

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/23/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/16/2023
NAME OF PROVIDER OR SUPPLIER MERRIAM GARDENS HEALTHCARE & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 9700 W 62ND STREET MERRIAM, KS 66203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000			
F 565 SS=E	The 2567 was sent electronically on 02/24/23 Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 565			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

02/24/2023

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 565	Continued From page 1 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to follow-up or resolve resident grievances, placing the residents at risk for unresolved concerns. Findings included: - On 02/14/23 at 10:30AM, during private discussion with the residents of the resident council, residents verbalized an ongoing unpleasant experience with the facility meals, stating the facility does not always have items on the menu, or on the alternate menu. Council members verbalized no resolution from the facility regarding the council's grievances. During the council meeting one of the Residents (R) stated he was given a breadstick instead of the cheeseburger he ordered. Council members verbalized a salad was served for supper and facility did not have any salad dressing for the residents' salads. Review of the council meeting minutes for October, November, December 2022 and January 2023, lacked documentation of the facility's action to resolve menu and food grievances.	F 565			

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F 565	Continued From page 2 Review of the facility's grievance log lacked documentation of grievances verbalized by the council. On 02/13/23 at 12:15PM, observation of the noon meal revealed three residents requesting crackers to eat with the beef stew which was served. Further observation revealed dietary staff informed the residents the facility was out of crackers. On 02/15/23 at 01:15PM, Activity Staff Z stated she takes notes at every resident council meeting and the resident grievances regarding food had been ongoing. Activity Staff Z stated grievances during resident council were given to the department responsible for the grievance and then there was to be follow up by that department with the resident council. On 02/15/23 at 03:00PM, Administrative Staff A verified she reviewed resident council meeting minutes. Administrative Staff A verified menu and food item problems and confirmed she had not addressed these grievances with the council. Administrative Staff A verified grievance resolutions were to be addressed with the council. The facility's "Resident Rights" dated 10/23/19, state the residents have the right to voice grievances. The facility must make prompt efforts to resolve grievances. The facility's "Resident and Family Grievance" policy dated 2017, stated the facility will make reasonable efforts to ensure grievances are adequately resolved. The facility will advise the	F 565			

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F 565	Continued From page 3 residents of the outcome of the grievance. The facility will develop steps of the resolution to include if residents were satisfied with the resolution of the grievance.	F 565			
F 657 SS=D	The facility failed to respond to resident council grievances, placing the residents in the facility at risk for unresolved issues. Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657			

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F 657	Continued From page 4 This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents. Based on observations, record review, and interview, the facility failed to update two resident care plans, Resident (R) 58 for falls and R63 for a Foley catheter (tube inserted directly into the bladder to drain urine). This placed the resident's at risk for unmet needs and cares. Findings included: - The electronic medical record (EMR) for R58 documented diagnosis of hypertension (high blood pressure), congestive heart failure (a condition with low heart output and the body becomes congested with fluid), unsteadiness on feet, and disorientation (loss of direction). The "Admission Minimum Data Set" (MDS), dated 04/09/22, documented R58 had severely impaired cognition and required extensive assistance of one staff for transfers, ambulation, dressing, and toileting. The assessment further documented R58 had unsteady balance, no functional impairment, and had falls prior to admission. The "Quarterly MDS," dated 01/27/23, documented R58 had severely impaired cognition and required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, and limited assistance of one staff for ambulation. The assessment further documented R58 had unsteady balance, no upper or lower functional impairment, and no falls. The "Fall Risk Assessments," dated 06/20/22,	F 657			

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F 657	Continued From page 5 09/19/22, 10/05/22, and 01/09/23 documented the resident was a high risk for falls. The "Fall Care Plan," dated 04/06/22, directed staff to keep R58's personal items within reach and educate R58 on the risks of overreaching; educate the resident to where his call light was; educate to stand still a moment when he first stands up, and raise his bed up when providing cares but return the bed to a height where his feet would be flat on the floor when he sat on the edge of the bed. The update, dated 04/19/22, directed staff to ensure that R58 wore appropriate non-skid footwear when ambulating. The update, dated 06/20/22, directed staff to remind R58 to use his call light for assistance with ambulation. The "Fall Investigation," dated 06/20/22 at 02:31 PM, documented R58 was on his hands and knees in his room and had stated he had tried to go to the bathroom. The investigation documented R58 did not have any injuries, and staff educated the resident to use his call light. The "Fall Investigation," dated 09/17/22 at 03:40 PM, documented R58 was found on the floor in his room, and R58 could not explain what he was doing. The investigation further documented the facility sent R58 to the hospital where he received eight staples to a laceration (a deep cut) to the back of his head. The "Fall Investigation," dated 10/05/22 at 12:17 PM, documented R58 was found on the floor by therapy, had no injuries, and could not state what he was trying to do. The investigation further documented R58 did not receive any injuries. On 02/15/23 at 08:18 AM, observation revealed	F 657			

