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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 5/13/21.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/13/2021

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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interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 48 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to promote care in a manner to maintain and enhance dignity and respect when staff placed residents, dependent upon staff for locomotion, at the dining table for extended period of time prior to meals being served and also used disposable plates and utensils on the Friendship Heights unit.

Findings include:

- Observation on 05/04/21 at 08:05 AM Staff wheeled Resident (R)15 in Broda chair (a specialized wheelchair with the ability to tilt and recline) from her room and placed her at a dining table. No food or drink noted on the table. At 08:40 AM R15 received a drink, 35 minutes later. At 09:13 AM R15 received a bowl of pineapple tidbits, one hour and eight minutes after arriving in the dining room. At 09:16 AM a staff member sat down next to R15 to assist with eating.

Observation on 05/04/21 at 08:39 AM, revealed R29 sat at the dining room table in a wheelchair. No food or drink noted on the table in front of R29. At 09:14 AM, R29 was given a bowl of fruit,

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35 minutes after being in the dining room.

Observation on 05/05/21 at 07:33 AM revealed R15 and R32 sat in Broda chairs at the dining room tables. R32 had a drink on the table. No food or drink was noted on the table for R15. At 08:26 AM, R15 and R32 were given a shake supplement to drink, 53 minutes later. At 08:49 R15 and R32 were given a breakfast meal, one hour and 16 minutes after being in the dining room.

Observation on 05/05/21 at 08:00 AM revealed R29 sat at the dining room table in a wheelchair. At 08:36 AM R29 was given a coffee to drink, 36 minutes later. At 08:49 R29 was given a breakfast meal, 49 minutes after being in the dining room

Observation on 05/05/21 at 08:39 AM revealed that the meal trays were prepared with disposable plates and disposable utensils.

Interview on 5/6/21 at 12:34 PM revealed Certified Nurse Aide (CNA) N stated residents that were in the dining room before meals were served drinks and shake supplements. CNA N also stated that staff offered sips of drinks to those residents that were unable to feed themselves while waiting for meals.

Interview on 5/6/21 at 12:35 PM revealed Licensed Nurse (LN) G stated that residents in the dining room before meals were served drinks and shake supplements. She stated staff were to assist any resident that needed assistance by offering sips of drinks until meals were served. She also stated that they did not provide activities for anyone in the dining room prior to the meals being served.

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F 550	Continued From page 3 Interview on 5/6/21 at 01:16 PM with Administrative Nurse D revealed that the expectation was for a resident to have a drink within 15 minutes of arrival in the dining room and have a meal served within 45 minutes of arrival into the dining room. Administrative Nurse D stated that over an hour is too long of a wait time and that the staff should have at least offered something while waiting. Administrative Nurse D also stated that he is unsure of how the determination was made of which residents are brought out to the dining room and when they are brought out based on the level of assistance needed. The facility's "Dining Profile" policy revised on April 26, 2019, documented that a Dining Profile will be completed by conducting a resident interview to determine resident dining and food preferences, and gathering nutritional data. The facility failed to provide a dining environment that promotes dignity and respect for their residents. This put the residents at both potential nutritional and psychosocial risks.	F 550		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of	F 679		

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each resident, encouraging both independence and interaction in the community.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 48 residents. The sample included 15 residents; one resident reviewed for activities. Based on observations, record reviews, and interviews, the facility failed to consistently provide personalized, resident-centered activities to Resident (R) 10.

Findings included:

- The "Diagnoses" tab of R10's electronic medical record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, and major depressive disorder (major mood disorder).

The "Annual Minimum Data Set" (MDS) dated 11/25/20 documented R10 had a Brief Interview for Mental Status (BIMS) score of five which indicated severe cognitive impairment. R10 had activity preferences documented that it was very important to have magazines, newspapers, and books to read; music to listen to; keep up with the news; do things with groups of people, do her favorite activities; go outside for fresh air when weather is good; and participate in religious services. R10 required limited physical assistance with one staff member for walking and extensive physical assistance with one staff member for transfers.

The "Quarterly MDS" dated 02/22/21 documented R10 had a BIMS score of three which indicated

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severe cognitive impairment. R10 required limited physical assistance with one staff member for walking and extensive physical assistance with one staff member for transfers.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 11/25/20 documented R10 had dementia and struggled with short term memory. Staff attempted to anticipate R10's needs and recognized at times she required more supervision for safety purposes.

The "Life Enrichment Care Plan" dated 09/10/19 documented R10 had a potential for low attendance/participation in activities due to personal preferences with interventions that R10 enjoyed listening to music, staff provided crosswords for R10 to challenge her brain and for her enjoyment, R10 attended Catholic services, and R10 loved to watch sports of all kinds on the television.

The "Daily Point of Care (POC) Charting" tab of R10's EMR documented activity participation. R10 participated in activities five out of 28 days in February 2021, six out of 31 days in March 2021, eight out of 30 days in April 2021, and one out of five days in May 2021.

In an observation on 05/04/21 at 02:40 PM, R10 sat in recliner in day area, eyes open. Tray table with cup of water in front of R10, television on but R10 was not watching it. No activities observed.

In an observation on 05/04/21 at 04:05 PM, R10 sat in recliner in day area, eyes closed. Tray table with cup of water to the side of the recliner. No activities observed.

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In an observation on 05/05/21 at 08:52 AM, R10 sat in recliner in day area, tray table in front of her with breakfast on it. R10 appeared comfortable and ate breakfast independently. No activities observed.

In an observation on 05/05/21 at 02:29 PM, R10 sat in recliner in day area, eyes closed, appeared to be resting comfortably. No activities observed.

In an observation on 05/05/21 at 02:47 PM, R10 ambulated with walker and staff assistance from recliner in day area to restroom in hallway.

In an observation on 05/05/21 at 02:56 PM, R10 ambulated with walker and staff assistance from restroom in hallway back to recliner in day area.

In an observation on 05/05/21 at 03:27 PM, R10 sat in recliner in day room, eyes closed. R10 appeared to be resting comfortably. No activities observed.

In an observation on 05/06/21 at 07:47 AM, R10 sat in recliner in day room, eyes open. R10 appeared to be comfortable with no signs of distress and watched television on and off.

In an observation on 05/06/21 at 09:14 AM, R10 sat in recliner in day room, eyes open. R10 ate breakfast independently and without signs of distress. No activities observed.

In an interview on 05/06/21 at 11:50 AM, Certified Nurse Aide (CNA) M stated the aides charted on activities and the activities staff also charted on activities. She stated the activity director oversaw activities.

