Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	70505	A. BUILDING: _____ B. WING _____	C 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT MELBOURNE INC	1420 SOUTH OAK STREET MELBOURNE, FL 32901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	INITIAL COMMENTS Relicensure survey was conducted in conjunction with complaint #2025000968. The complaint was not substantiated. but Avante At Melbourne had deficiencies found at the time of the visit.	N 000		
N 054 SS=D	59A-4.107(5), FAC Follow Physician Orders All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, facility nurses failed to follow physician's orders to monitor ˙ ˙ for 1 of 1 resident reviewed for change of condition, of a total sample of 43 residents, (#93). Findings: Review of the medical record revealed resident #93, a ˛ male was admitted to the facility from an acute care hospital on with diagnoses that included, ˛ and (partial , ˛), generalized ˛ (difficulty swallowing), (high), ˛ (˛) status, (abnormal rhythm), ( ), and . The most recent Minimum Data Set 5-day Assessment with an Assessment Reference Date of noted during the look- periods, resident #93 had difficulty swallowing, required a for nutrition and hydration, received injections for 7 out of 7 days, and high risk	N 054	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. Avante at Melbourne maintains the alleged deficiencies do not individually jeopardize the health and/or safety of its residents nor are they if such character as to limit the provider's capacity to render adequate resident care. Furthermore, Avante at Melbourne asserts that it is in substantial compliance with regulations governing the operation of long-term care facilities, and this Plan of Correction in its entirety constitutes the provider's credible allegation of compliance. A) What corrective action(s) will be accomplished for those residents found to have been affected by this practice?	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/25

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N 054	Continued From page 1 ( ), and (lowering) medications. The Order Summary Report noted active physician's medication orders included Diabetisource AC (before meals) ( ) formula 60 milliliters per hour from 8:00 PM to 6:00 AM, 6.25 Milligrams (MG) twice daily for , 1 MG at bedtime for 45 Units (U) twice daily for , Lispro 4 U four times daily for , and Lispro dosage per stick results before meals for . The Comprehensive Care Plan included focuses for with interventions for nurse monitoring of and risk of complications, and dependence on feeding for nutrition with interventions for nurse monitoring of functioning/maintenance and risk of complications. During a medication administration observation on at 11:32 AM, Licensed Practical Nurse (LPN) E collected resident #93's stick with a result of 175 milligrams per deciliter (mg/dl). The nurse said physician's orders were to give the resident an extra 2 units of Lispro . She explained, she was unable to locate resident #93's Lispro in the medication cart. The nurse explained the facility's on emergency medication kit did not contain Lispro. At 12:04 PM, LPN E said she contacted the physician and obtained orders to hold the Lispro and re-check resident #93's every hour until the refill arrived from the pharmacy. Review of a nurse progress note completed by	N 054	a. On an assessment was completed on resident number 93 no signs or symptoms of hyper or were noted. b. On staff member received education on entering physician orders in the medical record when received orders for abnormal lab results. B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? a. On Director of Nursing/designee completed an audit to ensure resident with order changes related to abnormal results ensure all orders are followed. C) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? a. By the Director of Nursing/designee completed education with licensed nurses when orders are received related to abnormal results a physician order is placed in the resident medical record. D) How will the corrective actions be monitored to ensure the practice will not recur; what quality measures will be put into place? a. Director of Nursing/designee to complete random audit to ensure resident with order changes related to abnormal results ensure all orders are followed compliance with N054 weekly x 4 weeks then monthly for 2 months or until substantial compliance is achieved.	