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F 657	Continued From page 6 R58 in bed, Certified Nurse Aide (CNA) M took R58's hands to assist him to stand. CNA M did not put a gait belt on R58 but stood the resident, and had to tell him multiple times to turn and sit down into the wheelchair. On 02/15/23 at 08:20 AM, CNA M stated that the resident was a fall risk and a one-person transfer. CNA M further stated he had not had any falls when she was on duty. On 02/15/23 at 08:49 PM, Licensed Nurse (LN) G stated R58's bed should be lowered all the way to the floor because he would get up out of bed by himself and fall. On 02/15/23 at 03:30 PM, Administrative Nurse D stated R58's cognition was severely impaired, and he could not be re-educated to use a call light. Administrative Nurse D stated new interventions for his falls should have been implemented to prevent further falls. The facility "Care Plan Revisions Upon Status Change" policy, dated 02/01/20, documented the care plan would be reviewed and revised as necessary when a resident experienced a status change, and the care plan would be updated with new or modified interventions. The facility failed to implement appropriate, resident -centered fall interventions for cognitively impaired R58 who was severely cognitively impaired and had multiple falls. This placed the resident at risk for further falls and injury. - R63 was admitted to the hospital for a diagnosis of pneumonia (infection that inflames air sacs in one or both lungs which may fill with fluid) on	F 657			

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F 657	Continued From page 7 01/27/23 and returned to the facility on 02/01/23 with a urinary catheter. The "Quarterly Minimum Data Set" dated 01/08/23, documented the resident with moderately impaired cognition, required total assistance with bed mobility, transfers and toileting. Resident frequently incontinent of urine. The "Bowel and Bladder" care plan dated 01/08/23, directed the staff to provide incontinent care as needed. The "Physician Orders for Readmission" from the hospital on 02/01/23, documented the resident had a urinary catheter and lacked a diagnosis for the use of the urinary catheter. R63's medical record lacked a care plan update for the use of the urinary catheter. On 02/14/23 at 07:55AM, observation revealed R63 laid on her bed on her left side. Further observation revealed a urinary catheter drainage bag attached to the side of the bed. On 02/14/23 at 10:00AM, Licensed Nurse (LN) I verified R63 had a urinary catheter and the medical record lacked a diagnosis for the use of the urinary catheter. LM I verified there were no care plan updates for the use of the urinary catheter. On 02/14/23 at 04:00PM, Administrative Nurse D verified R63 had a urinary catheter and the medical record lacked a diagnosis for the use of the urinary catheter. Administrative Nurse D verified R63 returned to the facility from the hospital with the urinary catheter thought R63 did	F 657			

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F 657	Continued From page 8 not have one when she was transferred to the hospital from the facility on 01/27/23. Administrative Nurse D verified R63 lacked a care plan update for the use of the urinary catheter. The "Care Plan Revision" policy dated 01/01/20, the facility will provide a consistent process for reviewing and revising the care plan for residents experiencing a status change. The "Appropriate Use of Indwelling Catheter" facility policy dated 09/09/20, stated an indwelling urinary catheter will be utilized only when a resident's clinical condition demonstrates the catheterization was necessary. The use of a urinary catheter will include diagnosis of clinical condition making the use of the catheter necessary. The facility failed to revise and update the care plan for the use of the urinary catheter for R63, placing her at risk for inadequate urinary catheter care.	F 657			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents, with five reviewed	F 689			

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F 689	Continued From page 9 for accidents. Based on observation, record review, and interview, the facility failed to identify and implement appropriate, resident-centered interventions for Resident (R) 58, who had multiple falls. This placed the resident at risk for further falls. Findings included: - The Electronic Medical Record (EMR) for R58 documented diagnosis of hypertension (high blood pressure), congestive heart failure (a condition with low heart output and the body becomes congested with fluid), unsteadiness on feet, and disorientation (loss of direction). The "Admission Minimum Data Set" (MDS), dated 04/09/22, documented R58 had severely impaired cognition and required extensive assistance of one staff for transfers, ambulation, dressing, and toileting. The assessment further documented R58 had unsteady balance, no functional impairment, and had falls prior to admission. The "Quarterly MDS," dated 01/27/23, documented R58 had severely impaired cognition and required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, and limited assistance of one staff for ambulation. The assessment further documented R58 had unsteady balance, no upper or lower functional impairment, and no falls. The "Fall Risk Assessments," dated 06/20/22, 09/19/22, 10/05/22, and 01/09/23 documented the resident was a high risk for falls. The "Fall Care Plan," dated 04/06/22, directed	F 689			

