Concern Management" effective [redacted] revealed that the following: "12. Complete a concern report investigation with summary and conclusion."	F 585		
F 758 SS=D	Free from Unnec[redacted] Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) [redacted] Drugs. §483.45(c)(3) A [redacted] drug is any drug that affects activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) [redacted]; (ii) [redacted]; (iii) [redacted]; and ( ) [redacted] Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used [redacted] drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		

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F 758	Continued From page 17 §483.45(e)(2) Residents who use [redacted] 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 [redacted] 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 [redacted] 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 [redacted] 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 by: Based on observations, interviews, and record review, the facility failed to ensure side effects and/or behavioral monitoring with the use of [redacted] medications for two (Resident #43 and Resident #98) of five sampled residents. Findings include: On [redacted] at 10:43 a.m., Resident #43 was observed seated in her room in a wheelchair. Resident #43 was able to answer questions	F 758	1. Resident #43 had side effects monitoring added to the orders in PCC for [redacted] by the DON on [redacted]. Resident #98 had behavioral monitoring order added to the orders in PCC for [redacted] by the DON on [redacted]. 2. All current residents were audited for [redacted] medications by the DON to ensure behavior monitoring and side effects monitoring orders were in place or added to PCC orders if required.	

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F 758	Continued From page 18 related to care and services in the facility. The resident stated she had been in the facility for several months. The resident appeared clean, dry and had no signs of distress or unusual behaviors noted during the interview. Resident #43 stated she was very sick with COVID last year and that started her decline. On [redacted] at 1:00 p.m., Resident #43 was observed in room resting quietly. The resident had no signs of distress, and no behaviors were observed. A review of the medical record for Resident #43 indicated the resident was admitted to the facility on [redacted] with diagnoses including [redacted] and major [redacted]. A review of the physician order sheet for Resident #43 revealed an order for [redacted] capsule delayed release particles give 60 mg by [redacted] one time a day for [redacted]. A review of the comprehensive care plan for Resident #43 revealed a focus area for [redacted] Medications as follows: Resident #43 uses [redacted] medications: [redacted] to manage mod/behavior/[redacted] initiated on [redacted]. Goal: Will have no side effects of [redacted] medications. Participate in activities of choice. Interventions: Administer medications as ordered. Observe/document for side effects and effectiveness; [redacted] observe/document for potential side effects may include [redacted], drowsiness, [redacted], dry [redacted], retention, [redacted]. A review of the [redacted] Medication	F 758	3. Nurses were educated by the SDC/Designee on requirements for behavior monitoring and side effects monitoring for residents receiving [redacted] medications. 4. The DON/designee is auditing new orders for residents with [redacted] medications for behavior monitoring and monitoring of side effects when the medication is ordered during the clinical meeting 5 times a week for 1 month and then randomly for 2 months. The DON will present the audits to QA&A for 3 months for further recommendations or until substantial compliance is achieved.	

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F 758	Continued From page 19 Administration Record (MAR) for Resident #43 revealed no monitoring for side effects was completed by nursing for the resident. On [redacted] at 10:53 a.m., Resident #98 was observed sleeping soundly in the bed. There were [redacted] mats observed on the floor and the resident had no signs of distress, or any behaviors noted. A review of the medical record revealed Resident #98 was admitted to the facility on [redacted] with a diagnosis of [redacted]. A review of the physician order sheet for Resident #98, revealed an order for [redacted] capsule 30 mg give one capsule by [redacted] every 24 hours as needed for [redacted]. A review of the comprehensive care plan for Resident #98 revealed a focus area for [redacted] medications as follows: [Resident #98] uses [redacted] medications [redacted] and [redacted] to manage [redacted] /behavior// [redacted] / [redacted] initiated on [redacted]. Goal: Improve sleep pattern, participate in activities of choice, will have no side effects of [redacted] medication. Interventions: Administer medications as ordered. Observe/document for side effects and effectiveness; [redacted] observe/document for potential side effects may include [redacted], drowsiness, [redacted], dry [redacted], retention, [redacted] observe/document for potential side effects may include [redacted], daytime drowsiness, [redacted], irritability, amnesia, sleep walking, sleep eating, palpitations, [redacted]	F 758		

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A review of the Medication Administration Record (MAR) for Resident #98 revealed no behavior monitoring was completed by nursing for the resident.

On at 5:01 p.m. Resident #98 was observed lying in his bed sleeping. There were no signs of distress.