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In an in interview on 05/06/21 at 12:46 PM, Licensed Nurse (LN) G stated the activity staff member for that unit was responsible for activities.

In an interview on 05/06/21 at 01:06 PM, Activity staff AA stated she was responsible for activities and the activity assistants charted on activities. She stated R10 really liked music, visits with family, naps, and group activities. She stated she expected activities to be provided to residents in the morning and afternoon every day. She stated activities were charted in POC and she encouraged her activity staff to chart a progress note too.

In an interview on 05/06/21 at 01:16 PM, Administrative Nursing Staff D stated he expected activities to be provided at least daily.

The facility's "Life Enrichment Programming" policy last revised 04/26/19 directed an ongoing program of activities were designed to meet the interests and physical, mental, and psychosocial well-being of residents. The policy directed the program of activities included a combination of large and small groups, one-to-one, and self-directed activities and staff recognized that there were times residents preferred not to participate in any planned Life Enrichment programming but would prefer to sit idly independent which was appropriate as long as it was the resident's choice, was not prolonged, and was not the result of lack of appropriate stimulation.

The facility failed to provide consistent activities for R10 which had the risk for a decline in physical, mental, and psychosocial well-being and

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F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility identified a census of 48 residents. The sample included 15 residents. Based on observations, interviews, and record reviews the facility failed to maintain acceptable parameters for nutritional status when they did not consistently monitor the meal percentages (%) and supplements consumed for Resident (R)20 with a documented weight loss in two months and failed to ensure the proper food consistency was served to R15, to enhance her ability to eat her meal.	F 692		

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Findings included:

- R20's electronic medical record (EMR) documented diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) and protein-calorie malnutrition.

The "Admission Minimum Data Set" dated 03/17/21 documented a Brief Interview for Mental Status score of 11 which, indicated moderately impaired cognition. She required supervision with eating. R20 had no weight loss during the look back period and no trouble swallowing or trouble with her teeth.

The "Nutritional Status Care Area Assessment" dated 03/24/21 documented R20 was on a regular diet with thin liquids. She had a good appetite and made her preferences known. She was weighed weekly and received nutritional interventions for pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) healing.

The "Care Plan" dated 03/31/21 documented R20 was at risk for an alteration in nutrition related to her history of malnutrition. She received a regular diet, fortified shakes twice daily, and was weighed weekly. R20 required set up assistance with her meals. Weight fluctuations were possible due to edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

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The "Physician's Order Sheet" documented orders for:
Fortified shakes 120 cubic centimeters (ccs.) three times daily for supplement dated 03/11/21
Fortified food with meals dated 03/11/21
Regular diet dated 04/29/21

Review of the Physician's "Initial History and Physical" report dated 03/16/21 documented R20 had protein-calorie malnutrition and was on nutritional supplements. R20's weights and oral intake were monitored.

Review of the "Eating" tab from 03/16/21 through 5/4/21 revealed a lack of percentages of meals eaten in March and April and nine of 12 meals in May.

Review of the "Supplement Intake" tab reviewed from 03/11/21 to 05/04/21 revealed no documentation for percentages consumed two of 61 doses in March, seven of 93 does in April, and two of 12 doses in May.

The EMR documented the following weights:
03/15/21= 107.2 pounds (lbs.)
03/22/21= 109.7 lbs.
03/29/21= 101.8 lbs.
04/05/21=101.1 lbs.
04/12/21= 103.1 lbs.
04/19/21= 99.7 lbs.
04/26/21= 101.7 lbs.
05/3/21= 100.1 lbs

Review of the "General Skin Checks" tab from 03/11/21 through 04/29/21 revealed no documentation for the presence of edema.
On 05/06/21 at 11:01 AM Certified Nurse Aide (CNA) P stated the CNAs documented the

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percentages of meals eaten by the residents.

On O5/06/21 at Licensed Nurse H stated weights are obtained at monthly on all residents. The CNAs documented the percentages of meals and supplements consumed by the residents. R20 had been eating and had taken nutritional supplements well this week.

On 05/06/21 at 01:12 PM Administrative Nurse D stated the facility considered a substantial weight loss of more than 5% in a month substantial. The staff documented the amount of meals and nutritional supplements consumed by the residents.

The facility's "Nutritional Status" policy dated 06/07/19 documented an unplanned weight loss of greater than 5% in one month and 7.5% in three months was considered severe.

The facility failed to ensure consistent monitoring of nutritional supplement and meal intake for R20. This had the potential for inaccurate assessments of nutritional status.

- The "Diagnoses" tab of R15's electronic medical record (EMR) documented diagnoses of Parkinson's (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) disease and dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbances.

The "Admission Minimum Data Set" (MDS) dated 09/04/20 documented R15 had a Brief Interview

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for Mental Status (BIMS) score of six which indicated severe cognitive impairment. R15 required extensive physical assistance with two staff members for transfers and supervision with one staff member for eating. R15 did not have any swallowing difficulties during the assessment period.

The "Quarterly MDS" dated 03/01/21 documented R15 was unable to complete a BIMS assessment. R15 required extensive physical assistance with two staff members for transfers and extensive physical assistance with one staff member for eating. R15 had coughing or choking with meals during the assessment period.

The "Nutritional Status Care Area Assessment" (CAA) dated 09/20/20 documented R15 was on a regular diet and fed herself with set up and verbal cues to stay on task.

The "Nutritional Status Care Plan" dated 08/31/20 documented R15 experienced weight loss related to end-stage Parkinson's disease and required set up assistance with eating and at times required more assistance. The "Care Plan" documented an intervention dated 03/09/21 that R15 was on a regular, fortified foods diet.

The "Interdisciplinary (ID) Notes" of R15's EMR documented a note on 03/30/21 at 10:07 PM that R15 had choked during dinner and had difficulty breathing. Heimlich maneuver (first-aid procedure for dislodging an obstruction from a person's windpipe in which a sudden strong pressure is applied on the abdomen between the naval and rib cage) was performed and was able to get pieces of food out. Hospice nurse was notified, and new order obtained for mechanical soft diet.

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The "Orders" tab of R15's EMR documented an order with a start date of 03/30/21 for a mechanical soft diet (diet designed for people who have trouble chewing and swallowing).

In an observation on 05/04/21 at 09:14 AM, R15 sat in a Broda wheelchair (specialized wheelchair with the ability to tilt and recline) at the dining room table. Staff served R15 a bowl of canned pineapple tidbits. R15 attempted to feed herself with left hand but pineapple fell off the spoon and was unable to feed herself.