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N 054	Continued From page 2 LPN E on at 12:17 PM, read, " unavailable at the moment awaiting pharmacy to deliver STAT [immediately/urgently] MD [physician] notified and said to keep checking bs [ ] once every hour until gets here." On at 3:25 PM, LPN L said LPN E had left for the day and she received off-going report from her. The nurse said LPN E had not mentioned resident #93 was out of nor that the doctor had given orders to check his every hour until the refill arrived. Review of the and Vitals Summary Report noted a struck-out entry by LPN L on at 3:31 PM, of a stick measurement of 157 mg/dl and an additional measurement of 137 mg/dl at 4:30 PM. On at 10:47 AM, LPN E recalled on at lunchtime, she obtained doctor's orders to re-check resident #93's once an hour. She said she completed re-checks every hour until the end of her shift at 3:00 PM and stated, "it was in a good range." On at 12:46 PM, the Unit Manager recalled on , LPN E obtained a doctors order to hold resident #93's lunchtime and re-check the until the was delivered because it wasn't in the emergency medication kit. The Unit Manager checked the medical record and was unable to locate any re-checks by LPN E on . She acknowledged there were no re-checks until LPN L's was recorded at 4:30 PM, four hours after LPN E received physician's orders. The nurse stated, "she didn't check it every hour per the MD [physician] order; it's important for them to	N 054	b. Findings will be reported monthly at the QA/Risk management meeting until such a time substantial compliance has been determined.	

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N 054	Continued From page 3 re-check, especially if it was a brittle person." On at 10:13 AM, the Director of Nursing (DON) explained nurses were expected to follow doctor's orders and monitor residents for abnormal to prevent re-hospitalization and complications. The DON stated, "the nurse should have monitored the resident." Review of the facility's standards and guidelines titled Change in Condition Process dated noted nurses were expected to evaluate the resident's status and document findings in the electronic medical record. The Facility Assessment noted the facility provided nursing services and care including management of medication and medical conditions including . Class III	N 054		
N 110 SS=E	400.141(1)(h) FS; 59A-4.122(1) FAC Physical Environment - Safe, Clean, Homelike 400.141(1)(h) FS Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner. 59A-4.122(1) FAC The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible	N 110		

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N 110	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on observation, and interview, the facility failed to provide a homelike environment for residents who ate in the dining rooms on the two (North and South) nursing units. This affected all residents who chose to eat in the nursing unit's dining areas, which varied from approximately residents per meal of the 98 residents at the facility. Findings: On at 12:35 PM, four staff were observed serving trays to residents on the North unit from the food cart. There were seven residents sitting at tables in the North unit dining room waiting to be served. There were no tablecloths or centerpieces on the tables and the dishes were left on the serving trays. On at 1:38 PM, lunch was provided to approximately thirteen residents in the South unit dining room. There were no tablecloths or centerpieces on the tables. All the dishes, flatware, cups and food items were left on the resident's trays while they ate. On at 5:59 PM, residents were observed eating in the South unit room dining room from their trays. The undecorated tables held newspapers and pieces of paper with word puzzles on them that had been used earlier in the day. On at 1:18 PM, during the lunch service on the South and North unit's dining rooms the residents ate from their trays on undecorated tables as they did the previous day.	N 110	A) What corrective action(s) will be accomplished for those residents found to have been affected by this practice? a. On table clothes and centerpieces were provided on the tables for North and South wing. b. On dishes, flatware, cups and food items were removed from the serving tray. B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? a. On the Director of Nursing/designee completed an audit to ensure North and South dining room tables have table clothes and centerpieces on the tables. b. On the Director of Nursing/ designee completed an audit to ensure all dishes, flatware, cups, and food are removed from the tray unless the resident declines to have items removed per their plan of care. C) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? a. By Director of Nursing/designee completed education with staff to ensure North and South unit tables have table clothes and center pieces. b. By the Director of Nursing/ designee completed education with staff to remove dishes, flatware, cups, and food removed from the tray unless the	

