STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425368	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Johns Island Post Acute	3647 Maybank Highway Johns Island, SC 29455

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31846 Based on review of facility policy, record reviews and interviews, the facility failed to ensure Resident (R)1 was free from neglect. Specifically, R1 did not receive care and services, to address the residents therapeutic diet, resulting in R1 expiring. For 1 of 1 resident reviewed for neglect. On 10/23/24 at 3:36 PM, the Administrator and Director of Nursing were notified that the failure to provide care and services to a resident, who was on a therapeutic diet, resulting in death, constituted Immediate Jeopardy (IJ) at F600. On 10/23/24 at 3:36 PM, the Survey Team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 10/20/24. The IJ was related to 42 CFR 483. 12 Freedom from Abuse, Neglect, and Exploitation. On 10/23/24 at 6:20 PM, the facility presented an acceptable IJ Removal Plan. On 10/23/24 the survey team, validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F600 at a lower scope and severity of D. An Extended Survey was conducted in conjunction with the Complaint Survey for non-compliance at F600, constituting substandard quality of care. Findings include: Review of the facility policy titled Recognizing Signs and Symptoms of Abuse/Neglect states as the policy statement, Our facility will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor or to the Director of Nursing Services immediately. The policy interpretation and implementation states, 2. Neglect, is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. b. Signs of Actual Physical Neglect: 9. Leaving someone unattended who needs supervision. Review of R1's Face Sheet revealed the facility admitted R1 on 09/03/24, with diagnoses including but not limited to: adult failure to thrive, protein calorie malnutrition, dementia, major depressive disorder, dysphagia, duodenal ulcer, gastric ulcer, gall stones, constipation, gastrostomy tube and pneumonia. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Johns Island Post Acute	3647 Maybank Highway Johns Island, SC 29455

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R1's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/06/24, revealed a Brief Interview of Mental Status (BIMS) score of 9 out of 15, indicating R1 had moderate cognitive impairment. Review of R1's Medical Record revealed R1 had a signed DNR (Do Not Resuscitate) by a legally appointed guardian. Review of the video footage from the incident on 10/20/24, revealed, R1 was sitting on a couch in the common area watching TV. There were no other residents around. Two Certified Nursing Assistants (CNA)s and a Licensed Practical Nurse (LPN) were at the nurses desk charting and talking among themselves. R1 got up from the couch and noticed a meal tray on a dining room table several feet away from where he was sitting. R1 walked over to the table, picked up the food from the tray and started placing the food into his mouth. It was unclear if R1 was chewing or swallowing the food. Further review of the video footage revealed R1 stopped placing the food in his mouth for a small amount of time and would drink milk from an opened carton of milk. R1 also opened a bottle of water and drank from the bottle of water. R1 then sat down at the table and continued placing food into his mouth. R1 got up from the table and took the tray with him back to the couch. R1 sat down on the couch and soon after, was slumped over on the couch. The staff at the nurses station did not notice R1 eating the food from the tray or slumped over on the couch. One of the nurses walked passed R1, went to the nourishment kitchen and came out with R1's bolus tube feeding and than noticed R1 was slumped over on the couch. The nurses station provided a direct line of site to the common area and the resident. Review of the reportable submitted by the facility revealed that R1 was observed ambulating in the hallway on 10/20/24 at 8:00 PM. Licensed Practical Nurse (LPN)1 came out of the nutrition kitchen 5 minutes later with R1's bolus tube feeding. The nurse noted the resident on the couch in the common area, slumped over with a bluish color to his face. She felt he possibly had something obstructing his airway so she initiated the Heimlich Maneuver. Other staff were assisting the nurse with the Heimlich and the suctioning. 911 was called. R1 was pronounced by EMS (Emergency Medical Services) staff at 8:15 PM. The Coroner was on the scene and the body was taken for further evaluation and cause of death. When LPN 1 was asked if anything came up when the Heimlich was performed, the nurse stated that a small piece of apple, and that was all. The investigation was initiated immediately. R1 had consumed a regular diet that was left on a dining room table, after another resident had finished eating earlier. R1 was ordered to receive a regular pureed diet with nectar thick liquids and a bolus tube feeding of Jevity 1.5. R1 receives a bolus feeding of 360 milliliters (mls) at 8:00 PM and a flush of 60 mls of water before and after the bolus. Review of R1's Physician Orders revealed an order with a start date of 09/03/24, for, Regular diet Dysphagia Puree texture, Thickened Liquid Nectar consistency. Further review revealed an order with a start date of 09/16/24, for, Enteral Feed Order one time a day Bolus Jevity 1.5, 360mL via PEG tube and flush with 60mL before and after. Review of the menu for 10/20/24 revealed a regular diet of: Herb lemon chicken, braised liver and onions, steamed zucchini squash, green peas, mashed potatoes with gravy, steamed rice, wheat bread, and cinnamon apple slices. (continued on next page)