On at 12:00 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated that nursing was responsible for implementing side effects and behavior monitoring for all medications. She stated, each morning during the morning clinical meeting, all orders were checked for any new medications which might require side effects and behavior monitoring. When a medication was identified, the team would assure the side effects and behavior monitoring was in place for the medication. The DON indicated that the nursing staff were also able to initiate side effects and behavior monitoring when they place a new order for a . The DON indicated the initiation of the order was not a pharmacy process. When asked to review the side effects and behavior monitoring records for Resident #43 and Resident #98 the DON confirmed no side effects monitoring was in place for Resident #43 and no behavioral monitoring was in place for Resident #98. She stated she would correct the records immediately.

On , an interview was conducted by phone with the Clinical Pharmacist for the facility. She confirmed that side effects monitoring should be in place for Resident #43 for use of . The Clinical Pharmacist stated the facility did not

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F 758	Continued From page 21 do behavioral monitoring for [illegible] like [illegible]. A policy was requested with the resident records for [illegible] medications but was not received.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility did not ensure a medication error rate of less than 5%. During the medication pass observation, there were twenty five opportunities with six errors resulting in a 24% medication error rate for two (Residents #63 and #35) of five residents observed. Findings included: On at 9:00 a.m. medication administration was observed with Staff A, RN with Resident #63. The resident had an order for [brand name] Patch 4% apply to [illegible] one time a day for non-acute [illegible]. The nurse applied the patch to the residents lower . On at 9:13 a.m. Staff A, RN passed medications to Resident #35. The resident had current orders for and was given the following medications:	F 759	1. Resident #35 had no adverse effects from the medication error on . The physician/RR was notified by DON on & a medication error report was filed. Resident # 35 had no adverse effects from the medication errors on . The physician/RR was notified, and a medication error was filed. Staff member A was educated immediately by SDC on concerning safe administration of medications and following physician orders. 2. During the morning Clinical Meeting 5 days a week, the DON will identify discontinued medications and verify removal of the medications from the medication cart. The Unit Managers will audit the medication carts to ensure the current medications ordered are available on the medication cart for administration twice a week for 1 month and randomly for 2 months.	

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F 759	Continued From page 22 give 30 mg (milligrams) by one time a day for nutritional support 325 mg give 1 tablet by one time a day for nutritional supplementation Tablet give 40 mg by one time a day for tablet 10 mg give 1 tablet by three times a day for ( ) The resident had the following order, but only received a half dose (6.25 mg): tablet ( ) give 12.5 mg by two times a day for The resident had current orders for the following medications, that were not distributed, but marked as given: give 1000 units by one time a day for nutritional supplementation Tablet give 25 mg by one time a day for hold for (-top number) <110 DBP (diastolic -bottom number) <60 HR (rate) <60 Voltaren gel 1% ( ) Apply to both two times a day for The resident was administered the following medication, which was not on their current order set: 75 mg On at 2:21 p.m., in an interview with Staff A, RN, she said that creams and patches are usually treatments, but if they are on the MAR (medication administration record), then they are considered medications. "I will ask the DON (director of nursing) to make sure, but that is what	F 759	3. Staff was educated on following physician orders as written, verifying correct medication, dose, route, frequency, and other considerations such as proper placement before administration to resident. Nurses were educated by the SDC/Designee on safe & accurate medication administration & following physician orders as written. 4. The DON /designee is completing medication administration competencies with nurses to ensure safe medication administration, including following physician orders 3 times a week for 1 month and randomly for 2 months. The results of medication cart audits will be presented to the QA&A Committee for 3 months for further recommendations or until substantial compliance is achieved. The nurse medication administration competencies will be presented and reviewed by the QA&A committee for 3 months for further recommendations or until substantial compliance is achieved.	

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F 759	Continued From page 23	F 759		

I think it is." If I make a medication error or give a medication that doesn't belong to a resident, then I would fill out an incident report, call the physician, call the family, tell the resident, and then monitor them for any side effects. When I pass medications, I pull the medication, compare it to the computer, make sure that the resident is the right resident, you know, make sure of the 5-rights of passing medications."

On [redacted] at 2:22 p.m., the DON confirmed that if a medication is on the MAR it is considered a medication.

On [redacted] at 10:44 a.m., in an interview with the DON, she said, "I'm going to do some training and education with the nurses. I'm going to do some spontaneous medication passes. I expect the nurses to follow current physician orders and notify them if a medication is missing and unable to be given. When giving a wrong medication, they (the nurses) must do a medication error report and observe the resident for possible side effects. If a medication is not ordered, they shouldn't give it. We have to call the physician and let them know what happened as soon as the error is discovered."

On [redacted] at 3:15 p.m., an interview with the facility's Consultant Pharmacist was obtained my phone. She said that it was her expectation that the nurse followed the current physician orders when passing medications.

In a policy given by the facility titled "Medication Preparation" dated [redacted] under procedures step 3 reads "Prior to administration, review and confirm medication orders for each individual resident on the medication administration record.