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F 689	Continued From page 10 staff to keep R58's personal items within reach and educate R58 on the risks of overreaching; educate the resident to where his call light was; educate to stand still a moment when he first stands up, and raise his bed up when providing cares but return the bed to a height where his feet would be flat on the floor when he sat on the edge of the bed. The update, dated 04/19/22, directed staff to ensure that R58 wore appropriate non-skid footwear when ambulating. The update, dated 06/20/22, directed staff to remind R58 to use his call light for assistance with ambulation. The "Fall Investigation," dated 06/20/22 at 02:31 PM, documented R58 was on his hands and knees in his room and had stated he had tried to go to the bathroom. The investigation documented R58 did not have any injuries, and staff educated the resident to use his call light. The "Fall Investigation," dated 09/17/22 at 03:40 PM, documented R58 was found on the floor in his room, and R58 could not explain what he was doing. The investigation further documented the facility sent R58 to the hospital where he received eight staples to a laceration (a deep cut) to the back of his head. The "Fall Investigation," dated 10/05/22 at 12:17 PM, documented R58 was found on the floor by therapy, had no injuries, and could not state what he was trying to do. The investigation further documented R58 did not receive any injuries. On 02/15/23 at 08:18 AM, observation revealed R58 in bed. Certified Nurse Aide (CNA) M took R58's hands to assist him to stand. CNA M did not put a gait belt on R58 but stood the resident, and had to tell him multiple times to turn and sit	F 689			

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F 689	Continued From page 11 down into the wheelchair. On 02/15/23 at 08:20 AM, CNA M stated that the resident was a fall risk and a one-person transfer. CNA M further stated he had not had any falls when she was on duty. On 02/15/23 at 08:49 PM, Licensed Nurse (LN) G stated R58's bed should be lowered all the way to the floor because he would get up out of bed by himself and fall. On 02/15/23 at 03:30 PM, Administrative Nurse D stated R58's cognition was severely impaired, and he could not be re-educated to use a call light. Administrative Nurse D stated new interventions for his falls should have been implemented to prevent further falls. The facility "Accidents and Supervision" policy, undated, documented the resident's environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistive devices to prevent accidents. The facility would use interventions based on the evaluation and analysis of information about hazards and risks, development of interim safety measures may be necessary. The facility failed to implement appropriate, resident -centered fall interventions for cognitively impaired R58 who was severely cognitively impaired and had multiple falls. This placed the resident at risk for further falls and injury.	F 689			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690			

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F 690	Continued From page 12 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents. Two residents were reviewed for urinary incontinence and	F 690			

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F 690	Continued From page 13 urinary catheter (a tube in the bladder to drain urine) . Based on observation, record review and interview the facility failed to have an appropriate indication for the use of a urinary catheter for Resident (R) 63 and failed to offer toileting for R58 placing the residents at increased risk for bladder infection and incontinence related complications. Findings included: - R63 was admitted to the hospital for a diagnosis of pneumonia (infection that inflames air sacs in one or both lungs which may fill with fluid) on 01/27/23 and returned to the facility on 02/01/23 with a urinary catheter. R63's "Quarterly Minimum Data Set" dated 01/08/23, documented the resident had moderately impaired cognition, and required total assistance with bed mobility, transfers and toileting. R63 was frequently incontinent of urine. The "Bowel and Bladder" care plan dated 01/08/23, directed the staff to provide incontinent care as needed. The "Physician Orders" for readmission from the hospital on 02/01/23 documented R63 had a urinary catheter and lacked a diagnosis for the use of the urinary catheter. On 02/14/23 at 07:55AM, observation revealed R63 laid on her bed on her left side. Further observation revealed a urinary catheter drainage bag attached to the side of the bed. On 02/14/23 at 10:00AM, Licensed Nurse (LN) I verified R63 had a urinary catheter and verified	F 690			

