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
	75910	A. BUILDING: _____ B. WING _____	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE ON THE GREEN	500 VILLAGE PLACE LONGWOOD, FL 32779

(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) COMPLETE DATE
N 000	INITIAL COMMENTS A relicensure survey was conducted on to . Village on the Green had deficiencies found at the time of the survey.	N 000		
N 201 SS=E	400.022(1)(l), FS Right to Adequate and Appropriate Health Care (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide services and treatments to prevent further decrease in range of motion for 2 of 3 residents reviewed for positioning and mobility of a total sample of 23 residents, (#1 and #14). Findings: 1. Resident #1 was admitted to the facility on with diagnoses including , and Review of the Minimum Data Set (MDS) quarterly assessment with assessment reference date (ARD) of revealed resident #1 had a ( ) score of 10 which indicated she had moderate . She required extensive to total assistance with Activities of Daily Living (ADLs).	N 201	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider of the truth of the items alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state laws. 1: Resident #1 MD was notified, and new order received for eval and treat. Resident #14 MD was notified, and new orders received for eval and treat. 2: An audit was completed on all residents to review ROM/Mobility and use of assistive devices/equipment. Any areas noted out of compliance were corrected. 3: An in-service was provided to the	

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N 201	Continued From page 1 The document revealed the resident did not exhibit any behavioral symptoms including rejection of care. The assessment indicated resident #1 had limited range of motion (ROM) to one side of her body for both upper and lower extremities. A care plan for limited physical mobility related to [illegible] with right sided [illegible] was initiated [illegible] and revised [illegible]. Interventions included monitor/document/report as needed any signs/symptoms of immobility: [illegible] forming or worsening, and [illegible]; [illegible]/Occupation [illegible] referrals as ordered; and passive range of motion to right upper extremity. Review of resident #1's "Medication Review Report" for [illegible] revealed a physician order dated [illegible] for [illegible] ( ) to evaluate and treat as indicated and an order dated [illegible] for [illegible] ( ) to evaluate and treat. The report did not contain an order for any [illegible]. On [illegible] at 11:35 AM, [illegible] at 3:26 PM, [illegible] at 9:11 AM and [illegible] at 9:56 AM, resident #1 was observed in bed. Her right [illegible] and arm were [illegible] and held tightly to her [illegible]. Resident #1 did not have a [illegible] on her right arm or [illegible] and did not have a [illegible] roll in her right [illegible]. On [illegible] at 10:21 AM, Certified Nursing Assistant (CNA) A stated the resident was dependent on staff for most ADLs. She reported the resident was [illegible] on her right side and did not have a [illegible] or assistive device. She could not recall the resident ever having a [illegible].	N 201	licensed nurses, CNAs and [illegible] on the facility's policy and procedure for "Assistive Devices and equipment." 4: The DON and/or designee will perform random audits of assistive devices/equipment monthly for three months to ensure plan of care being followed. Audit findings will be reported and reviewed in the monthly QAPI committee and as needed.	

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N 201	Continued From page 2 CNA A explained she washed resident #1's right as part of ADL care and used a washcloth to clean inside her and between her . She reported the resident expressed discomfort when she performed ADL care on her right . CNA A demonstrated how she washed the resident's and the resident grimaced but allowed CNA to open her . At this time CNA A searched the resident's room but was unable to find a . On at 10:44 AM, the , Director stated resident #1 was not currently on caseload. He recalled she had been evaluated in and was seen up by from - . The , Director reviewed the , notes and reported worked with the resident on right upper extremity range of motion and , tolerance for hours. He explained resident #1 was transferred to restorative nursing program at discharge from , with a restorative form completed and emailed to the restorative nurse. At 11:04 AM, the , Director entered resident #1's room and assessed the resident's right and ROM to the right arm. The resident grimaced as he attempted to straighten her right arm. He stated the resident needed a right , and a right , . He conveyed the , would reduce , and allow staff to clean her and provide nail care. He recalled an , was recommended but stated she should had a , as well. The , Director explained when were not being used, the tighten and shorten causing a . He clarified that a , would help to prevent a and did not say why resident #1 did not have one. On at 11:17 AM, B recalled resident	N 201		