In an observation on 05/06/21 at 09:13 AM, R15 sat in a Broda wheelchair at the dining room table. A bowl of tropical fruit including pineapple sat in front of her within her reach. She was not attempting to feed self at that time.

In an interview on 05/06/21 at 11:23 AM, Dietary staff CC stated mechanical soft diet can have soft fruits and that pineapple was okay, she assumed, because it was soft. She stated she was not sure if there was a list or reference in the kitchen to what foods were acceptable on mechanical soft diet.

In an interview on 05/06/21 at 12:04 PM, Dietary staff BB stated typically a mechanical soft diet included soft, canned fruit but pineapple was not acceptable. He stated there was a binder in the dietary office that listed what foods were acceptable for mechanical soft diet.

In an interview on 05/06/21 at 01:11 PM, Certified Nurse Aide (CNA) N stated the resident care profile listed the resident's diet. She stated acceptable fruits for mechanical soft diet were

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F 692	Continued From page 14 mandarin oranges, peaches, and soft fruits but she was unsure about pineapple. In an interview on 05/06/21 at 01:12 PM, Licensed Nurse (LN) G stated the resident care profile listed the resident's diet and most of the time dietary brought the food up from the kitchen. She stated pineapple was acceptable if cut up in small pieces for mechanical soft diet. In an interview on 05/06/21 at 01:16 PM, Administrative Nursing Staff D stated nursing relied on kitchen to send acceptable mechanical soft foods and that pineapple was not acceptable since it was not soft. According to https://Dysphagia-Diet.com and the "National Dysphagia Diet: Standardization for Optimal Care. American Dietetic Association" for mechanical soft diets: "fresh, canned, or cooked pineapple should be avoided." The facility's "Diet Orders" policy, last revised 03/07/2019, directed the physician determined the resident's diet and consistency of the diet on admission as well as for any diet change. The policy lacked direction of mechanical soft diets. The facility failed to follow the order for a mechanical soft diet for R15 when she was served canned pineapple. This deficient practice had the risk for choking, aspiration, and unwarranted physical complications.	F 692		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who	F 698		

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require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 48 residents. The sample included 15 residents, with one resident reviewed for hemodialysis (procedure using a machine to remove excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Based on observations, record reviews, and interviews, the facility failed to retain dialysis communication sheets and obtain or document vital signs and/or assessments after dialysis for Resident (R) 40.

Findings included:

- The "Diagnoses" tab of R40's electronic medical record (EMR) documented diagnoses of end stage renal disease (ESRD- inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes) and dependence on renal dialysis.

The "Admission Minimum Data Set" (MDS) dated 04/05/21 documented R40 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. R40 received dialysis while a resident during the assessment period.

The "Urinary Incontinence (involuntary loss of bladder) and Indwelling Catheter (tube inserted into the bladder to drain urine into a collection bag) Care Area Assessment" (CAA) dated 04/05/21 documented R40 had ESRD and

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required dialysis three times a week.

The "Dialysis Care Plan" dated 03/30/21 documented R40 required assistance with management of dialysis care and instructed staff assisted R40 with management of dialysis care per nursing standards and physician orders and to observe for signs and symptoms of hypotension (low blood pressure), bleeding, and pain.

The "Orders" tab of R40's EMR documented an order with a start date of 03/30/21 for dialysis Monday, Wednesday, and Friday.

The "Hemodialysis Communication Form" used by facility included three sections: medications received and vital signs before dialysis, section for dialysis facility to complete, and vital signs with assessment of dialysis site to be completed by facility after dialysis.

The "Hemodialysis Communication Forms" were reviewed in R40's physical chart. The following dates had partial completion of the communication form with no vital signs and/or assessment documented upon return to facility from dialysis: 04/02/21, 04/19/21. The following dates were dialysis dates the resident attended but no communication form was in the chart: 04/16/21, 04/21/21, 04/23/21, 04/26/21, 04/30/21, and 05/05/21.

In an observation on 05/05/21 at 02:04 PM, R40 was propelled in wheelchair by transportation staff to transportation van for her dialysis appointment. R40 smiled and stated she was finally leaving for her appointment.

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F 698	Continued From page 17 In an interview on 05/06/21 at 11:50 AM, Certified Nurse Aide (CNA) M stated she only assisted dialysis residents with getting ready for their appointment. In an interview on 05/06/21 at 12:46 PM, Licensed Nurse (LN) G stated the facility had documentation to fill out before and after resident dialysis appointments and included vital signs and assessment of the dialysis site. In an interview on 05/06/21 at 01:16 PM, Administrative Nursing Staff D stated he expected the dialysis communication form to be completed before and after dialysis and was to be sent with the resident to dialysis for the dialysis center to fill out their portion as well. The "Dialysis- Coordination Care" policy last revised November 2015 directed it was the responsibility of the facility for the delivery of care and services to the resident before and after dialysis and directed the resident was assessed before and after transfer to dialysis center. The facility failed to retain dialysis communication sheets and obtain or document vital signs and/or assessments after dialysis for R40 which had the potential for adverse outcomes and unwarranted physical complications.	F 698		
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.	F 756		

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§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 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:
The facility identified a census of 48 residents. The sample included 15 residents; five residents were sampled for unnecessary medication review. Based on observation, record reviews, and interviews, the facility failed to act upon

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medication regimen review (MRR) by the Consultant Pharmacist (CP) for R12 and failed to ensure the CP identified and reported insulin (medication used to treat diabetes mellitus [when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin]) given outside of ordered parameters and failure to notify physician as ordered for blood sugar (concentration of glucose in the blood) below parameters for Resident (R) 12, the facility's lack of current Abnormal Involuntary Movement Scale Assessment (AIMS) for R1, and the facility's failure to administer as needed (PRN) medications as ordered for constipation for a resident who had not had a bowel movement for more than three days for R1.

Findings included:

- The "Diagnoses" tab of R12's electronic medical record (EMR) documented a diagnosis of diabetes mellitus, dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

The "Significant Change Minimum Data Set" (MDS) dated 06/08/20 documented R12 had a Brief Interview for Mental Status (BIMS) score of zero which indicated severe cognitive impairment. R12 received insulin seven days in the seven day look back period.

The "Quarterly MDS" dated 02/15/21 documented R12 had a BIMS score of zero which indicated severe cognitive impairment. R12 received insulin seven days in the seven day look back period.