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Johns Island Post Acute	3647 Maybank Highway Johns Island, SC 29455

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R1's Comprehensive Plan of Care included the following: Malnutrition - R1 has a diagnosis of protein calorie malnutrition. Resident is at risk for altered nutrition and hydration related to dysphagia, history of sufficient weight loss, depression, gastric and duodenal ulcers, adult failure to thrive, dementia and pneumonia. Interventions include: Observe for signs or symptoms of dysphagia, as evidenced by, pocketing, coughing, choking, drooling and holding foods in his mouth. Refer to Registered Dietitian as needed. Resident is at risk for aspiration, choking, and difficulty swallowing related to dysphagia. The goal: The risk of aspiration is minimized to the extent possible. Interventions: No straws. Position upright as possible for meals. Serve diet as ordered. Resident has a peg tube and is at risk for enteral nutrition complications related to dysphagia. Resident is at risk for elopement/exit seeking/wandering related to altered cognitive status, dementia or other cognitive behavior, exit seeking behaviors, mood or behavior disorders, psychotropic mood altering medications. The goal revealed, resident will not wander out of the facility. The interventions: Allow wandering in safe areas within the facility. Assess for pain and/or discomfort and medicate as needed. Monitor whereabouts frequently. During an interview on 10/23/24 at an unspecified time, the Director of Nursing (DON) and Administrator, the Administrator stated he was going to be open and straight forward about the incident. The Administrator stated that he and the DON was very upset and shed tears over the incident. The DON stated the nurse told them a piece of apple came out the residents mouth (confirmed by video footage). During an interview on 10/23/24 at 12:05 PM, Certified Nursing Assistant (CNA)2 stated that she was at the nurse's station charting prior to the incident. CNA2 stated the nurse told her she was going to the nourishment kitchen to get the tube feeding and medication for the resident, and I decided I would get him ready for bed at the same time. When the nurse came out of the nourishment kitchen she looked over to see the resident slumped over on the couch. CNA2 stated the nurse called his name and he did not answer, so they both ran over to help him. CNA2 had no further comments regarding the incident. During an interview on 10/23/24 at 12:07 PM, Licensed Practical Nurse (LPN)1 stated, I went to the nourishment kitchen to retrieve the tube feeding for [R1]. As I walked out of the nourishment kitchen I saw the resident on the couch, slumped over and blue. He was literally just sitting up watching TV. I called his name and he did not respond, so I ran over to help him along with the CNA. I asked the CNA to call the nurse from the [NAME] Unit and she did, when she arrived she called 911. I started the Heimlich Maneuver because I thought he might have something obstructing his airway. LPN1 further stated that the resident will put things in his mouth and did so all the time. The CNA was helping me, and we got the suction machine and tried to suction his mouth but nothing came out. Review of CNA1's statement documented, I worked on the Angel Oak hall on 10/20/2024 second shift. I was charting at the desk close to the bathroom. The resident was walking around as he normally does. The nurse stated that she was going to grab his medication and bolus feeding and then she entered the nourishment kitchen. I entered the restroom and when I came out the nurse was doing the Heimlich Maneuver on the resident. I assisted as well. I ran to grab the nurse from the [NAME] Unit for her assistance. We continued the Heimlich as the nurse from the [NAME] Unit called 911. Then EMS arrived. Multiple attempts were made to contact CNA1, but were unsuccessful. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Johns Island Post Acute	3647 Maybank Highway Johns Island, SC 29455