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N	Continued From page 3 #1 was on caseload previously with ROM to upper extremities. He stated the goal was for resident to wear a right . and a right , for hours per day to prevent . He could not recall if the ., was left for the resident. He validated in the absence of a ., , the expected nursing intervention was to use a towel roll. On at 11:43 AM, the , Director reviewed the "Restorative Nursing Documentation Tool" and acknowledged the form did not contain any ., information. On at 11:46 AM, Restorative Aide CNA C stated she was familiar with resident #1 and reported the resident was on restorative , 3 times a week for upper and lower ROM. She verbalized she was aware of her right but did not have a , program for her. Restorative Aide CNA C reviewed the restorative program for resident #1 and verified the program contained information for Passive and Active ROM but no information for , . On at 12:00 PM, the Administrator brought a clear plastic bag that contained a blue hard plastic , which extended from to and stated it was in resident #1's upper drawer of the bedside table. The Administrator explained she asked the resident if she wanted to wear the , and the resident declined. The Administrator was informed the drawers were searched by CNA A and there was no , in any of the drawers or in the closet. On at 12:06 PM, CNA A validated she searched all drawers in the dresser, bedside table and closet and did not see a , . She informed the Administrator that surveyors were present	N 201		

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N 201	Continued From page 4 when she searched the room and the ., was not in the drawer at that time. The Administrator said, "I wonder who has been in that room since then." The Administrator was informed that the ., she held was not the type of ., that was recommended by , ,. Restorative Aide CNA C was present in the hallway and confirmed she had never seen that , and did not recall the resident wearing a ., on either her . . . or her . CNA A confirmed that she had never seen the ., either. The Administrator could not explain where the , came from or why the ., was not of the recommended type. On . . . . at 2:11 PM, the ., Director stated B erroneously checked completion goal for resident's , but not the . , . The ., Director confirmed he was still unsure of what happened to the . . . ., . . The , , Director recalled his earlier assessment resident #1 and reiterated she would benefit from both a , and , . On at 2:29 PM, the Director of Nursing (DON) stated she served as the restorative nurse. She explained when , , determined a resident had met goals and needed a maintenance plan, the , created a restorative plan and emailed it to the nursing team to implement. The DON acknowledged she did not have a plan for resident #1's discharge from ., on . She verbalized her expectation if a resident had a . . . . . with no obvious treatment or device in place, the staff member should report it to a floor nurse, to or to the DON. She conveyed she would expect staff to place a rolled washcloth if a resident did not have a , or refused , . The DON stated she reviewed the current restorative plan for resident #1 and noted, "Obviously there is a	N 201		

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N 201	Continued From page 5 break in the process since we missed the form from ." She acknowledged the possibility of a decline for resident with a that was not maintained. 2. Resident #14 was admitted to the facility on with diagnoses of , , and , following affecting left non-dominant side, unspecified ankle, , in right ankle and joints of right , in left ankle and joints and . Review of the MDS quarterly assessment with ARD of revealed resident #14 had a score of 14 which indicated she was . She required extensive to total assistance with ADLs. The document revealed the resident did not exhibit any behavioral symptoms including rejection of care. The assessment indicated resident #14 had limited ROM to one side of her body for both upper and lower extremities. A care plan for history of , initiated and revised included interventions to maintain good body alignment to prevent , use braces and , as ordered and encourage resident/caregivers to use and correctly apply all , and braces. On at 10:51 AM, resident #14 was in bed and two multi-, were noted on the floor next to a recliner. The resident stated she did not wear the because they were stretched out and did not fit properly. She said she requested new ones from , but only received one.	N 201		

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N 201	Continued From page 6 On at 8:58 AM, the resident was in bed and the were no longer beside the recliner in her room. She stated she was not wearing them and did not know where they were. On at 10:52 AM, the Director explained resident #14 had been on case load but was not currently not being seen by . He recalled she had been treated for management and was supposed to wear multi-, to prevent flexion and by keeping her in a neutral position. He noted he was not aware the were too big. On at 10:56 AM, resident #14 was observed in a wheel chair next to her bed. The multi-, were on the floor next to her recliner. The resident stated it had been about two years since she wore them. The Director checked both on the floor and noted they were both large size. He located another multi-, in the resident's closet which was regular size. He stated the resident should be wearing them when she was out of bed. He explained restorative nursing program would have initially been assigned to put the on the resident. On at 11:28 AM, B stated he was familiar with resident #14 and recalled he recommended resident to wear her the while up in the wheel chair and when in bed. On at 11:52 AM, Restorative Aide CNA C verified resident #14 had multi-, and mentioned they were too big. She reviewed the restorative program for resident #14 and noted	N 201		