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N 110	Continued From page 5 On at 5:21 PM, resident #77 described the dining area felt like a cafeteria, and could be made nicer with tablecloths or decorations. On at 10:28 AM, the Registered Dietetic Technician (DTR) stated she thought everyone would enjoy a little more decoration in the dining room, like centerpieces in the area in which they dine. On at 1:10 PM, the Administrator observed all residents in the South unit dining room ate from trays. She acknowledged that serving all residents on trays could be considered a dignity issue because it was more institutional, than home-like. Pattern Class III	N 110	resident prefers to have items on the tray per the plan of care. D) How will the corrective actions be monitored to ensure the practice will not recur; what quality measures will be put into place? a. Director of Nursing/designee to complete random audit to ensure North and South wings tables have table clothes and center pieces compliance with N 110 weekly x 4 weeks then monthly for 2 months or until substantial compliance is achieved. b. Director of Nursing/designee to complete random audit to ensure to remove dishes, flatware, cups, and food removed from the tray unless the resident prefers to have items on the tray per the plan of care compliance with federal regulation F584 weekly x 4 weeks then monthly for 2 months or until substantial compliance is achieved. c. Findings will be reported monthly at the QA/Risk management meeting until such a time substantial compliance has been determined.	
N 201 SS=E	400.022(1)(i), FS Right to Adequate and Appropriate Health Care (I) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the	N 201		

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N 201	Continued From page 6 agency. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide emergency equipment available for accidental extubation for a resident on with a , ( ) per nursing standards of practice for 1 of 1 resident reviewed for , (#22); failed to ensure nurses followed physician's orders to monitor monitoring for 1 of 1 resident reviewed for change of condition, (#93); failed to properly monitor the clinical condition, nutritional status, needs, and preferences, and failed to identify loss and nutritional risk of residents experiencing , nutrition, hydration and/or skin integrity for 3 of 8 residents reviewed for nutrition and hydration, (#15, #52, #34), of a total sample of 40 residents. Findings: 1. Resident #22 was initially admitted on and re-admitted on with diagnoses which included , failure with , , (low ,), anoxic damage, , , (trouble swallowing), hypertensive , and , status. A " , (also called a ,) is an opening surgically created through the into the (windpipe) to allow air to fill the . After creating the , opening in the , surgeons insert a tube through it to provide an airway and to remove from the . The person with a , breathes through the , tube (tube or obturator) rather than through the and ." An extubation (when the tube is	N 201	A) What corrective action(s) will be accomplished for those residents found to have been affected by this practice? a. On an extra tube (emergency kit) was placed at bedside for resident number 22 b. On an assessment was completed on resident number 93 no signs or symptoms of hyper or , , were noted. c. On staff member received education on entering physician orders in the medical record when received orders for abnormal lab results. d. On RD completed review to assess nutritional status of resident numbers, 15, 52, and 34. B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? a. On Director of Nursing/ designee completed an audit to ensure extra tube kept at bedside (Emergency kit). b. On Director of Nursing/designee completed an audit to ensure resident with order changes related to abnormal results ensure all orders are followed. c. On Audit completed to ensure nutritional status of residents has been assessed. d. On Audit completed to ensure nutritional status of resident with have been assessed.	

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N 201	Continued From page 7 displaced) creates an emergency that requires an obturator be readily available and staff are knowledgeable to reinsert it, (retrieved on from www.hopkinsmedicine.org). On at 10:09 AM, resident #22 was observed in bed, calm, and awake with tubing connected to the concentrator. The tubing and the suction tip which was bedside were undated. A bag valve mask (BVM) or Ambu bag was in a clear plastic bag on the wall directly over the of the resident's bed, but there was no emergency kit in the clear plastic bag nor at the bedside. The assigned Licensed Practical Nurse (LPN) G was in resident #22's room at that time and validated the observations. LPN G stated it was the night shift nurses' responsibility to change and date the tubing along with the suction tip but she did not know how often the tubing needed to be changed. LPN G explained she thought the night shift set up the equipment. She explained she knew how to perform care and suction the resident, but was unsure about what to do if there was an emergency and was unaware of the need for an emergency kit at bedside. LPN G was unsure who was responsible for the emergency supplies at bedside but felt it was possibly Central Supply. A review of the resident #22's medical record revealed physician orders for care to be done every day and as needed, mask tubing /humidifier mask to be changed every week, on night shift every Friday. The physician's orders did not contain an order for emergency supplies including replacement obturator needed for resident #22. A review of the resident's Care Plan identified the resident had a but did not contain interventions for emergency	N 201	C) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? a. By the Director of Nursing/ designee completed education with licensed Nurses on ensuring we have extra tube is kept at bedside (Emergency Kit). b. By the Director of Nursing/designee completed education with licensed nurses when orders are received related to abnormal results a physician order is placed in the resident medical record. c. By Director of Nursing/designee to complete education with RD and nurse management team to ensure nutritional status is reviewed and assessed. D) How will the corrective actions be monitored to ensure the practice will not reoccur; what quality measures will be put into place? a. Director of Nursing/designee to complete random audit extra tube is stored at bedside (emergency kit) ensure compliance with N201Right to Adequate and Appropriate Heel care weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved. b. Director of Nursing/designee to complete random audit to ensure resident with order changes related to abnormal results ensure all orders are followed compliance with N201 weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved.	