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/23/24 at 6:20 PM, the facility presented an acceptable IJ Removal Plan, which included: Immediate Actions Taken: -Statements were written by all staff on duty 10/20/2024. -Nurse on duty was interviewed via phone by RDCS and DON. She stated she noted him slumped over and bluish color to face and observed what she felt to be a possible obstruction to his airway, so she initiated the Heimlich and attempted to suction his airway until EMS arrived. -Camera footage was observed by Administrator and DON on 10/21/2024 in the AM to establish a timeline and confirm he had eaten food from a tray sitting in the common area. -Education was initiated with all staff on 10/21/2024 regarding picking up all trays timely and not leaving any food trays unattended on a unit. -Audits were initiated on 10/21/2024 of all resident who wander or have behaviors to ensure all are care planned for wandering and staff are aware of this behavior and risk for getting food that is not theirs. -An audit was initiated on 10/22/2024 for all residents on a mechanically altered diet to ensure orders are correct and tray cards and care plans also reflect correct diets as ordered. Actions Taken as a Result of ADHOC QA Meeting: Problem identified as tray was left sitting out in a common area after mealtime was over and not secured in kitchenette. -Standup/stand down imitated x2/day to track progress of the abatement plan. Audits initiated for the following: -All residents on a mechanically altered diet to ensure that orders are correct and correlate with tray cards and care plans to reflect current orders. -All residents who have behaviors of wandering and would be at risk to take food from other residents or areas that is not their ordered diet to ensure care plan is reflective of the behavior. Education initiated immediately for the following: -All staff to ensure understanding of timely removal of trays from the unit and not left unattended. All newly hired staff and or agency staff will receive the education prior to first shift worked. -Educations was sent to all staff via CORV on 10/23/2024. Wet signatures will be obtained as staff report for duty on next scheduled shift. -Education provided to all staff on 10/23/2024 related to neglect. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-All newly hired staff and or agency staff will receive the education prior to their first shift worked. On going audits: -Administrative staff will be conducting audits of all units during meal times to ensure monitoring of all residents for safety during mealtime and to ensure that at the end of the meal or assisting residents with eating that the trays are removed timely and not left unattended and are returned to the tray cart and to the kitchen. -Audits will be completed for every meal for the first 72 hours, then three times per x2 weeks, then weekly x2 weeks then monthly x2 months then random thereafter. -All audits and data will be reported to the QA committee for review, recommendation, and follow-up. Date of Compliance: 10/23/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31846 Based on review of facility policy, record reviews and interviews, the facility failed to ensure Resident (R)1 was adequately supervised and free from accident and hazards, for 1 of 1 residents reviewed for accidents. Specifically, R1, who was on a therapeutic diet, consumed food from another resident's meal tray that was left on a dining room table, resulting in R1 expiring. On 10/23/24 at 3:36 PM, the Administrator and Director of Nursing were notified that the failure to provide adequate supervision of a resident, who was on a therapeutic diet, resulting in death, constituted Immediate Jeopardy (IJ) at F689. On 10/23/24 at 3:36 PM, the Survey Team provided the Administrator with a copy of the CMS Immediate Jeopardy (IJ) Template and informed the facility IJ existed as of 10/20/24. The IJ was related to 42 CFR 483. 25 Quality of Life. On 10/23/24 at 6:20 PM, the facility presented an acceptable IJ Removal Plan. On 10/23/24 the survey team, validated the facility's corrective actions and removed the IJ. The facility remained out of compliance at F689 at a lower scope and severity of D. An Extended Survey was conducted in conjunction with the Complaint Survey for non-compliance at F689, constituting substandard quality of care. Findings include: Review of the facility's policy titled, Accidents and Incidents - Investigating and Reporting did not contain any pertinent information. The facility did not provide a policy regarding prevention of accidents and reducing hazards for residents. Review of R1's Face Sheet revealed the facility admitted R1 on 09/03/24, with diagnoses including but not limited to: adult failure to thrive, protein calorie malnutrition, dementia, major depressive disorder, dysphagia, duodenal ulcer, gastric ulcer, gall stones, constipation, gastrostomy tube and pneumonia. Review of R1's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/06/24, revealed a Brief Interview for Mental Status (BIMS) of 9 out of 15, indicating R1 had moderate cognitive impairment. Further review of the MDS indicated R1 exhibited behaviors not directed towards others and an overall presence of behavioral symptoms that interferes with the resident's care, puts others at risk for physical injury, and significantly disrupts care or living environment. The MDS also indicated that R1 exhibited wandering behaviors. R1 also exhibited signs of loss of liquids/solids from mouth when eating or drinking, and coughing or choking during meals or when swallowing medications. (continued on next page)

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Johns Island Post Acute	3647 Maybank Highway Johns Island, SC 29455