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N 201	Continued From page 7 the resident was on a restorative program for the multi-, to be applied during the day. On at 12:02 PM, CNA D stated she was familiar with resident #14. She reported the resident had multi-, that were applied by restorative CNA. She recalled the did not fit well. On at 3:45 PM, the , Director provided the " , Plan of Care" for resident #14 with an end date of . Review of the plan revealed resident only had one proper fitting , at the time and the , was donning a brace one at a time while waiting for the new , . On , the , documented , was on hold due to waiting on ankle brace/ , . The , Director clarified the plan was to use the that fit and alternate ankles until the new arrived. He acknowledged the mentioned in plan were never delivered. Review of the job description for "Rehabilitation Program Manager" dated , revealed the program manager would "develop programs appropriate to the needs of the residents in the facility, to assist them in achieving their highest feasible level of functioning." Review of the job description for "Director of Nursing Services" dated , revealed the DON's essential job functions included "organize resident care programs which include the interdisciplinary team, resident care planning team, the restorative care program and other programs as necessary to provide optimal care." The facility's policy and procedure for "Assistive Devices and Equipment" provided policy	N 201		

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N 201	Continued From page 8 interpretation and implementation guidelines that included assessing the resident for lower extremity strength, range of motion, balance and abilities when determining the safest use of devices and equipment; and, the equipment is measured to fit the resident's size and . Pattern Class III	N 201		

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F 000	INITIAL COMMENTS A recertification survey was conducted on to . Village on the Green was not in compliance with 42 CFR Part 483 and 488, Requirements for Long Term Care Facilities.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. ( ) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain the survey book with all surveys conducted in the past three years.	F 577	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/2022

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 577	Continued From page 1 Findings: Review of the survey book located in the facility's main lobby revealed it did not include all recent surveys. A complaint survey conducted on . . . . . resulted in deficiencies and the survey book did not include the statement of deficiencies or the facility's plan of correction for viewing by residents, visitors, and staff. On at 3:20 PM, the Administrator acknowledged the complaint investigation results of were not included in the survey book. There were no additional survey books readily available for review and the Administrator acknowledged it was her responsibility to update the survey book.	F 577	the truth of the items alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state laws. 1. . . . . Complaint Survey statement of deficiencies was immediately placed in survey result binder. 2. An audit was completed to ensure 3 years-worth of statements of deficiencies were present in the survey results binder. No other areas noted out of compliance. 3. An in-service was provided to the administrator on the resident's right to have access to surveys, certifications, complaint investigations during the 3 preceding years. 4. The Administrator and/or designee will perform random audits for three months to ensure surveys, certifications, complaint investigations during the 3 preceding years are present in the survey results binder. Audit findings will be reported and reviewed in the monthly QAPI committee and as needed.	
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in	F 688		

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F 688	Continued From page 2 range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide services and treatments to prevent further decrease in range of motion for 2 of 3 residents reviewed for positioning and mobility of a total sample of 23 residents, (#1 and #14). Findings: 1. Resident #1 was admitted to the facility on [redacted] with diagnoses including [redacted] and [redacted]. Review of the Minimum Data Set (MDS) quarterly assessment with assessment reference date (ARD) of [redacted] revealed resident #1 had a [redacted] ( ) score of 10 which indicated she had moderate [redacted]. She required extensive to total assistance with Activities of Daily Living (ADLs). The document revealed the resident did not exhibit any behavioral symptoms including	F 688	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider of the truth of the items alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state laws. 1: Resident #1 MD was notified, and new order received for [redacted] eval and treat. Resident #14 MD was notified, and new orders received for [redacted] eval and treat. 2: An audit was completed on all residents to review ROM/Mobility and use of assistive devices/equipment. Any areas noted out of compliance were corrected. 3: An in-service was provided to the licensed nurses, CNAs and [redacted] on	