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F 690	Continued From page 14 R63's medical record lacked a diagnosis for the use of the urinary catheter. On 02/14/23 at 04:00PM, Administrative Nurse D verified R63 had a urinary catheter and the medical record lacked a diagnosis for the use of the urinary catheter. Administrative Nurse D verified R63 returned to the facility from hospital with the urinary catheter and did not have one when she was transferred to the hospital from the facility on 01/27/23. The "Appropriate Use of Indwelling Catheter" facility policy dated 09/09/20, stated an indwelling urinary catheter will be utilized only when a resident's clinical condition demonstrates the catheterization was necessary. The use of a urinary catheter will include diagnosis of clinical condition making the use of the catheter necessary. The facility failed to have an appropriate indication or diagnosis for the use of the urinary catheter for R63, placing her at increased risk for infection and incontinence. - The Electronic Medical Record (EMR) for R58 documented diagnosis of hypertension (high blood pressure), congestive heart failure (a condition with low heart output and the body becomes congested with fluid), unsteadiness on feet, disorientation (loss of direction), and edema (puffiness caused by excess fluid trapped in the body's tissue). The "Quarterly Minimum Data Set" (MDS), dated 01/27/23, documented R58 had severely impaired cognition and required extensive assistance of one staff for bed mobility, transfers,	F 690			

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F 690	Continued From page 15 dressing, toileting, and limited assistance of one staff for ambulation. The assessment further documented R58 was frequently incontinent of bladder and bowel. The "Care Plan," dated 01/19/23, directed staff to establish voiding patterns, offer toileting upon rising, before and after meals, before lying down and assist when she voiced the urge to use the bathroom. The care plan further directed staff to provide frequent reminders to call for assistance to ambulate to the bathroom, and check R58 every two to three hours for wetness and soiling, and provide continent care with peri wipes or soap and water. The "Bowel and Bladder Assessment," dated 04/09/22, documented R58 was incontinent of urine, wore incontinence pads, was forgetful but followed commands, was sometimes mentally aware of toileting needs and was a candidate for schedule time voiding. On 02/15/23 at 08:18 AM, observation revealed R58 in bed. Certified Nurse Aide (CNA) M stated she was going to check and change R58. CNA M removed his soiled incontinence brief, performed pericare, put a clean incontinence brief on and got him dressed for the day, and did not offer to take him to the bathroom. On 02/15/23 at 08:20 AM, CNA M stated she just checked and changed R58 throughout the day and did not take him into the bathroom. On 02/15/23 at 08:49 AM, Licensed Nurse (LN) G stated staff assisted R58 with toileting when he needed it, he would sometimes tell staff when he needed to go to the bathroom.	F 690			

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F 690	Continued From page 16 On 02/15/23 at 09:35 AM, CNA P stated staff take R58 to the bathroom two or three times in a shift and staff often asked the resident if he needed to go to the bathroom. On 02/15/23 at 03:30 PM, Administrative Nurse D stated staff should follow R58's toileting care plan. The facility "Incontinence" policy, dated 09/09/20, documented, based on the comprehensive assessment, all residents that were incontinent would receive appropriate treatment and services. The facility must ensure that residents who are continent of bladder and bowel upon admission received appropriate treatment, services and assistance to maintain continence unless his or her clinical condition was or becomes such that continence was not possible to maintain. The resident that were incontinent of bladder or bowel would receive appropriate treatment to prevent infections and to restore continence to the extent possible. The facility failed to follow R58's toileting plan, placing him at risk for infections and skin breakdown.	F 690			
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-	F 692			

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F 692	Continued From page 17 §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 had a census of 75 residents. The sample included 18 residents, with one reviewed for hydration. Based on observation, record review, and interview, the facility failed to adequately monitor and ensure staff were aware that Resident (R) 27 was on a 1500 milliliter (ml) daily physician ordered fluid restriction so they could educate the resident and update the providers on his fluid consumption. This placed the resident at risk for fluid overload. Findings included: - The Electronic Medical Record (EMR) for R27 documented diagnoses of chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), chronic myeloid leukemia (a type of blood-cell cancer), anxiety (mental or	F 692			

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F 692	Continued From page 18 emotional reaction characterized by apprehension, uncertainty and irrational fear, bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods, and congestive heart failure (a condition with low heart output and the body becomes congested with fluid). The "Annual Minimum Data Set" (MDS), dated 11/11/2022, documented R27 had intact cognition and required extensive assistance of one staff for bed mobility, dressing, toileting and personal hygiene. The assessment further documented R27 was independent with set up assistance for eating. The "Congestive Heart Failure Care Plan," dated 11/22/22, documented R27 chose to not follow the fluid restriction and directed staff to remind him of his ordered fluid restriction then honor his right to choose, provide the requested liquids; do not leave water pitchers or cups in R27's room. The "Dehydration/Fluid Volume Care Plan," dated 11/22/22, documented R27 had fluid overload related to his choice not to follow his fluid restriction and directed staff to encourage him to adhere to the fluid restriction, ensure all snacks and beverages offered at activities comply with diet ad fluid restrictions, monitor vital signs as ordered observe parameters, notify physician of significant abnormalities, monitor for any signs and symptoms of fluid overload such as increased respirations, difficulty breathing, edema, confusion, anxiety, and congestion or cough. The "Physician's Order," dated 12/18/20, directed staff to obtain daily weights and if R27's weight	F 692			