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the video footage from the incident on 10/20/24, R1 was sitting on a couch in the common area watching TV. There were no other residents around. Two Certified Nursing Assistants (CNA)s and a Licensed Practical Nurse (LPN) were at the nurses desk charting and talking among themselves. R1 got up from the couch and noticed a meal tray on a dining room table several feet away from where he was sitting. R1 walked over to the table, picked up the food from the tray and started placing the food into his mouth. It was unclear if R1 was chewing or swallowing the food. Further review of the video footage revealed R1 stopped placing the food in his mouth for a small amount of time and would drink milk from an opened carton of milk. R1 also opened a bottle of water and drank from the bottle of water. R1 then sat down at the table and continued placing food into his mouth. R1 got up from the table and took the tray with him back to the couch. R1 sat down on the couch and soon after, was slumped over on the couch. The staff at the nurses station did not notice R1 eating the food from the tray or slumped over on the couch. One of the nurses walked passed R1, went to the nourishment kitchen and came out with R1's bolus tube feeding and than noticed R1 was slumped over on the couch. She starts asking for assistance while putting the tube feeding onto the counter at the nurses desk. Both CNAs come to help her with the resident. The nurse starts with the Heimlich Maneuver. The nurses station provided a direct line of site to the common area and the resident. Review of the reportable submitted by the facility revealed that R1 was observed ambulating in the hallway on 10/20/24 at 8:00 PM. Licensed Practical Nurse (LPN)1 came out of the nutrition kitchen 5 minutes later with R1's bolus tube feeding. The nurse noted the resident on the couch in the common area, slumped over with a bluish color to his face. She felt he possibly had something obstructing his airway so she initiated the Heimlich Maneuver. Other staff were assisting the nurse with the Heimlich and the suctioning. 911 was called. R1 was pronounced by EMS (Emergency Medical Services) staff at 8:15 PM. The Coroner was on the scene and the body was taken for further evaluation and cause of death. When LPN 1 was asked if anything came up when the Heimlich was performed, the nurse stated that a small piece of apple, and that was all. The investigation was initiated immediately. R1 had consumed a regular diet that was left on a dining room table, after another resident had finished eating earlier. R1 was ordered to receive a regular pureed diet with nectar thick liquids and a bolus tube feeding of Jevity 1.5. R1 receives a bolus feeding of 360 milliliters (mls) at 8:00 PM and a flush of 60 mls of water before and after the bolus. Review of R1's Physician Orders revealed an order with a start date of 09/03/24, for, Regular diet Dysphagia Puree texture, Thickened Liquid Nectar consistency. Further review revealed an order with a start date of 09/16/24, for, Enteral Feed Order one time a day Bolus Jevity 1.5, 360mL via PEG tube and flush with 60mL before and after. Review of the menu for 10/20/24 revealed a regular diet of: Herb lemon chicken, braised liver and onions, steamed zucchini squash, green peas, mashed potatoes with gravy, steamed rice, wheat bread, and cinnamon apple slices. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R1's Comprehensive Plan of Care included the following: Malnutrition - R1 has a diagnosis of protein calorie malnutrition. Resident is at risk for altered nutrition and hydration related to dysphagia, history of sufficient weight loss, depression, gastric and duodenal ulcers, adult failure to thrive, dementia and pneumonia. Interventions include: Observe for signs or symptoms of dysphagia, as evidenced by, pocketing, coughing, choking, drooling and holding foods in his mouth. Refer to Registered Dietitian as needed. Resident is at risk for aspiration, choking, and difficulty swallowing related to dysphagia. The goal: The risk of aspiration is minimized to the extent possible. Interventions: No straws. Position upright as possible for meals. Serve diet as ordered. Resident has a peg tube and is at risk for enteral nutrition complications related to dysphagia. Resident is at risk for elopement/exit seeking/wandering related to altered cognitive status, dementia or other cognitive behavior, exit seeking behaviors, mood or behavior disorders, psychotropic mood altering medications. The goal revealed, resident will not wander out of the facility. The interventions: Allow wandering in safe areas within the facility. Assess for pain and/or discomfort and medicate as needed. Monitor whereabouts frequently. Review of CNA1's statement documented, I worked on the Angel Oak hall on 10/20/2024 second shift. I was charting at the desk close to the bathroom. The resident was walking around as he normally does. The nurse stated that she was going to grab his medication and bolus feeding and then she entered the nourishment kitchen. I entered the restroom and