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F 688	Continued From page 3 rejection of care. The assessment indicated resident #1 had limited range of motion (ROM) to one side of her body for both upper and lower extremities. A care plan for limited physical mobility related to [illegible] with right sided [illegible] was initiated [illegible] and revised [illegible]. Interventions included monitor/document/report as needed any signs/symptoms of immobility: [illegible] forming or worsening, and [illegible] /Occupation [illegible] referrals as ordered; and passive range of motion to right upper extremity. Review of resident #1's "Medication Review Report" for [illegible] revealed a physician order dated [illegible] for [illegible] ( ) to evaluate and treat as indicated and an order dated [illegible] for [illegible] ( ) to evaluate and treat. The report did not contain an order for any [illegible]. On [illegible] at 11:35 AM, [illegible] at 3:26 PM, [illegible] at 9:11 AM and [illegible] at 9:56 AM, resident #1 was observed in bed. Her right [illegible] and arm were [illegible] and held tightly to her [illegible]. Resident #1 did not have a [illegible] on her right arm or [illegible] and did not have a [illegible] roll in her right [illegible]. On [illegible] at 10:21 AM, Certified Nursing Assistant (CNA) A stated the resident was dependent on staff for most ADLs. She reported the resident was [illegible] on her right side and did not have a [illegible] or assistive device. She could not recall the resident ever having a [illegible]. CNA A explained she washed resident #1's right	F 688	the facility's policy and procedure for "Assistive Devices and equipment." 4: The DON and/or designee will perform random audits of assistive devices/equipment weekly for three months to ensure plan of care being followed. Audit findings will be reported and reviewed in the monthly QAPI committee and as needed.	

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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 688	Continued From page 4 as part of ADL care and used a washcloth to clean inside her and between her . She reported the resident expressed discomfort when she performed ADL care on her right . CNA A demonstrated how she washed the resident's and the resident grimaced but allowed CNA to open her . At this time CNA A searched the resident's room but was unable to find a . On at 10:44 AM, the Director stated resident #1 was not currently on caseload. He recalled she had been evaluated in and was seen up by from - . The Director reviewed the notes and reported worked with the resident on right upper extremity range of motion and tolerance for hours. He explained resident #1 was transferred to restorative nursing program at discharge from with a restorative form completed and emailed to the restorative nurse. At 11:04 AM, the Director entered resident #1's room and assessed the resident's right and ROM to the right arm. The resident grimaced as he attempted to straighten her right arm. He stated the resident needed a right and a right . He conveyed the would reduce and allow staff to clean her and provide nail care. He recalled an was recommended but stated she should had a as well. The Director explained when were not being used, the tighten and shorten causing a . He clarified that a would help to prevent a and did not say why resident #1 did not have one. On at 11:17 AM, B recalled resident	F 688		

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	105556	A. BUILDING _____ B. WING _____	07/28/2022

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F 688	Continued From page 5 #1 was on caseload previously with ROM to upper extremities. He stated the goal was for resident to wear a right . and a right , for hours per day to prevent . He could not recall if the ., was left for the resident. He validated in the absence of a ., , the expected nursing intervention was to use a towel roll. On at 11:43 AM, the , Director reviewed the "Restorative Nursing Documentation Tool" and acknowledged the form did not contain any ., information. On at 11:46 AM, Restorative Aide CNA C stated she was familiar with resident #1 and reported the resident was on restorative , 3 times a week for upper and lower ROM. She verbalized she was aware of her right but did not have a , program for her. Restorative Aide CNA C reviewed the restorative program for resident #1 and verified the program contained information for Passive and Active ROM but no information for , . On at 12:00 PM, the Administrator brought a clear plastic bag that contained a blue hard plastic , which extended from to and stated it was in resident #1's upper drawer of the bedside table. The Administrator explained she asked the resident if she wanted to wear the , and the resident declined. The Administrator was informed the drawers were searched by CNA A and there was no , in any of the drawers or in the closet. On at 12:06 PM, CNA A validated she searched all drawers in the dresser, bedside table and closet and did not see a ., . She informed	F		

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F 688	Continued From page 6	F 688		

the Administrator that surveyors were present when she searched the room and the , was not in the drawer at that time. The Administrator said, "I wonder who has been in that room since then." The Administrator was informed that the , she held was not the type of , that was recommended by . . , , . Restorative Aide CNA C was present in the hallway and confirmed she had never seen that ., and did not recall the resident wearing a , on either her or her . . CNA A confirmed that she had never seen the ., either. The Administrator could not explain where the ., came from or why the , was not of the recommended type.

On at 2:11 PM, the , , Director stated B erroneously checked completion goal for resident's , but not the ., . The . , , Director confirmed he was still unsure of what happened to the , . The . , , Director recalled his earlier assessment resident #1 and reiterated she would benefit from both a . . ., and . . . ., .