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F 759	Continued From page 24 Compare the medication and dosage schedule on the residents MAR with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule. In the same policy under "Medication Administration" step 1 reads "Medications are administered in accordance with written orders of the prescriber ...." Step 9 reads: "Verify medication is correct three (3) times before administering the medication. A. When pulling a medication package from med cart. B. When dose is prepared. C. Before dose is administered." In the same policy under "Documentation" step 2 reads "IF a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time ...the space provided on the front of the MAR for that dosage administration is initialed and circled ...."	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		

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F 761	Continued From page 25 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Prevention and Control Act of 1976 and other drugs subject to , except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility did not ensure that a refrigerated controlled substance was secured in a separately locked, permanently affixed container on one of three units. Findings included: On at 4:29 p.m., Staff B LPN (Licensed Practical Nurse), entered the medication storage room on Unit 1 to get a medication from the refrigerated emergency drug kit (EDK). He pulled out an opaque plastic container with a clear top that measured approximately 7-inches by 11-inches from the refrigerator. On top of this plastic container, attached to one of the corners by hook and loop fastener tape, was a small clear plastic container about the size of a pack of playing cards. When the nurse was asked what the small clear plastic container had in it, and he said " " (.). Staff B, LPN was asked to count how many vials of medication was in the small clear plastic container, and he answered "four ". Upon further inspection, it was	F 761	1. The in medication storage # refrigerator was immediately placed in the lock box on . 2. All other medication rooms & refrigerators were checked for unsecure controlled drugs with no issues identified. 3. Nurses were educated by the DON/Designee on storage of medication and securing of controlled drugs. 4. The DON/designee will complete a medication storage audit 3 times a week for 1 month and then random audit for storage of medications for 2 months. The DON will present the medication audits to the QA&A committee for review and further recommendations for 3 months or until substantial compliance is achieved.	

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F 761	Continued From page 26 noted that .. ml vials of .. ...., ... were inside of the small clear plastic container. Staff B, LPN confirmed that the small container was only secured to the larger container by a hook and loop tape system. At 4:31 p.m., the Director of Nursing (DON) confirmed that the container was unsecured .. .., , and that it should have been locked in the lock box inside of the refrigerator in the medication room. She said that as soon as the EDK came from pharmacy, the . should be taken off the larger plastic container and placed in the metal lock box immediately. The DON had the .. .., put into the separately locked refrigerated container. On ..... at 3:15 p.m., in a phone interview with the facility's Consultant Pharmacist, she said that it was her expectation that .. .. be double locked. She said, "I know that facility has a lock system, and it should have been in the lock system, not still attached to the EDK." In a policy given by the facility titled "Controlled Medication Storage" under procedures, #4 reads "Controlled medications requiring refrigeration are stored within a locked, permanently affixed box within the refrigerator."	F 761		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs.	F 805		

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F 805	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observations of meals, interview with residents and facility staff, and review of the facility's menu and materials on the facility's new diet, (IDDSI - International , , ِ Diet Standardization Initiative), the facility failed to ensure residents who were on mechanically altered diets received foods that had been correctly prepared to follow the IDDSI guidelines and ensure the foods were safe for two (Residents #60 and #22) of 41 residents identified as having physician orders for mechanically altered diets. Findings included: 1- On at 12:30 p.m., Resident # 60 was observed at lunch. She was observed to be sitting up in bed, with her over the bed table across her waist and her lunch tray accessible in front of her. She had been served a total of three, two scoops of fried rice with pork, broccoli and a wheat roll. The resident had inserted her fork into her roll and was holding the roll up like a flag. The roll looked to be a solid and was stable on the tines of the fork. When asked if she needed a knife to cut off a bite of it, she shook her . . . no and put the fork with the roll . . . down on her tray. The Dietary Manager ( ) was passing in front of the resident's room and was called in to look at the resident's lunch tray. When asked why she would have received three scoops of fried rice with pork, the reported she wasn't sure. The diet slip that lists the resident's diet order and any preferences or changes or deletions on the diet was noted to be available on the lunch tray. Review of the diet slip revealed the resident's diet was Regular, SB6 (small bites level	F 805	1) Resident # 60 experienced no adverse effects related to the diet consistency served on . . . . . and continues to work with , , for , , ِ . Resident # 22 experienced no adverse effect related to the diet consistency served on . . . . . . 2) A facility wide audit of all diet orders was completed by the Registered Dietician with no other residents found to be affected by diet consistencies. 3) Regional Registered Dietician re-educated the Dietary Manager and the dietary staff on proper preparation, consistency, and identification of ordered diets for resident meals. Re-education was completed with dietary staff by the Regional Registered Dietician Consultant on proper preparation of the IDDSI diet Consistencies, checking of tray card tickets for accurate consistency of meal before presenting to resident. Registered Dietician will audit 3 times per meal service for proper consistency with IDDSI audit tool for consistency and 15 times per meal service for accuracy of tray cards. 4) Registered Dietician or Designee will audit 3 times per meal service, 3 times weekly for proper consistency with IDDSI audit tool for consistency and 15 times per meal service, 3 times weekly for accuracy of tray cards by checking meals prior to being served to resident. Registered Dietician or Designee will audit for a period of 1 month and 2 months randomly or until substantial compliance is	