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F 692	Continued From page 19 was greater than 235 pounds (lbs), or if R27 had increased difficulty breathing, swelling, bloating or gained 2 lbs. in 24 hours or 5 lbs. in 1 week , call the heart failure clinic. The "Medication Administration Record" for December 2022 documented weights on the following days that were over the 2 lbs in 24 hours and the heart failure clinic was not notified: 12/12/22- 175.2 lb 12/13/22- 186.6 lb The "Medication Administration Record" or February 2023 documented weights on the following days that were over the 2 lbs in 24 hours and the heart failure clinic was not notified: 02/03/23 - 184.4 02/04/23 - 186.6 The "Physician's Order," dated 12/17/20, directed staff to implement a 1500 ml fluid restriction for R27 consisting of clinical staff to provide 300 ml on 7 AM-3 PM shift, 210 ml on 3 PM-11 PM shift, 100 ml on the 11 PM-7 AM shift, 30 ml for medication pass, and for dietary to supply 250 ml at each meal. The order further directed staff to documented ml intake each shift. Review of the "Medication Administration Record" for December 2022 documented the following daily fluid intakes: 12/02/22- 2900 ml 12/03/22- 1800 ml 12/04/22- 2500 ml 12/05/22- 2480 ml 12/06/22- 2200 ml 12/07/22- 2280 ml 12/09/22- 2200 ml 12/10/22- 2800 ml	F 692			

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F 692	Continued From page 20 12/11/22- 3460 ml 12/12/22- 3450 ml 12/13/22- 1750 ml 12/14/22- 3500 ml 12/15/22- 1700 ml 12/16/22- 2500 ml 12/17/22- 2450 ml 12/18/22- 2800 ml 12/18/22- 3120 ml 12/20/22- 3100 ml 12/21/22- 1900 ml 12/22/22- 2100 ml 12/23/22- 2400 ml 12/26/22- 3500 ml 12/27/22- 2400 ml 12/28/22- 2800 ml 12/29/22- 2000 ml 12/30/22- 2200 ml 12/31/22 4600 ml Review of the "Medication Administration Record" for January 2023 documented the following daily fluid intakes: 01/01/23- 4000 ml 01/02/23- 2800 ml 01/04/23- 2900 ml 01/05/23- 4200 ml 01/06/23- 4700 ml 01/07/23- 2900 ml 01/09/23- 3200 ml 01/10/23- 3600 ml 01/11/23- 4100 ml 01/12/23- 3900 ml 01/13/23- 4000 ml 01/14/23- 4000 ml 01/15/23- 3400 ml 01/16/23- 3900 ml 01/17/23- 1800 ml 01/18/23- 3400 ml	F 692			

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F 692	Continued From page 21 01/19/23- 3800 ml 01/20/23- 3700 ml 01/21/23- 2360 ml 01/23/23- 3480 ml 01/24/23- 2800 ml 01/27/23- 2300 ml 01/28/23- 2900 ml 01/29/23- 3600 ml 01/30/23- 4000 ml 01/31/23- 2400 ml Review of the "Medication Administration Record" for February 2023 documented the following daily fluid intakes: 02/01/23- 2700 ml 02/02/23- 3800 ml 02/03/23- 4000 ml 02/04/23- 2610 ml 02/05/23- 3300 ml 02/07/23- 4200 ml 02/09/23- 1900 ml 02/10/23- 2150 ml 02/11/23- 3000 ml 02/12/23- 2300 ml 02/13/23- 5000 ml On 02/14/23 at 91:30 PM, observation revealed two 34 ounce (oz) pink mugs of ice chips on R27's bedside table. On 02/14/23 at 01:00 PM, Administrative Nurse D stated R27 was non-compliant with his fluid restriction and that staff encourage him not to go over the 1500 ml but he does it anyway. Administrative Nurse D thought he was care planned for one large mug of ice chips at his bedside but verified that it was not in the care plan. Administrative Nurse D stated they have educated the resident but did not have evidence	F 692			