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The "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 06/08/20 documented R12 had Alzheimer's disease and did not answer any of the assessment questions. She stated staff anticipated her needs.

The "Diseases/Conditions Care Plan" dated 07/29/19 documented R12 had the potential for hypo/hyper glycemia (low/high blood sugar) due to diagnoses of diabetes and directed staff to notify physician if blood sugar was below 70 milligrams per deciliter (mg/dL) and/or above 400 mg/dL. The "Care Plan" directed staff to administer insulin per physician orders and monitor for any signs or symptoms of adverse reactions of insulin.

The "Orders" tab of R12's EMR documented an order with a start date of 12/31/20 for Lantus (insulin medication) 30 units daily for diabetes mellitus with directions to hold if blood glucose was less than 100 mg/dL and an order with a start date of 10/22/20 for finger-stick blood sugar (FSBS) twice daily for diabetes mellitus with directions to notify the medical doctor if results were less than 70 mg/dL or greater than 400 mg/dL.

Review of R12's "Medication Administration Record" (MAR) from February 2021 to May 2021 revealed the following dates where blood glucose was documented less than 70 mg/dL: 03/02/21, 03/15/21, 03/18/21, 03/29/21, 03/30/21, 04/02/21, and 04/06/21. The following dates documented that Lantus was given outside of ordered parameters: 03/13/21, 03/28/21, and 04/24/21.

Review of the "Interdisciplinary Notes" tab of

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R12's EMR lacked documentation of provider notification for ordered parameters of blood sugar less than 70 mg/dL.

R12's MRR for November 2020 revealed a CP recommendation to ensure lab results were up-to-date and that the last glycated hemoglobin (hemoglobin A1c- test that measures the level of hemoglobin A1c in the blood as a means of determining the average blood sugar concentrations for the preceding two to three months) was in 2019. Review of the EMR and physical chart lacked evidence of A1c after November 2020.

Review of R12's MRRs for February 2021 to May 2021 lacked evidence the CP identified and reported the facility's failure of notification to provider when blood sugar readings were outside of parameters as ordered and failure to hold Lantus when blood sugar readings were outside of parameters as ordered.

In an observation on 05/04/21 at 04:17 PM, R12 sat in a Broda wheelchair (specialized wheelchair with the ability to tilt and recline) in day area, eyes open. R15 smiled and laughed at staff, she appeared comfortable with no signs of distress.

In an interview on 05/06/21 at 12:46 PM, Licensed Nurse (LN) G stated the MRRs came to the floor nurses after the doctor reviewed them and responded to the recommendations. She stated it was the floor nurse's responsibility to put new orders in. She stated majority of the time, the orders for blood pressure or insulin medications had parameters and if there was a blood sugar outside of parameters then she notified the doctor. She stated if there was an insulin order

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with parameters to hold if less than 100 mg/dL then she held the medication and documented a nurses note that it was held. She stated if the doctor was notified then it was documented in a nurse note.

In an interview on 05/06/21 at 01:16 PM, Administrative Nursing Staff D stated the CP sent monthly report to him or another staff member who sent the recommendation to the provider. The nurses received the new orders and ensured they were placed in the EMR. He stated he expected nursing to follow the parameters on the orders and call the provider if blood sugar was outside of parameters as ordered. He stated the notification should be documented. He stated if a blood sugar was outside of parameters, he expected nursing to hold insulin and call provider.

In an interview on 05/10/21 at 10:21 AM, CP GG stated she reviewed blood sugars monthly to determine if insulin was given outside of ordered parameters. She stated she was not always able to find notification to provider of blood sugar outside of ordered parameters in the ID notes.

The facility's "Drug Regimen Review," (DRR) last revised 06/10/18 directed that if an irregularity did not require urgent action but should have been addressed before the next DRR, the facility staff and CP conferred on the timeliness of attending physician responses to identified irregularities based on the specific resident's condition. Pharmacist recommendations were noted in resident record.

The facility's "Notification Parameters- Primary Care Provider (PCP)" policy, last revised 06/10/19, directed licensed nurses had the

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responsibility of contacting the PCP any time a resident had developed a clinical problem requiring PCP intervention and if it was a non-immediate notification then the PCP was informed during normal office hours, no later than the next regular office day.

The facility's "Blood Glucose Monitoring" policy, last revised 05/15/19, directed the PCP order contained specific parameters for notifying PCP of abnormal results.

The facility failed to act upon recommendations by CP for lab testing and failed to ensure CP identified and reported the facility's failure to notify the physician when blood sugar was outside of parameters and when Lantus insulin was given outside of ordered parameters for R12. This failure had the risk for unnecessary medication use and unwarranted physical complications.

- R1's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), psychosis (any major mental disorder characterized by a gross impairment testing), and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Significant Change Minimum Data Set" (MDS) dated 01/26/21 documented a Brief Interview of Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS documented R1 required extensive assistance of one staff member for activities of daily living (ADLs). The MDS also documented R1 received antipsychotic (class of medications

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used to treat psychosis and other mental emotional conditions) medications for seven days during the look back period.

R1's " Psychotropic Drug Use Care Area Assessment" (CAA) dated 02/02/21 documented she received Seroquel (an antipsychotic medication) for psychosis. She tolerated the medication without side effects

R1's "Care Plan" dated 11/01/19 documented that the pharmacist would review her medication monthly to monitor for side effects.

Review of the "EMR Forms" tab revealed an "Abnormal Involuntary Movement Scale" assessment (AIMS) was completed on 04/19/20. The EMR lacked a more recent AIMS assessment.

Review of the "Physician Orders" tab revealed the following orders:

Seroquel 50 milligrams (mgs) at bedtime (HS) for psychosis dated 03/19/21.

Seroquel 25mg daily for psychosis dated 03/10/21.

Bisacodyl (laxative medication used to stimulate or facility evacuation of the bowels) rectal suppository daily as needed (PRN) for constipation dated 02/10/21.

Docusate sodium (laxative) 100mg twice daily for hard stools dated 10/31/20.

MiraLAX (laxative) 17 gram mix with four ounces of water or juice daily PRN for constipation dated

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03/12/20.

R1's "Point of Care" tab in the EMR reviewed from January 2021 to May 7, 2021 revealed no bowel movements documented between: 01/28/21 to 02/02/21 (six days); 02/05/02/09/21 (4 days- Bisacodyl was administered on 02/05/21); 02/20/21 to 02/23/21 (four days); 04/13/21 to 04/17/21 (four days); 04/21/21 to 05/19/21 (nine days).