when I came out the nurse was doing the Heimlich Maneuver on the resident. I assisted as well. I ran to grab the nurse from the [NAME] Unit for her assistance. We continued the Heimlich as the nurse from the [NAME] Unit called 911. Then EMS arrived. During an interview on 10/23/24 at an unspecified time, the Director of Nursing (DON) and Administrator, the Administrator stated he was going to be open and straight forward about the incident. The Administrator stated that he and the DON was very upset and shed tears over the incident. The DON stated the nurse told them a piece of apple came out the resident's mouth (confirmed by video footage). During an interview on 10/23/24 at 12:05 PM, Certified Nursing Assistant (CNA)2 stated that she was at the nurse's station charting prior to the incident. CNA2 stated the nurse told her she was going to the nourishment kitchen to get the tube feeding and medication for the resident, and I decided I would get him ready for bed at the same time. When the nurse came out of the nourishment kitchen she looked over to see the resident slumped over on the couch. CNA2 stated the nurse called his name and he did not answer, so they both ran over to help him. CNA2 had no further comments regarding the incident. Multiple attempts were made to contact CNA1, but were unsuccessful. During an interview on 10/23/24 at 12:07 PM, Licensed Practical Nurse (LPN)1 stated, I went to the nourishment kitchen to retrieve the tube feeding for [R1]. As I walked out of the nourishment kitchen I saw the resident on the couch, slumped over and blue. He was literally just sitting up watching TV. I called his name and he did not respond, so I ran over to help him along with the CNA. I asked the CNA to call the nurse from the [NAME] Unit and she did, when she arrived she called 911. I started the Heimlich Maneuver because I thought he might have something obstructing his airway. LPN1 further stated that the resident will put things in his mouth and did so all the time. The CNA was helping me, and we got the suction machine and tried to suction his mouth but nothing came out. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/23/24 at 6:20 PM, the facility presented an acceptable IJ Removal Plan, which included: Immediate Actions Taken: -Statements were written by all staff on duty 10/20/2024. -Nurse on duty was interviewed via phone by RDCS and DON. She stated she noted him slumped over and bluish color to face and observed what she felt to be a possible obstruction to his airway, so she initiated the Heimlich and attempted to suction his airway until EMS arrived. -Camera footage was observed by Administrator and DON on 10/21/2024 in the AM to establish a timeline and confirm he had eaten food from a tray sitting in the common area. -Education was initiated with all staff on 10/21/2024 regarding picking up all trays timely and not leaving any food trays unattended on a unit. -Audits were initiated on 10/21/2024 of all resident who wander or have behaviors to ensure all are care planned for wandering and staff are aware of this behavior and risk for getting food that is not theirs. -An audit was initiated on 10/22/2024 for all residents on a mechanically altered diet to ensure orders are correct and tray cards and care plans also reflect correct diets as ordered. Actions Taken as a Result of ADHOC QA Meeting: Problem identified as tray was left sitting out in a common area after mealtime was over and not secured in kitchenette. -Standup/stand down imitated x2/day to track progress of the abatement plan. Audits initiated for the following: -All residents on a mechanically altered diet to ensure that orders are correct and correlate with tray cards and care plans to reflect current orders. -All residents who have behaviors of wandering and would be at risk to take food from other residents or areas that is not their ordered diet to ensure care plan is reflective of the behavior. Education initiated immediately for the following: -All staff to ensure understanding of timely removal of trays from the unit and not left unattended. All newly hired staff and or agency staff will receive the education prior to first shift worked. -Educations was sent to all staff via CORV on 10/23/2024. Wet signatures will be obtained as staff report for duty on next scheduled shift. -Education provided to all staff on 10/23/2024 related to neglect. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-All newly hired staff and or agency staff will receive the education prior to their first shift worked. On going audits: -Administrative staff will be conducting audits of all units during meal times to ensure monitoring of all residents for safety during mealtime and to ensure that at the end of the meal or assisting residents with eating that the trays are removed timely and not left unattended and are returned to the tray cart and to the kitchen. -Audits will be completed for every meal for the first 72 hours, then three times per x2 weeks, then weekly x2 weeks then monthly x2 months then random thereafter. -All audits and data will be reported to the QA committee for review, recommendation, and follow-up. Date of Compliance: 10/23/24