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F 692	Continued From page 22 the education was provided and understood by the resident. On 02/15/23 at 07:54 AM, observation revealed R27 at the medication cart talking to the nurse, further observation revealed R27 holding two- 34 oz pink mugs full of ice chips to the top of the mug. On 02/15/23 at 11:51 AM, observation revealed R27 at the dining table with two 34 oz pink mugs full of ice chips, a coffee cup, and a small glass of chocolate milk. On 02/15/23 at 08:45 AM, Certified Nurse Aide (CNA) M stated she did not know of any residents who were on a fluid restriction that she was caring for in R27's household On 02/15/23 at 10:00 AM, CNA P stated he was unaware of any residents on a fluid restriction that he was caring for in R27's household. On 02/15/23 at 08:55 AM, Licensed Nurse (LN) G stated there was not any residents that she was the nurse for that were on a fluid restriction for R27's household. On 02/15/23 at 03:30 PM, Administrative Nurse D stated all staff should be aware of the resident's fluid restriction and stated, the staff who are not aware must be agency staff. The facility "Fluid Restriction" policy, undated, documented the policy of the facility was to ensure that fluid restrictions would be followed in accordance to physician's orders, the resident had a right to refuse the fluid restriction, and if he/she refused, documentation should support	F 692			

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F 692	Continued From page 23 the reason for the refusal, education benefits and risks, and any supporting documentation of the resident's continued refusal, an assessment for any changes in condition related to the refusal, notification to the physician about the resident's refusal, and the food and nutrition department would be notified of the facility communication methods of the fluid restriction. The facility failed to adequately monitor and ensure staff were aware of the resident's physician ordered fluid restriction. This placed the resident at risk for fluid overload.	F 692			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility had a census of 75. The sample included 18 residents of which one was reviewed for respiratory care. Based on observation, record review, and interview, the facility staff failed to provide cares that included checking oxygen amounts in portable oxygen canister for Resident (R) 5. This placed the R5 at risk for running out of oxygen causing respiratory distress (severe shortness of breath). Findings included:	F 695			

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F 695	Continued From page 24 - R5's Electronic Medical Record (EMR) documented the resident had diagnoses of shortness of breath and chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R5's "Quarterly Minimum Data Assessment" (MDS), dated 01/09/23, documented the resident required extensive staff assistance with transfers, limited staff assistance with dressing and toilet use and staff supervision with bed mobility, locomotion on and off unit, and personal hygiene. The MDS documented the resident received oxygen. R5's "Respiratory Care Plan," revised 12/06/22, documented the resident had emphysema (long-term, progressive disease of the lungs characterized by shortness of breath) and COPD and instructed staff to monitor the resident every shift for shortness of breath with activity, and while lying flat. The plan directed staff to monitor for cyanosis (physical sign causing bluish discoloration of the skin and lips, gums, nail beds, and around the eyes), use of accessory intercostal (muscle groups that are situated in between the ribs that create and move the chest wall) which assist with breathing) use, chest wall movement and/or shape abnormalities, presence of cough and or sputum, peripheral (outside, surface, or surrounding area of an organ, other structure or field of vision) edema (swelling resulting from an excessive accumulation of fluid in the body tissues), change in level of consciousness and check pulse oximetry (oxygen saturation of the blood and the pulse rate) with	F 695			

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F 695	Continued From page 25 abnormal findings. The care plan instructed staff to monitor/document/report as needed (PRN) any signs symptoms of respiratory infection: fever, chills, an increase in sputum (document the amount, color and consistency), chest pain, increased difficulty breathing and increased coughing or wheezing. The care plan lacked directions to staff on how often to check R5's portable oxygen canister to see if it had oxygen. The "Physician Order," dated 10/07/22, instructed staff to provide R5 with continuous oxygen at three liters per nasal cannula every shift. On 02/13/23 at 3:20 PM, observation revealed R5 sat on the edge of her bed and reported she was short of breath. The portable oxygen canister hooked to her oxygen tubing was out of oxygen. Certified Nurse Aide (CNA) O was notified; she came into R5's room and stated the portable oxygen canister was out of oxygen. CNA O, then removed the canister, took it to the oxygen closet to fill with oxygen but did not provide another source of supplemental oxygen for R5, who continued to be short of breath. Further observation revealed CNA O was notified again R5 was still short of breath, and she returned to R5's room, without the portable oxygen canister, and hooked R5's nasal cannula tubing to the oxygen concentrator (electric device which concentrates the oxygen from the air by selectively removing nitrogen to supply an oxygen-enriched product gas stream) and turned it to four liters. Observation revealed the nurse arrived, listened to R5's lungs and checked the resident's oxygen saturation which was at 97%. On 01/13/23 at 03:20 PM, CNA O stated she does not routinely check R5's portable oxygen	F 695			