The MMR, performed by the CP, reviewed from May 2020 through May 2021 did not address the lack of an AIMS assessment for R1 who had received an antipsychotic medication during the reviews. The MRR's failed to address the lack of bowel monitoring for R1 during the review period.

Observation on 05/06/21 at 08:03 AM R1 sat in the common area and visited with another resident. No abnormal facial or extremality movement noted.

On 05/06/21 at 12:04 PM during an interview, Licensed Nurse (LN) I stated the night shift nurse rans a bowel report for the previous three days or nine shifts and the day nurse reviewed if there were no administration of any PRN's or notifications to the physician. LN, I stated that the AIMS assessment was completed by the nurse on the unit for any resident that received an antipsychotic medication. LN I also stated that the "Director of Nursing" (DON) notified the nurse when an AIMS assessment was due.

On 05/06/21 at 01:12 PM during an interview with Administrative Nurse D stated that every morning the nurse managers on each unit reviewed the bowel report for the past three days or nine shifts

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F 756	Continued From page 26 for every resident. The nurse managers directed the nurse on the unit of the resident bowel list. Administrative Nurse D stated that AIMS assessments are completed every six months for any residents on antipsychotic medication. On 05/10/21 at 10:21 AM during an interview with CP GG, she stated that she reviewed the AIMS during MMR's. CP GG also had stated that the facility had recently talked to her about review of the resident's bowel movements monthly. The "Drug Regimen Review" policy dated 06/10/19 documented that the review of the drug regimen was to identify and if possible to prevent potential clinically significant medication adverse consequences. The facility failed to ensure the CP GG recognized and reported the lack of an AIMS assessment in the past year for R1 which put her at risk for adverse side effects and consequences of unnecessary psychotropic medication. The CP failed to identify and report the lack of bowel movement monitoring for R1. This deficient practice placed R1 at risk for adverse consequences related to unnecessary medication and potential delay in identifying and treating constipation.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including	F 757		

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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 757	Continued From page 27 duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 48 residents. The sample included 15 residents; five residents were sampled for unnecessary medication review. Based on observation, record reviews, and interviews, the facility failed to perform a glycated hemoglobin (hemoglobin A1c- test that measures the level of hemoglobin A1c in the blood as a means of determining the average blood sugar concentrations for the preceding two to three months) since 2019, failed to hold insulin (medication used to treat diabetes mellitus [when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin]) when blood sugar (concentration of glucose in the blood) was outside of ordered parameters and failed to notify physician as ordered for blood sugar below parameters for Resident (R) 12. The facility failed to administer as needed (PRN) medications as ordered for constipation for a resident who had not had a bowel movement for more than three days for R1.	F 757		

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Findings included:

- The "Diagnoses" tab of R12's electronic medical record (EMR) documented a diagnosis of diabetes mellitus, dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).

The "Significant Change Minimum Data Set" (MDS) dated 06/08/20 documented R12 had a Brief Interview for Mental Status (BIMS) score of zero which indicated severe cognitive impairment. R12 received insulin seven days in the seven day look back period.

The "Quarterly MDS" dated 02/15/21 documented R12 had a BIMS score of zero which indicated severe cognitive impairment. R12 received insulin seven days in the seven day look back period.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 06/08/20 documented R12 had Alzheimer's disease and did not answer any of the assessment questions. She stated staff anticipated her needs.

The "Diseases/Conditions Care Plan" dated 07/29/19 documented R12 had the potential for hypo/hyper glycemia (low/high blood sugar) due to diagnoses of diabetes and directed staff to notify physician if blood sugar was below 70 milligrams per deciliter (mg/dL) and/or above 400 mg/dL. The "Care Plan" directed staff to administer insulin per physician orders and monitor for any signs or symptoms of adverse

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reactions of insulin.

The "Orders" tab of R12's EMR documented an order with a start date of 12/31/20 for Lantus (insulin medication) 30 units daily for diabetes mellitus with directions to hold if blood glucose was less than 100 mg/dL and an order with a start date of 10/22/20 for finger-stick blood sugar (FSBS) twice daily for diabetes mellitus with directions to notify the medical doctor if results were less than 70 mg/dL or greater than 400 mg/dL.

Review of R12's "Medication Administration Record" (MAR) from February 2021 to May 2021 revealed the following dates where blood glucose was documented less than 70 mg/dL: 03/02/21, 03/15/21, 03/18/21, 03/29/21, 03/30/21, 04/02/21, and 04/06/21. The following dates documented that Lantus was given outside of ordered parameters: 03/13/21, 03/28/21, and 04/24/21.

Review of the "Interdisciplinary Notes" tab of R12's EMR lacked documentation of provider notification for ordered parameters of blood sugar less than 70 mg/dL.

R12's physical chart and EMR lacked A1c lab results in 2020 and 2021.

In an observation on 05/04/21 at 04:17 PM, R12 sat in a Broda wheelchair (specialized wheelchair with the ability to tilt and recline) in day area, eyes open. R15 smiled and laughed at staff, she appeared comfortable with no signs of distress.

In an interview on 05/06/21 at 12:46 PM, Licensed Nurse (LN) G stated majority of the time, the orders for blood pressure or insulin

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medications had parameters and if there was a blood sugar outside of parameters then she notified the doctor. She stated if there was an insulin order with parameters to hold if less than 100 mg/dL then she held the medication and documented a nurse's note that it was held. She stated if the doctor was notified then it was documented in a nurse note.

In an interview on 05/06/21 at 01:16 PM, Administrative Nursing Staff D stated he expected nursing to follow the parameters on the orders and call the provider if blood sugar was outside of parameters as ordered. He stated the notification should be documented. He stated if a blood sugar was outside of parameters, he expected nursing to hold insulin and call provider.

The facility's "Notification Parameters- Primary Care Provider (PCP)" policy, last revised 06/10/19, directed licensed nurses had the responsibility of contacting the PCP any time a resident had developed a clinical problem requiring PCP intervention and if it was a non-immediate notification then the PCP was informed during normal office hours, no later than the next regular office day.

The facility's "Blood Glucose Monitoring" policy, last revised 05/15/19, directed the PCP order contained specific parameters for notifying PCP of abnormal results. The policy lacked direction on A1c lab monitoring.

The facility failed to provide A1c lab testing since 2019, failed to hold Lantus insulin when blood sugar was outside of ordered parameters, and failed to notify the physician when blood sugar was outside of parameters as ordered for R12.