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N 201	Continued From page 8 supplies at bedside. On at approximately 10:45 AM, the Unit Manager (UM), Central Supply staff and a Regional Nurse were in resident #22's room and verified there was no emergency kit at the bedside. The Central Supply staff confirmed it was her responsibility to place the emergency kit at the bedside. The UM confirmed that emergency supplies were supposed to be at bedside and said, "this is not what is done here, [she was] not sure what happened..." On at 1:47 PM, the UM said she helped with the education of staff and participated in in-services because the facility did not have a Staff Educator. She verified the importance of having the emergency kit at bedside for residents with a , and stated the assigned nurse LPN G could get nervous at times but thought she knew what to do in an emergency. The UM explained that the Director of Nursing (DON) was responsible for staff orientation after hire. On at 1:51 PM, LPN H said that she had worked with resident #22 and knew the importance of having the emergency kit at bedside because, "if [the tube] accidentally dislodged they can use items in kit to replace the ." She explained at least once a shift she should ensure that the emergency supplies were at bedside. On at 2:16 PM, the DON who was working on the floor because of a nurse call out, explained the training process for new staff nurses. She said upon hire; she would go over the facility's policy then place the new nurse with a , , . She explained that new staff were	N 201	c. Director of Nursing/designee to complete random audit to ensure nutritional status of residents has been assessed to ensure compliance with N201 weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved. d. Findings will be reported monthly at the QA/Risk management meeting until such time substantial compliance has been determined.	

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N 201	Continued From page 9 oriented depending on how experienced they were, she would get feedback from the , , and proceed accordingly. The , , was responsible for showing the orientee most tasks and would have referred to her "if they were not comfortable with something." The DON stated she had a plan to do an in-service on care because one nurse reached out to her specifically. On at 11:51 AM, the DON stated the expectation was for the nurses to have verified that resident #22 had an emergency kit at the bedside in case of an accidental dislodgement. The Facility's Policy and Procedure for , , / , Care and Suctioning revised indicated, "the facility will ensure that residents who need , , care, including , care and suctioning is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences." 2. Review of the medical record revealed resident #93, a , male was admitted to the facility from an acute care hospital on	N 201		

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N 201	Continued From page 10 with diagnoses that included, , and (partial ,), generalized , (difficulty swallowing), (high), ( ) status, (abnormal rhythm), , ( ), , and . The most recent Minimum Data Set (MDS) 5-day Assessment with an Assessment Reference Date (ARD) of noted during the look-back periods, resident #93 had difficulty swallowing, required a for nutrition and hydration, received injections for 7 out of 7 days, and high risk , , ( ), and , (lowering) medications. The Order Summary Report noted active physician's medication orders included Diabetisource AC (before meals) ( ) formula 60 milliliters per hour from 8:00 PM to 6:00 AM, 6.25 Milligrams (MG) twice daily for , 1 MG at bedtime for , 45 Units (U) twice daily for , Lispro 4 U four times daily for , and Lispro , dosage per stick results before meals for . The Comprehensive Care Plan included focuses for with interventions for nurse monitoring of and risk of complications, and dependence on feeding for nutrition with interventions for nurse monitoring of functioning/maintenance and risk of complications. During a medication administration observation on at 11:32 AM, LPN E collected resident	N 201		