On . . . . . at 2:29 PM, the Director of Nursing (DON) stated she served as the restorative nurse. She explained when . , , determined a resident had met goals and needed a maintenance plan, the . , . created a restorative plan and emailed it to the nursing team to implement. The DON acknowledged she did not have a plan for resident #1's discharge from . . , , on . . . . . . She verbalized her expectation if a resident had a with no obvious treatment or device in place, the staff member should report it to a floor nurse, to or to the DON. She conveyed she would expect staff to place a rolled washcloth if a resident did not have a . . . ., or refused ., . The DON

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stated she reviewed the current restorative plan for resident #1 and noted, "Obviously there is a break in the process since we missed the form from ." She acknowledged the possibility of a decline for resident with a that was not maintained.

2. Resident #14 was admitted to the facility on with diagnoses of , and , following affecting left non-dominant side, unspecified ankle, in right ankle and joints of right in left ankle and joints and .

Review of the MDS quarterly assessment with ARD of revealed resident #14 had a score of 14 which indicated she was . She required extensive to total assistance with ADLs. The document revealed the resident did not exhibit any behavioral symptoms including rejection of care. The assessment indicated resident #14 had limited ROM to one side of her body for both upper and lower extremities.

A care plan for history of , initiated and revised included interventions to maintain good body alignment to prevent , use braces and as ordered and encourage resident/caregivers to use and correctly apply all and braces.

On at 10:51 AM, resident #14 was in bed and two multi-, were noted on the floor next to a recliner. The resident stated she did not wear the because they were

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stretched out and did not fit properly. She said she requested new ones from , , but only received one.

On ..... at 8:58 AM, the resident was in bed and the were no longer beside the recliner in her room. She stated she was not wearing them and did not know where they were.

On at 10:52 AM, the , , Director explained resident #14 had been on case load but was not currently not being seen by , , . He recalled she had been treated for ..... management and was supposed to wear multi-, ... to prevent , ... flexion and , by keeping her in a neutral position. He noted he was not aware the were too big.

On at 10:56 AM, resident #14 was observed in a wheel chair next to her bed. The multi-, were on the floor next to her recliner. The resident stated it had been about two years since she wore them. The , , Director checked both ..... on the floor and noted they were both large size. He located another multi-, ... in the resident's closet which was regular size. He stated the resident should be wearing them when she was out of bed. He explained restorative nursing program would have initially been assigned to put the on the resident.

On at 11:28 AM, B stated he was familiar with resident #14 and recalled he recommended resident to wear her the , ... while up in the wheel chair and when in bed.

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F 688	Continued From page 9 On at 11:52 AM, Restorative Aide CNA C verified resident #14 had multi-, and mentioned they were too big. She reviewed the restorative program for resident #14 and noted the resident was on a restorative program for the multi-, to be applied during the day. On at 12:02 PM, CNA D stated she was familiar with resident #14. She reported the resident had multi-, that were applied by restorative CNA. She recalled the did not fit well. On at 3:45 PM, the , Director provided the " , , Plan of Care" for resident #14 with an end date of . Review of the plan revealed resident only had one proper fitting , at the time and the , was donning a brace one at a time while waiting for the new , . On , the , documented , was on hold due to waiting on ankle brace/ , . The , Director clarified the plan was to use the that fit and alternate ankles until the new arrived. He acknowledged the mentioned in plan were never delivered. Review of the job description for "Rehabilitation Program Manager" dated , revealed the program manager would "develop programs appropriate to the needs of the residents in the facility, to assist them in achieving their highest feasible level of functioning." Review of the job description for "Director of Nursing Services" dated , revealed the DON's essential job functions included "organize resident care programs which include the interdisciplinary team, resident care planning	F 688		

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F 688	Continued From page 10 team, the restorative care program and other programs as necessary to provide optimal care." The facility's policy and procedure for "Assistive Devices and Equipment" provided policy interpretation and implementation guidelines that included assessing the resident for lower extremity strength, range of motion, balance and [illegible] abilities when determining the safest use of devices and equipment; and, the equipment is measured to fit the resident's size and [illegible].	F 688		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the	F 756		

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F 756	Continued From page 11 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow-up on pharmacy recommendations for 1 of 5 residents reviewed for unnecessary medications of a total sample of 23 residents, (#1). Findings: Resident #1 was admitted to the facility on with diagnoses including , , , , and . A care plan for "resident has , , , " was initiated with interventions for staff to administer replacement medication as ordered and obtain and monitor lab/diagnostic work as ordered. Review of the pharmacy "Consultation Report" for , revealed a recommendation for the facility to monitor resident #1's , ( ) concentration on the	F 756	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider of the truth of the items alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state laws. 1: Resident #1 MD was notified, and new orders received to obtain level. 2: An audit was conducted of all resident to ensure pharmacy recommendations were addressed. Any recommendations noted out of compliance were corrected. 3: An In-service was provided to the DON and Medical Records Clerk on the facility's policy and procedure on "Medication Regimen Review".	