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This failure had the risk for unnecessary medication use and unwarranted physical complications.
- R1's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), psychosis (any major mental disorder characterized by a gross impairment testing), and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Significant Change Minimum Data Set" (MDS) dated 01/26/21 documented a Brief Interview of Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS documented R1 required extensive assistance of one staff member for activities of daily living (ADLs). The MDS also documented R1 received antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) medications for seven days during the look back period.

R1's " Psychotropic Drug Use Care Area Assessment" (CAA) dated 02/02/21 documented she received Seroquel (an antipsychotic medication) for psychosis. She tolerated the medication without side effects

R1's "Care Plan" dated 11/01/19 documented that the pharmacist would review her medication monthly to monitor for side effects.

Review of the "Physician Orders" tab revealed the following orders:

Bisacodyl (laxative medication used to stimulate

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or facility evacuation of the bowels) rectal suppository daily as needed (PRN) for constipation dated 02/10/21.

Docusate sodium (laxative) 100mg twice daily for hard stools dated 10/31/20.

MiraLAX (laxative) 17 gram mix with four ounces of water or juice daily PRN for constipation dated 03/12/20.

R1's "Point of Care" tab in the EMR reviewed from January 2021 to May 7, 2021 revealed no bowel movements documented between: 01/28/21 to 02/02/21 (six days); 02/05/02/09/21 (4 days- Bisacodyl was administered on 02/05/21); 02/20/21 to 02/23/21 (four days); 04/13/21 to 04/17/21 (four days); 04/21/21 to 05/19/21 (nine days).

Observation on 05/06/21 at 08:03 AM R1 satin the common area as she visited with another resident. No abnormal facial or extremality movement noted.

On 05/06/21 at 11:52 AM during an interview with Certified Nurses Aide (CNA) O stated that the nurse notified the staff every shift which residents that had been on the bowel list for that day. The CAN O stated that the staff offered prune and prune juice at meals.

On 05/06/21 at 12:04 PM during an interview, Licensed Nurse (LN) I stated the night shift nurse ran a bowel report for the previous three days or nine shifts and the day nurse reviewed if there were no administration of any PRN's or notifications to the physician.

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F 757	Continued From page 33 On 05/06/21 at 01:12 PM during an interview with Administrative Nurse D stated that every morning the nurse managers on each unit reviewed the bowel report for the past three days or nine shifts for every resident. The nurse managers directed the nurse on the unit of the resident bowel list. The facilitydid not provide related bowel monitoring policy. The facility failed to ensure consistent bowel monitoring was done for R1 which put her at risk for adverse consequences related to unnecessary medication and potential delay in identifying and treating constipation.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		

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§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 48 residents. The sample included 15 residents of which five residents were reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed ensure that R1 had an "Abnormal Involuntary Movement Scale" assessment (AIMS) completed in an approximate time fame to monitor for adverse side effects of antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) medication use.

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Findings included:

- R1's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), psychosis (any major mental disorder characterized by a gross impairment testing), and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Significant Change Minimum Data Set" (MDS) dated 01/26/21 documented a Brief Interview of Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS documented R1 required extensive assistance of one staff member for activities of daily living (ADLs). The MDS also documented R1 received antipsychotic medications for seven days during the look back period.

R1's " Psychotropic Drug Use Care Area Assessment" (CAA) dated 02/02/21 documented she received Seroquel (an antipsychotic medication) for psychosis. She tolerated the medication without side effects

R1's "Care Plan" dated 11/01/19 documented that the pharmacist would review her medication monthly to monitor for side effects.

Review of the "EMR Forms" tab revealed an "Abnormal Involuntary Movement Scale" assessment (AIMS) was completed on 04/19/20.

Review of the "Physician Orders" tab revealed the following orders:

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F 758	Continued From page 36 Seroquel 50 milligrams (mgs) at bedtime (HS) for psychosis dated 03/19/21. Seroquel 25mg daily for psychosis dated 03/10/21. Observation on 05/06/21 at 08:03 AM R1 sat in the common area as she visited with another resident. No abnormal facial or extremity movement noted. On 05/06/21 at 12:04 PM during an interview, Licensed Nurse (LN) I stated that the AIMS assessment was completed by the nurse on the unit for any resident that received an antipsychotic medication. LN I also stated that the "Director of Nursing" (DON) notified the nurse when an AIMS assessment was due. On 05/06/21 at 01:12 PM during an interview with Administrative Nurse D stated that AIMS assessments are completed every six months for any residents on antipsychotic medication. The "Psychoactive Psychopharmacological Medications" policy dated 06/10/19 documented that an AIMS assessment was completed every six months in the EMR for the residents that take antipsychotic medication. The facility failed to ensure that an AIMS assessment was completed in the past year for R1 which put her at risk for adverse side effects and consequences of psychotropic/antipsychotic medication.	F 758		
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60	F 800		

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§483.60 Food and nutrition services.
The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 48 residents. There were four residents on puree diet (diet that are mechanically altered to a pudding-like consistency) in the facility. Based on observations, record reviews, and interviews, the facility failed to follow puree diet recipes during puree meal preparation and failed to ensure hot foods were held at 135 degrees Fahrenheit (F) or higher on the steam table.

Findings included:

- In an observation on 05/04/21 at 10:36 AM, Dietary DD pureed beef stroganoff with milk, no puree recipe observed. She stated she did not know what a puree recipe was.

In an observation on 05/05/21 at 07:15 AM, Dietary CC prepared pureed cinnamon roll. She placed eight cinnamon rolls, measured three-fourths cup of milk, and poured some melted butter into the food processor. She stated it was about half an ounce of butter. Puree recipe laid on the prep surface in staff's view.

In an observation on 05/05/21 at 07:24 AM, Dietary CC prepared pureed western scrambled eggs. She emptied a plastic container of prepared scrambled eggs into the food processor then added a measured one-fourth cup of milk. She

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stated she placed around two cups of scrambled eggs into the food processor and that she measured them before she placed them in the plastic container. Puree recipe laid on the prep surface in staff's view.

In an observation on 05/05/21 at 07:29 AM, Dietary CC prepared pureed sausage patties. She grabbed 11 sausage links with gloved hand from a container and placed in the food processor. She looked for a tablespoon but was unable to locate one. She added half a cup of hot water then pureed the sausage links; she added another half a cup of hot water then continued to puree. Puree recipe laid on the prep surface in staff's view.

In an observation on 05/05/21 at 08:18 AM, Dietary FF used a food thermometer to test the temperatures of breakfast food items on hall B. Mechanical soft bacon temperature was 100 degrees F, mechanical soft sausage was 120 degrees F, pureed oatmeal was 120 degrees F, pureed sausage was 120 degrees F.