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N	Continued From page 11 #93's ˅ stick ˅ with a result of 175 milligrams per deciliter (mg/dl). The nurse said physician's orders were to give the resident an extra 2 units of Lispro . She explained, she was unable to locate resident #93's Lispro in the medication cart. The nurse explained the facility's on emergency medication kit did not contain Lispro. At 12:04 PM, LPN E said she contacted the physician and obtained orders to hold the Lispro and re-check resident #93's ˅ every hour until the refill arrived from the pharmacy. Review of a nurse progress note completed by LPN E on at 12:17 PM, read, " unavailable at the moment awaiting pharmacy to deliver STAT [immediately/urgently] MD [physician] notified and said to keep checking bs [˅] once every hour until gets here." On at 3:25 PM, LPN L said LPN E had left for the day and she received off-going report from her. The nurse said LPN E had not mentioned resident #93 was out of nor that the doctor had given orders to check his ˅ every hour until the refill arrived. Review of the ˅ and Vitals Summary Report noted a struck-out entry by LPN L on at 3:31 PM, of a ˅ stick ˅ measurement of 157 mg/dl and an additional measurement of 137 mg/dl at 4:30 PM. On at 10:47 AM, LPN E recalled on at lunchtime, she obtained doctor's orders to re-check resident #93's ˅ once an hour. She said she completed re-checks every hour until the end of her shift at 3:00 PM and stated, "it was in a good range."	N 201		

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N 201	Continued From page 12 On at 12:46 PM, the Unit Manager recalled on , LPN E obtained a doctors order to hold resident #93's lunchtime and re-check the until the was delivered because it wasn't in the emergency medication kit. The Unit Manager checked the medical record and was unable to locate any re-checks by LPN E on . She acknowledged there were no re-checks until LPN L's was recorded at 4:30 PM, four hours after LPN E received physician's orders. The nurse stated, "she didn't check it every hour per the MD [physician] order; it's important for them to re-check, especially if it was a brittle person." On at 10:13 AM, the DON explained nurses were expected to follow doctor's orders and monitor residents for abnormal to prevent re-hospitalization and complications. The DON stated, "the nurse should have monitored the resident." Review of the facility's standards and guidelines titled Change in Condition Process dated noted nurses were expected to evaluate the resident's status and document findings in the electronic medical record. The Facility Assessment noted the facility provided nursing services and care including management of medication and medical conditions including . 3. Review of the medical record revealed resident #52, a female was admitted to the facility on with diagnoses that included type 2 , major , persistent	N 201		

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N 201	Continued From page 13 Affect (uncontrollable crying/laughing), and communication The most recent MDS Quarterly Assessment with an ARD of revealed during the look- periods, resident #52 had vision, was rarely/never understood, and unable to complete the ( ). Staff assessed the resident had short term and long term memory problems, was severely , had continuous inattention and disorganized thinking that did not fluctuate, , and she was dependent on staff to complete all Activities of Daily Living (ADLs). The resident did not walk, required a wheelchair, had no loss or gain, required scheduled and as needed medication, a mechanically altered diet, and she received high-risk , and medications. The Order Summary Report included active physician's orders for monthly . Medication orders included , (blocker) 10 Milligrams (MG) at bedtime for , (hormone) 112 Micrograms once daily for , (agent) 20-10 MG every twelve hours for Affect, (, ,) 50 MG three times daily for , and (,) 25 MG at bedtime for , . The Comprehensive Care Plan included focuses for , risk for , communication and hearing, risk for , with behaviors, high-risk medication adverse effects monitoring, , required staff assistance for all ADLs, and	N 201		

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N 201	Continued From page 14 Long Term Care (LTC) with a goal to assure maintenance of the resident's safety and comfort, and observance of distress. On at 10:45 AM, resident #52 was observed awake and lying in bed in her room. The resident did not answer questions and was unable to participate in an interview. On at 3:43 PM, Certified Nursing Assistant (CNA) J said resident #52 was often included in her assignment, required staff assistance to eat, and needed cues and reminders to ensure she was eating enough. Review of the Dietary Progress Note dated noted resident #52 was evaluated for loss, insufficient intake, and a low ( ). Orders for calorically dense supplements twice daily between meals and fortified foods were implemented for loss and low . The and Vitals Report showed on , resident #52 had a 8.7% or loss over two months. Additional were not completed after , for three months. In a , interview with the Dietary Technician (DT) and Registered Dietician (RD) on at 12:09 PM, the DT said she visited the facility once weekly to complete evaluations for new admissions and concerns when she was informed by nursing. She said loss was tracked from a facility provided report and was acted on for identified loss. She explained that typically, nutritional supplements were added to help avoid nutritional complications of loss and were often re-checked more	N 201		

Agency for Health Care Administration

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N 201	Continued From page 15	N 201		

frequently with loss in , aging residents.