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F 805	Continued From page 28 6)/Mech (Mechanical), Thin (liquids). The diet slip listed the two scoops of the sweet sour pork SBMM (soft bites minced & moist), plus one #8 scoop (cup) of fried rice, pureed. The individual scoop of fried rice was not pureed. All rice scoops were noted to contain rice that had separated into individual grains. The diet slip also listed a wheat roll slurried. The reported that the roll should be soft enough to press with the fork and break apart. When the roll that the resident had held aloft with her fork was pointed to, and the was asked why it was still a solid . . . , the reported she would have to look into it. 2- On at 12:30 p.m., Resident #22 was observed in the dining room with an aide who was assisting her with her meal. The diet slip that accompanied the resident's lunch indicated her physician ordered diet was Regular, SB6 (small bites level 6)/Mech (mechanical), thin (liquids). The resident had been served small chunks of chicken in gravy, green beans that were soft and able to be mashed with a fork, and white rice. The diet slip indicated the rice was to be rice pilaf. A dinner roll was on the plate and when the aide tried to break it apart with the side of the fork, she was unable to do so. A cookie was on a small plate and it had been slurried, which the resident was able to pick up and even though it crumbled in her . . . she was able to put it into her . 3- On at 1:00 p.m., while temperatures on the steam table were being monitored, the was asked about the slurried rolls. She demonstrated with tongs how the rolls had been placed into a deep steam table pan and thickened milk was poured over	F 805	achieved. Registered Dietician will present the audits to the QA&A committee for review and further recommendations for 3 months or until substantial compliance is achieved.	

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F 805	Continued From page 29	F 805		

them to slurry them. She reported that the rolls should soak up the milk and be soft enough to break apart. She stabbed one of the rolls with the tongs and pushed it around the bottom of the pan. The slurried roll did not break up and she was not able to pull the tongs out of the slurried roll.

During the observation of the steam table on , the Regional Registered Dietitian confirmed that the cook had not added the seasoning mix to the rice to make rice pilaf. She confirmed the residents were receiving plain white rice.

4- On at 10:20 a.m., an interview was conducted with the facility's Registered Dietitian (RD) who confirmed the facility had made the decision to follow the IDDSI (International , , , Diet Standardization Initiative) diet consistencies rather than follow the prior diet consistencies - regular, mechanical soft, and pureed. She reported she had received training from a Corporate RD, who also assisted in reviewing the diets and changes to be made in all the residents' diets. She reported that the Regional RD had provided training to the dietary aides and cooks. She also reported that the Speech , reassessed all residents who had been on Mechanical Soft or Pureed diets to determine which diet would be appropriate for them from the new IDDSI plan.

The facility's RD reported that their roll-out date for the new diet and menu items was . . . . . , She confirmed that once the new diet and menus were introduced there had not been audits of the served meals.

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F 805	Continued From page 30	F 805		

On /2021 at 3:15 p.m., the Regional RD provided an example of a slurried roll and the consistency that it should attain prior to serving to a resident. The slurried dinner roll pulled apart and allow for easy chewing and swallowing. It did not have the consistency that was observed when the demonstrated the slurried roll to the surveyor during the tray line monitoring. It did not have the consistency that was observed on the two resident's lunch plates observed on and .

The Regional RD described her process in slurrying the rolls which followed the recipe: slice the rolls in half horizontally and using a toothpick make multiple holes across the surface area. Combine 2% milk with a food thickener to make a slurry. Using 2 ounces of slurry per roll, pour one ounce of slurry onto a plate, place roll halves on slurry and pour remaining one ounce over roll, covering the entire surface area.
The Regional RD provided a copy of the recipe.
It was noted that during the lunch observation of the slurried rolls, the rolls had not been sliced in half or with a toothpick to allow the slurry to saturate the roll. The Regional RD confirmed that the cook had not followed the recipe to slurry the rolls.

The Regional RD also provided a recipe for a sauce to be used with the pureed rice to allow it to be safely consumed. Review of the IDDSI materials indicated that "Rice requires a sauce to moisten it and hold it together. Rice should not be sticky or gluey and should not separate into individual grains when cooked and served." The Regional RD confirmed that the plain white rice should not have been served to residents on the SB6 diet without a thick sauce.

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