The facility's "Pureed Cinnamon Roll" recipe for five servings called for five cinnamon rolls, three-fourths cup of milk, and one-half ounce of margarine.

The facility's "Pureed Western Scrambled Eggs" recipe for five servings called for two and a half cups of western scrambled eggs and one-fourth cup of milk.

The facility's "Pureed Sausage Patty" recipe for five servings called for five sausage patties, one-half cup of hot water, and one-fourth teaspoon of ham or pork base.

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In an interview on 05/04/21 at 10:36 AM, Dietary EE stated the puree recipes were in the office, but she was unable to pull them out.

In an interview on 05/06/21 at 11:23 AM, Dietary CC stated she asked whoever was in charge how to prepare a puree meal and that sometimes a puree recipe was available and sometimes she followed it. She stated food temperatures were monitored before they left the kitchen then once again before serving on the neighborhoods. She stated if a food item was not at the required temperature, she would have heated the food item up.

In an interview on 05/06/21 at 12:04 PM, Dietary BB stated there was a recipe book that dietary staff had access to and referred to. He stated he expected dietary staff to follow the puree recipe and that staff made substitutions if needed. He stated food temperatures were monitored when food was pulled out of the ovens, when delivered to the neighborhoods, and once again before food was served. He stated holding temperature was 145 degrees F and he expected staff to remove an item that was below acceptable holding temperature and heat up before they returned it to the service line.

The facility's "Food Production Activities" policy, last revised 03/07/19, directed standardized recipes were used for all menu items and food was prepared according to the census and type of diets ordered.

The facility's "Food Handling Practices for Potentially Hazardous Foods and Time/Temperature Controlled Foods" policy, last

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F 800	Continued From page 40 revised 03/07/19, directed dietary staff were aware of critical food handling practices that helped prevent foodborne illness, including cooling procedures, thawing procedures and temperature maintenance, proper internal cooking temperatures and reheating foods. The policy directed foods were cooked to the proper internal cooking temperature and verified with a thermometer before removing for service. The facility failed to ensure dietary staff followed recipe during puree diet preparation and failed to ensure food was held at 135 degrees F at the steam table before serving. This deficient practice had the risk for altered nutritional status, unpalatable food, transmission of food-borne illness to residents, and unwarranted physical complications.	F 800		
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	F 812		

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serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 48 residents. Based on observations, record reviews, and interviews, the facility failed to ensure expired milk was discarded, dishes were stored inverted, and food was handled in a sanitary manner.

Findings included:

- An observation on 05/04/21 at 07:50 AM revealed there were two unopened half gallons of two percent milk that expired on 05/02/21 and three gallons of unopened whole milk that expired on 05/03/21 in the walk-in refrigerator.

An observation on 05/04/21 at 07:59 AM revealed dishes on a storage cart in the employee serving line were not inverted or covered. There was an opened gallon of whole milk that expired 05/03/21 in the refrigerator in the employee serving area. There were dishes stored under the steam tables in the employee serving area that were not inverted or covered.

An observation on 05/05/21 at 07:29 AM revealed Dietary CC grabbed container of sausage links and bacon out of warmer then donned (put on) gloves, no hand hygiene performed before donning. She grabbed sausage links with her gloved hand and placed in food processor.

An observation on 05/05/21 at 07:52 AM revealed dishes under steam tables in the employee serving line were not inverted or covered.

An observation on 05/05/21 at 08:31 AM

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revealed Certified Nurse Aide (CNA) M performed hand hygiene, donned gloves, removed plastic from food containers then opened drawer to grab food scooper, then grabbed Styrofoam containers. CNA M grabbed sausage and bacon with her gloved hand and placed on Styrofoam container. She grabbed bacon and cinnamon roll with gloved hand and placed on another Styrofoam container. She placed a scoop of oatmeal into a bowl, opened the container of brown sugar and scooped sugar into oatmeal bowl, and opened two creamer packets into bowl of oatmeal. While she wore same gloves, she placed a scoop of eggs onto a Styrofoam container, grabbed a slice of bread from the bag and placed in toaster, then grabbed bacon with hands to place on Styrofoam container. She doffed gloves and passed Styrofoam containers to two residents.

An observation on 05/05/21 at 08:39 AM revealed CNA M donned gloves without hand hygiene, grabbed bacon and cinnamon roll with gloved hand, placed on Styrofoam container.

An observation on 05/06/21 at 11:21 AM revealed dishes under steam tables in the employee serving line were not inverted or covered.

In an interview on 05/04/21 at 07:56 AM, Dietary EE stated the dishwasher staff checked for expired containers on Tuesdays and Fridays.

In an interview on 05/04/21 at 08:02 AM, Dietary EE stated the dishes under the employee serving line needed to be taken out and the dish storage cart in the employee serving area was usually covered.

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In an interview on 05/06/21 at 11:23 AM, Dietary CC stated she washed her hands after she removed her gloves. She stated the dietary staff member who put away the truck shipment checked for expired items. She stated dishes were always covered on the storage cart and dishes were to be stored upside down. She stated the dishes under the employee serving line were not safe from contamination.

In an interview on 05/06/21 at 11:50 AM, CNA M stated food should not have been touched after touching other surfaces while wearing same gloves.

In an interview on 05/06/21 at 12:04 AM, Dietary BB stated hand hygiene was performed after changing gloves and touching food. He stated food items should have been checked daily for expired items but were checked thoroughly on delivery days on Tuesdays and Fridays. He stated dishes were stored upside down and the dishes under the employee serving line were not safe from contamination.

In an interview on 05/06/21 at 12:46 PM, Licensed Nurse (LN) G stated staff did not touch food after touching other surfaces with same gloves.

In an interview on 05/06/21 at 01:04 PM, Dietary BB stated staff should not have touched food with gloves after touching other surfaces with same gloves.

In an interview on 05/06/21 at 01:16 PM, Administrative Nursing Staff D stated he expected staff not to touch the food directly after touching other surfaces while wearing the same gloves.