On at 1:56 PM, the Unit Manager said all residents were on admission, and at least monthly and it was assigned by the DON. She explained the facility's Dietician monitored residents for any loss concerns.

In a interview with the DT, RD, and DON, the DT checked resident #52's medical record and said the last progress note dated showed the resident triggered for significant loss. She said orders were added for Med Pass (supplement) and fortified foods. She checked the medical record and said no had been completed for the resident since , so she was not aware of the resident's status since that time. The RD stated, " maintenance is important because it affects healing and optimal health and well-being."

4. Review of the medical record revealed resident #15, a female was admitted to the facility on with diagnoses that included , , , , , , (clot of), major , , , , and D deficiency.

The most recent MDS Quarterly Assessment with an ARD of revealed during the look-periods, resident #15 scored 1 out of 15 on the which indicated she was severely . The assessment showed the resident had range of motion functional limitations in both upper extremities (, , ,), and she was fully dependent on staff to complete all ADLs, including eating. The resident

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N 201	Continued From page 16 did not walk, required a wheelchair, had no ˅ loss or gain, and she received high-risk ˅ ( ) and ( ) medications. The Care Plan Report included focuses for staff dependence to complete all ADLs including eating related to limitations in both with a goal to receive assistance necessary to improve/maintain quality of life, and an intervention for physician notifications for significant intake changes. Additional focuses included, , risk for , , and , risk for , , cognition and thought processes/memory loss, high-risk medication adverse effects monitoring, , with interventions to monitor diet and intake, missing natural , expected LTC needs due to limitations with a goal to assure maintenance of the resident's safety and comfort, and observance of distress and nutritional problems related to conditions, varied intake, and deficiency with an intervention for the RD to evaluate, monitor, and make recommendations. On at 9:22 AM, resident #15 was observed in her room lying in bed. She did not respond to questions and her uneaten breakfast tray was observed on the bedside table. On at 3:43 PM, LPN K said resident #15 required staff assistance to eat her meals. The nurse said the resident was and was dependent on staff to make sure she ate enough. Review of the ˅ and Vitals Summary noted the resident was ˅ , , , and . In two months, the resident had a ˅ , . The	N 201		

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N 201	Continued From page 17 resident was not ˅ again until , for three months and showed a ˅ , or 12.6%. Since the resident was admitted to the facility, she had a total ˅ , or 15.8%, over 5 months. Review of active physician's orders included monthly ˅ . The Nutrition Comprehensive Evaluation/Risk Screen dated noted resident #15 had abnormal nutrition related labs, other risk factors, a low ( ), and she was at nutritional risk. The dietician recommended increased larger protein portions at breakfast to meet nutritional needs. A Dietician progress note dated showed resident #15 was re-evaluated for significant ˅ loss over 90 days with recommendations to increase protein portions for all three meals. In a , interview with the DT, RD, and DON on at 2:05 PM, the DT said she completed a comprehensive nutritional assessment for resident #15 when she was admitted in that showed some nutritional risks, so she recommended additional protein intake at breakfast. She explained the facility did not report any ˅ loss in the monthly reports she received until and a re-evaluation was completed on for significant ˅ loss. The Dietary Technician explained, resident #15's ˅ loss wasn't reported for three months because the medical record showed the resident wasn't ˅ and a re-evaluation would have been completed if the facility had reported it. She checked the medical record and confirmed resident #15 triggered for ˅ loss and required another assessment and possibly	N 201		