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F 756	Continued From page 12 next convenient lab day and at least annually due to resident receiving , replacement medication, ... The report was unsigned and did not indicate whether the physician agreed or disagreed with the recommendation. Review of the "Medication Review Report" for . . . . . revealed resident #1 had a physician order dated for , Tablet 100 micrograms to be given every morning for low , hormone. The report did not contain an order for labs to monitor level. On . . . . . at 5:21 PM, the Administrator reviewed the pharmacist's recommendations and the resident #1's Electronic Medical Record and acknowledged there was not any physician order to monitor levels. On . . . . . at 5:22 PM, the Director of Nursing (DON) stated the consultant pharmacist reviewed medications monthly. The pharmacist then emailed recommendations to the facility which were printed and put in physician binders at the nursing stations. She explained once the recommendations were reviewed and signed by the physician, they were returned to her for reconciliation. The DON stated she was ultimately responsible for following through with pharmacy recommendations and acknowledged resident #1's recommendation to complete lab work for levels was missed. The facility's policy and procedure for "Medication Regimen Review" (MRR) dated included guidelines for the facility to "encourage Physician/prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to	F 756	4: The DON and/or designee will perform random audits of pharmacy recommendations monthly for three months to ensure recommendations have been addressed by the physician. Audit findings will be reported and reviewed in the monthly QAPI committee and as needed.	

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F 756	Continued From page 13 act upon the recommendations contained in the MRR. For those issues that require Physician/Prescriber intervention, Facility should encourage Physician/Prescriber to either (a) accept and act upon the recommendations contained within the MRR, or (b) reject all or some of the recommendation contained in the MRR and provide an explanation as to why the recommendation was rejected."	F 756		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure potentially hazardous foods were at a hot holding temperature of 135 degrees Fahrenheit, or above, to prevent foodborne illness.	F 812	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider of the truth of the items alleged or conclusion set forth in the Statement of	

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F 812	Continued From page 14 Finding Review of the facility's lunch menu on , revealed the residents had a choice of Baked Ziti or Turkey Enchilada Casserole. The side items included Green Peas, Red Potatoes and Coconut Cake. On at 11:55 AM, the lunch tray line was observed. There were two cooks and several dietary aides at or near the tray line. Cook A stated the Baked Ziti and Turkey Enchilada Casserole were in the "hot box," a full size temperature controlled, hot holding cabinet. The side items were on the steam table. The hot holding temperatures were checked with the facility's , bayonet style thermometer. The Turkey Enchilada Casserole had a hot holding temperature of 119 degrees Fahrenheit. Further temperatures taken of the Turkey Enchilada Casserole ranged from 119 to 129 degrees Fahrenheit. Cook B stated the holding temperature was supposed to be 160 degrees Fahrenheit. A few minutes later, the Chef was at the tray line and was informed of the hot holding temperatures of the food. The Chef instructed the cooks to reheat the Turkey Enchilada Casserole. When asked who took the hot holding temperatures prior to the start of tray line, Cook A and Cook B did not respond. Cook B indicated he did not take the temperatures as, "I was too busy." The Chef stated the lunch tray line holding temperatures had not been done. The United States Food and Drug Administration's Food Code 2017, notes in chapter that potentially hazardous foods, need to be at a hot holding temperature of 135 degrees or	F 812	Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state laws. 1: The turkey enchilada was immediately reheated to appropriate temperature. Cook A and B were educated on the policy and procedure on "Food Service Temperature." 2: No residents were affected. 3: An in-service was provided to all health center cooks on the policy and procedure on "Food Service Temperature." 4: The CDM and/or designee will perform random audits of food service temperatures weekly for 3 months to ensure hot holding temperatures have been completed. Audit findings will be reported and reviewed in the monthly QAPI committee and as needed.	

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F 812	Continued From page 15 above.	F 812		