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F 695	Continued From page 26 canister because R5 was alert and oriented and R5 would call staff when the canister was out of oxygen. On 02/16/23 at 08:09 AM, Licensed Nurse (LN) H stated staff do not routinely check R5's portable oxygen canister to see if it had oxygen, R5 could alert staff when it was out. On 02/15/23 at 03:37 PM, Administrative Nurse D stated staff should be checking R5's portable oxygen canister when they get her out of bed and when they lie her down. Administrative Nurse D stated the oxygen in the portable canister lasted for different amounts of time depending on how many liters a resident required. Upon request the facility failed to provide a policy regarding checking oxygen in a portable oxygen concentrator. The facility failed to provide routine oxygen checks for R5's portable oxygen concentrator, causing R5 to run out of oxygen. This placed R5 at risk for respiratory distress.	F 695			
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed;	F 803			

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F 803	Continued From page 27 §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: The facility had a census of 75 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to prepare and serve their planned menus for 02/13/23 and 2/14/23, due to unavailable food items and failed to update or notify the residents when food items were substituted so they were given the opportunity to change their order on two of the onsite days of the survey . This placed the residents at risk for disappointment and inadequate food intake. Findings included: - The "Lunch Planned Menu Sheet," for 02/13/23 documented the lunch meal would Mexican baked chicken, fiesta rice black beans, sour cream, pineapple tidbits, milk, coffee, fruit punch. The " Standing Chalkboard" located inside the entrance to the dining room read the same as	F 803			

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F 803	Continued From page 28 above. On 02/13/23 at 12:00 PM, observation revealed dietary staff served the residents beef stew, cottage cheese, cubed pineapples, and a roll. On 02/13/23 at 12:10PM, observation during dining services revealed four residents seated at a table together, two of the residents asked the dietary aide for crackers for the beef stew, and the dietary staff informed the residents the facility was out of crackers. On 02/13/23 at 9:00 AM, Registered Dietician (RD) DD stated the planned lunch meals for 02/13/23 would be substituted due to the facility kitchen did not have the planned food items in stock. On 02/13/23 at 12:52 PM, observation revealed RD DD temped a room tray food items and reported she could not serve the tray to the resident if warmed up because she had stuck her thermometer in it. RD DD stated she would have to go see what the resident would like to eat for lunch due to the kitchen was out of the beef stew. On 02/13/23 at 01:34 PM, Administrative Nurse D stated the facility did not have extra beef stew due to the facility kitchen was on a tight food budget. On 02/13/23 at 02:09 PM, R32 stated the facility kitchen runs out of food often. The " Lunch Planned Menu Sheet," for 02/14/23 documented consist of lasagna with meat sauce, sugar snap peas, garlic Texas toast, margarine, sliced apples, and milk, coffee, and fruit punch.	F 803			

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F 803	Continued From page 29 The " Standing Chalkboard" located inside the entrance to the dining room read the same as above. On 2/14/23 at 11:39 AM, Dietary Staff (DS) BB stated yesterday the facility kitchen had no items to serve on the planned lunch menu, so the RD changed the menu to canned beef soup because that is what they had, same with today's menu supposed to be lasagna with meat sauce, sugar snap peas, garlic Texas toast, margarine, sliced apples, milk, coffee, fruit punch changed to smothered beef steak, cooked carrots, mashed potatoes and gravy and sherbet ice cream. On 02/14/22 at 12:00 PM, observation revealed dietary staff served the residents burnt smothered beef steak, cooked carrots, mashed potatoes and gravy and sherbet ice cream. On 02/14/22 at 12:00 PM, observation revealed dietary staff served the residents burnt smothered beef steak, cooked carrots, mashed potatoes and gravy and sherbet ice cream. On 02/14/23 at 12:46 PM, R11 stated staff served the wrong menu for lunch and the steak was burnt, it happens all the time, and he was not happy. On 02/14/23 at 1 02:52 PM, Administrative Nurse D stated residents received a weekly chronicle paper which listed the planned menus and staff post the menu change on the standing chalk board in the dining room. Observation revealed the breakfast menu still on the chalk board. Administrative Nurse D verified the breakfast menu was on the standing chalk board.	F 803			

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F 803	Continued From page 30 On 02/14/23 at 3:40PM, Licensed Nurse (LN) I stated she worked the 7AM-7PM shift. She said the kitchen staff brought snacks to the nourishment room for the residents to have but it was primarily just crackers. LN I said there were never any sandwiches or protein snacks. On 02/15/23 at 01:56 PM, R5 and R10 stated they did not receive their room tray until 07:00PM the previous night and it was cold. R10 and R5 stated the kitchen changed the menu all the time without letting residents know about the change until the residents received their meals. The residents stated the kitchen runs out of food a lot, so residents cannot have seconds if they were still hungry. The facility's "Resident Rights," revised 10/23/19, documented the resident had the right to make choices about aspects of his or her life in the facility that are significant to the resident. The resident had the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility kitchen failed to notify the 68 residents, who received their meals from the facility kitchen, when staff changed the planned lunch menu so they were giving an opportunity to change their order. This placed the residents at risk for disappointment and inadequate food intake.	F 803			
F 812 SS=E	Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812			