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N 201	Continued From page 18 additional interventions. On at 2:15 PM, the DON said the facility's policy was to weigh all residents at least monthly by the 8th of every month, and more frequently when needed. She explained reports were generated monthly and CNAs completed for all residents due, as directed by the DON. The DON said she could not explain why there were no monthly resident completed between and and stated, "it's important to get to make sure they're not losing , to maintain nutrition and monitor underlying medical conditions or that may affect their health and well-being." Review of the facilities standards and guidelines titled Management and dated noted all residents were at least every month, monitored by "Dietary", and re- were obtained for any gain or loss of from the previous . 5. Resident #34 was admitted to the facility on with diagnoses which included ( ) with dependence on , secondary of without behavioral disturbance, and primary . The Admission Evaluation completed on indicated the resident's initial (not taken). This evaluation also indicated the resident's skin had some redness but was intact without any , and	N 201		

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N 201	Continued From page 19 had no issues with her appetite. Resident #34's care plan indicated she had a on her with interventions to monitor nutritional status and obtain weekly skin checks, document, and notify Medical Doctor of any changes in skin integrity (initiated). The Care Plan also indicated this resident had nutritional problem related to , , , therapeutic diet, and varied oral intake with a goal of resident tolerating diet and not having significant loss through review date. One of the interventions was to provide and serve supplements as ordered (initiated). The Nutrition Comprehensive Evaluation dated indicated resident #34's food intake varied between 25-100% of meals and was inadequate to meet her needs which were estimated to be between 2400-2800 calories and 96-112 grams protein/day. The nutritional assessment indicated the resident did not have any skin issues/ , which was obtained from the resident's nursing admission assessment. This was in conflict with the care plan which indicated the upon admission. The assessment indicated her current body ( ) or , (.) from the recorded during her recent hospital stay, the resident reported her appetite was diminished and she was not interested in the food being served. A recommendation for one , oral nutritional supplement was made due to varied food intake and . Resident #34's medical record revealed a physician order dated , which indicated nurses were to complete a weekly skin	N 201		

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N 201	Continued From page 20 observation every night shift on every Wednesday. The Weekly Skin Observation nursing reports dated , , and all indicated the resident had no old or new skin conditions. On at 9:23 AM, resident #34 stated she had a on her backside that hurt. On at 10:28 AM, the Registered Dietary Technician (DTR) stated the initial admission used by the facility for the nutritional assessment was from a prior hospital admission because there was no initial obtained when resident was admitted to the facility. She acknowledged that use of a measurement completed by another facility was not best practice for assessments or for projected change in the future. The DTR stated obtaining an initial at the facility was important. She stated she routinely emailed recommendations to nursing to obtain initial if they were missing from a resident's record, but confirmed she had not requested one for resident #34 to be . The DTR verified she forgot to put in the order for the nutrition supplement she had recommended, which she acknowledged was her responsibility. She indicated her email to nursing should also have indicated the start of , daily for varied food intake on . The DTR confirmed that no food preferences were obtained to assist the resident to improve her food intake through alternative meal choices and trying to mimic the meals the resident normally liked to eat. At that time, the Regional Director of Clinical Services (Regional Nurse) reviewed the resident's " and Initial Assessment" which she confirmed did not contain an initial upon admission.	N 201		

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N 201	Continued From page 21 On at 9:30 AM, the Regional Nurse stated when nursing identified a ⌄ loss or , they would make the RD or DTR aware through emails. She added after the RD/DTR assessed a resident and decided on supplements, they sent their recommendations to nursing via email. The RD/DTR would keep that resident on their caseload and follow them until their issues were resolved. She added the physician oversaw the RD/DTR recommendations and orders and decided whether they were appropriate or not. The Regional Nurse was not able to provide email communication from nursing to the RD/DTR that made them aware of for resident #34. The RD/DTR Progress Note dated reported resident #34's ⌄ ⌄ or ., which was a . ⌄ difference, and a 13% ⌄ loss from her ⌄ reported during the initial nutrition assessment on , one month prior. This significant ⌄ loss could not be verified as accurate since the initial ⌄ used was taken from a different facility's record, but it did reinforce the high risk nature of this resident's nutritional status, and the importance for obtaining an initial ⌄ for each resident upon admission. The facility's policy entitled, " ⌄ Management," dated indicated all residents admitted to the facility would be ⌄ upon admission and dietary staff would evaluate all ⌄ each month. The policy described the facility would attempt to obtain ⌄ at the same time of the day, preferably in the morning, and with the same scale to ensure accuracy and that the physician and resident or	N 201		