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F 812	Continued From page 44 The facility's "Food Storage" policy, last revised 03/07/19, directed food was stored on shelves in areas which provided the best preservation and stored at a proper temperature for appropriate lengths of time. The policy lacked direction on expired products. The facility's "Food Handling Practices for Potentially Hazardous Foods and Time/Temperature Controlled Foods" policy, last revised 03/07/19, directed dietary staff were aware of critical food handling practices that helped prevent foodborne illness, including cooling procedures, thawing procedures and temperature maintenance, proper internal cooking temperatures and reheating foods. The facility did not provide a policy on dish storage. The facility failed to ensure expired milk was discarded, dishes were stored inverted, and food was handled in a sanitary manner. This deficient practice had the risk to spread food-borne illness and infection to residents and staff.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		

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program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility reported a census 48 residents. The sample included 15 residents. Based on observations, record reviews and interviews, the facility failed to ensure staff practiced standard infection control practices regarding appropriate hand hygiene and use of personal protective equipment (PPE) in order to prevent the spread of infection. This had the potential to increase the residents' risk for transmission of infectious disease.

Findings included:

- On 05/04/21 at 08:40 AM Activity Staff Z washed her hands with soap and water, cut an orange into pieces, placed the pieces in a cup, rinsed the knife off with water, dried it with a paper towel, and placed the knife in a drawer. Activity Staff Z covered the oranges with plastic wrap, placed them on a wheeled cart, walked to the meal service counter and looked through

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papers, filled a glass of water and placed it on the cart and took the cart down the hall. Activity Staff Z did not don gloves or sanitize her hands.

On 05/04/21 at 09:15 AM a female staff member unwrapped a utensil package and placed the utensils on R 23's bowl and plate. She filled two Styrofoam cups with ice as she held them with two fingers inside the cup. She dispensed utensils to a female resident and gave the resident a bite of food. She then walked to the meal counter, received a bowl and plate and took to another female resident. She walked back to the kitchenette placed something in the cabinet, took a juice container from the refrigerator and poured a glass of juice to a resident. She did not sanitize her hands or don gloves. She placed the juice back in the refrigerator and washed her hands with soap and water.

On 05/04/21 at 09:18 AM an unidentified staff member placed meal trays in the dirty container and proceeded to assist a female resident with breakfast and did not perform hand hygiene.

On 05/05/21 at 07:15 AM Dietary Staff (DS) CC donned gloves, pureed cinnamon rolls, butter, and milk, doffed gloves, donned new gloves, placed the pureed food in three containers, took a wet cloth from a red disinfectant container, doffed gloves, donned new gloves, and did not perform hand hygiene.

On 05/05/21 at 07:44 AM Licensed Nurse (LN) H washed hands with soap and water, donned gloves, detached the tabs from the left side of R20's incontinence brief, took the soiled bandage off of her pressure wound (localized injury to the skin and/or underlying tissue usually over a bony

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prominence, as a result of pressure, or pressure in combination with shear and/or friction), placed it on R20's brief, removed packing from the inside of the wound with a clean cotton tipped swab, placed on the soiled bandage, cleaned the wound with spray wound cleanser and gauze pad, placed the cleanser bottle on the bed and checked the wound with the soiled cotton tip swab, placed the swab on top of the soiled gauze, doffed gloves, donned a new pair of gloves and did not sanitize hands. LN H took a pair of scissors out of his pocket, cut a strip of calcium alginate (a dressing used to soak up loose debris from a wound and provide an optimal environment for healing), placed it in the wound with a new cotton tipped swab, placed a clean bandage on the wound, took a pen out his pocket and wrote the date on the bandage, wrapped the soiled items in his gloves as he doffed. LN H placed the gloves on a clean box of bandages, then on the bedside table, and then disposed them in the trashcan. LN H washed his hands with soap and water.

On 05/05/21 at 08:31 AM Certified Nurse Aide (CNA) M performed hand hygiene and donned gloves. CNA M removed plastic wrap from some food, retrieved sausage, bacon, and a cinnamon roll with her hands and placed them on a food tray, placed a scoop of oatmeal in a bowl, opened a brown sugar container and two creamer containers into the oatmeal, placed a scoop of eggs on a plate, placed a slice of bread in a toaster and did not sanitize her hands.

On 05/06/21 at 07:14 AM LN H took a Dynamap (machine used to measure blood pressures and pulses) into R12's room. LN H placed a glucometer (machine used to test blood sugar

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levels), an alcohol pad, and a bottle of test strips (used to obtain the blood sample used to measure blood sugar levels) on top of R12's bedspread, obtained the blood sample, placed the glucometer and test strip bottle in a plastic bag and placed in the Dynamap basket. LN H doffed gloves and placed the soiled test strip and lancet (needled device used to obtain a blood sample) in the soiled gloves, placed the soiled gloves on R12's bedspread, donned new gloves, did not sanitize hands, and gave an insulin injection (medication used to treat diabetes-when the body can't use glucose, not enough insulin is made, or the body can't respond to the insulin), doffed the gloves and washed with soap and water. LN H took the Dynamap to the dining room and took a female resident's blood pressure with a wrist cuff, placed the cuff back in the Dynamap basket, wrote something on a piece of paper, and proceeded to take another resident's blood pressure with the wrist cuff. Neither the Dynamap nor wrist cuff were sanitized between residents. LN had not sanitized hands or donned gloves.

On 05/06/21 at 08:54 AM an unidentified female staff ate food while she served food in the kitchenette on "Friendship Heights". She had her protective mask under her chin with her nose and mouth exposed.

On 05/06/21 at 11:04 AM LN H stated he had received in-services on donning/doffing PPE and hand hygiene. The administrative staff had done spot checks on the staff's techniques for donning/doffing and hand hygiene. Hand sanitizer was used between tasks like medication administration, before treatments and doffing gloves, and soap and water were used when hands were visibly soiled. Sani-wipes (disinfecting

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cleaning cloths) were used to clean reusable equipment after use.

On 05/06/21 at 11:23 AM DS CC stated a staff member showed her how to perform hand hygiene properly. Hands were sanitized between tasks and after gloves were doffed

On 05/06/21 at 01:32 PM Administrative Nurse D stated staff sanitized their hands during meals, before and after providing resident cares, and after doffed gloves. The facility staff had received in-services on hand hygiene, donning/doffing PPE and sanitizing reusable medical equipment. The reusable medical equipment should be sanitized after each use.

The facility's "Emergent Infectious Disease (EID) Outbreak Management" policy dated 04/15/21 documented part of routine education of staff included methods of prevention such as hand hygiene and PPE usage. Measures to contain, control, and or prevent infections included but, were not limited to the use of PPE.

The facility failed to ensure staff practiced standard infection control precautions in order to prevent the spread of infection when staff failed to perform proper hand hygiene and PPE use. This had the potential to increase the risk for transmission of infectious disease to residents.