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F 812	Continued From page 31 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: The facility had a census of 75 residents. The sample included 18 residents. Based on observation, record review, and interview the facility failed to distribute and serve food in accordance with professional standards for food service safety and the prevention of food borne illness, for the 68 residents who resided in the facility and received their food from the facility kitchen when the facility failed to ensure clean and sanitary food prep and storage areas, and when staff failed to provide a room tray at the proper temperature for Resident (R) 38. This placed the residents at risk for foodborne illness. Findings included: - On 02/13/23 AM at 09:00 AM, observation in the kitchen revealed the following: A refrigerator had an open bag with a half of a	F 812			

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F 812	Continued From page 32 green pepper, onion peelings, and an open bag of celery stalks. The walk-in freezer floor made a crunching noise and felt unstable when stepped on. On 02/13/23 at 9:00 AM, Registered Dietician (RD) DD verified the above finding and stated the bag with the onion peeling and green pepper should be in a closed bag; she said she was unaware the celery needed to be in a closed bag, because celery was not in a closed bag in the grocery store. RD DD took the items and tossed them in the trash. RD DD verified the walk-in freezer floor instability and stated she always stepped very slowly into it. On 02/14/23 at 10:30 AM, observation in the kitchen revealed the following: The white wall behind the oven and grill down to the deep fat fryer had numerous size yellow and black substances on it. The three flour, sugar, and bread crumb bins were not dated. The fluorescent ceiling lights located by the oven hood had numerous different size black spots in them. Four ceiling vents had gray fuzzy substance on them. On 02/14/23 at 10:30 AM, Dietary Staff CC verified the above findings and stated the fluorescent ceiling lights and vents needed to be cleaned Dietary CC said staff should date the flour, sugar, and bread crumb bins with the date the items are placed in them; and the wall behind the oven and grill did need cleaned. Dietary Staff CC stated she was unaware of the kitchen cleaning schedule because she was only filling in	F 812			

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F 812	Continued From page 33 for the regular dietary manager. On 2/15/23 at 04:00 PM, Administrative Staff A verified the walk-in freezer floor did not seem safe when walking on it, and stated she would notify maintenance to see if maintenance could fix it. The facility's "Cleaning and Sanitation of Dining and Food Service Areas Policy," revised 5/01/17, documented the nutrition and food services staff would maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. Tasks shall be designated to be the responsibility of specific positions in the department. A cleaning schedule would be posted for all cleaning tasks, and staff would initial the tasks as completed. The facility's "Preventative Maintenance Program Policy," implemented 10/25/19, documented the maintenance director was responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner. The maintenance director shall assess all aspects of the physical plant to determine if preventative maintenance is required from recommendations, maintenance requests, grand rounds, live safety requirements , or experience. and would decide what tasks needed to be completed and how often to complete them. The "Kitchen Cleaning Schedule," undated, had different daily, weekly, monthly, and as needed (prn) cleaning tasks for staff to complete.	F 812			

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F 812	Continued From page 34 The facility failed to distribute and serve food in accordance with professional standards for food service safety and the prevention of food borne illness, for the 68 residents who resided in the facility and received their food from the facility kitchen, This placed the residents at risk for foodborne illness. - On 02/13/23 at 12:52 PM, dietary staff delivered R38's room tray to the nurse's station across and placed it on the counter; all food items were covered. Several staff walked passed the meal tray. At 01:14 PM the meal tray remained on the counter. There were two physical therapy staff in the nurses station visiting about charting. An aide walked up to the cart of drinks in front of the nurse's station and stated another aide had went on break, then took a glass of milk to a resident. Another staff walked by the resident's tray. Observation revealed at 01:19 PM, an aide and the resident care coordinator walked by the tray and continued walking to the front of the facility. At 01:20 PM, Administrative Nurse D picked up R38's tray and started to deliver it. Upon request Registered Dietician (RD) DD checked the food items with a thermometer. The cottage cheese was 86 degrees Fahrenheit (F), the beef stew was 108 degrees F, and the cubed pineapples were 78 degrees F. RD DD stated the beef stew was too cold, the cottage cheese was too warm and the food could not be served; RD DD took the food back to the kitchen. Upon request the facility failed to provide a policy regarding food temperature. The facility failed to serve food in accordance with professional standards for food service safety, when staff tried to deliver R38's meal tray with	F 812			

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F 812	Continued From page 35 food items at an inappropriate temperature. This placed the residents at risk for foodborne illness.	F 812			