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N 201	Continued From page 22 resident's representative would be notified by the nurse of any significant unexpected or unplanned changes. The facility's policy entitled, "Food and Nutritional Services," dated indicated the facility would ensure facility staff supported the nutritional well-being of the residents while respecting their right to make choices about his or her diet. In addition the facility would employ sufficient staff with the appropriate competencies and skill sets to carry out the functions of food and nutrition services, taking into consideration resident assessments, individual plans of care and the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment. A member of the Food and Nutrition Services staff must also participate on the Interdisciplinary team. Pattern Class III	N 201		
N 906 SS=F	400.147(1)(e), FS Measures to Minimize Risk (e) The development of appropriate measures to minimize the risk of adverse incidents to residents, including, but not limited to, education and training in risk management and risk prevention for all nonphysician personnel, as follows: This Statute or Rule is not met as evidenced by: Based on interview, and record review, the facility failed to maintain records, monitor, and effectively conduct Quality Assurance Performance Improvement (QAPI)/Quality Assurance and Assessment (QAA) activities which could affect facility wide processes impacting quality of care	N 906	A) What corrective action(s) will be accomplished for those residents found to have been affected by this practice? a. On PASSR resubmitted for resident # 62. No other deficient practice noted.	

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N 906	Continued From page 23 and quality of life for all residents. Findings: On at 8:43 AM, in a , interview with the Director of Nursing (DON) and Regional Director of Clinical Services, the Director said she initiated a Performance Improvement Plan (PIP) approximately one month prior for Pre-Admission Screening and Resident Review (PASARR). She stated in regards to resident PASARRs, "I would say maybe 25% have been looked at and some were redone." She said she had to locate the documentation and audits to clarify. On at 10:08 AM, the Regional Director of Clinical Services explained she was unable to locate any records for the PIPs and stated, "they're not on record and not organized." On at 11:59 AM, the Nursing Home Administrator (NHA) said she had been the NHA since . She explained she had conducted QAPI meetings on and . She explained the last meeting included discussions concerning regulatory compliance and survey management. She said she initiated a PIP for facility wide environmental concerns and maintenance repairs. The NHA checked previous records that showed a QAPI meeting was conducted in with notes that PIPs were implemented for facility issues with control, , , care, and PASARR. A handwritten log was observed in the binder that noted the titles of PIPs she verbalized. No reports or documents related to the PIPs aside from the environmental/maintenance plans were located in the NHA's QAPI records. The NHA was unable to locate any records for clinical PIPs and said she	N 906	B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? a. On A full house audit was completed for PASSR's needing resubmission due new diagnosis. No other deficient practice noted. C) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? a. On the DON/designee conducted education with social services and DON on ensuring request for new submission of PASSR is completed with new diagnosis meeting criteria, with an emphasis on the components of Federal regulation F644. D) How will the corrective actions be monitored to ensure the practice will not reoccur; what quality measures will be put into place? a. The DON/Designee will conduct an audit of residents with new diagnosis meeting criteria for resubmission of PASSR to ensure compliance with N906 weekly X 4 weeks then monthly for 2 months or until substantial compliance is achieved. b. Findings will be reported monthly at the QA/Risk management meeting until such a time substantial compliance has been determined.	

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N 906	Continued From page 24 could not speak to what occurred before she took over. The NHA stated, "there are no records for clinical; QAPI is in place to monitor, analyze, and correct problems so residents get the care and services they need and have the right to." Review of the Quality Assurance Meeting minutes dated provided by the NHA noted there were no QAA Committee recommendations, and read, "Plan implemented based on recommendations: N/A" Review of the facility's standards and guidelines titled Quality Assurance and Performance Improvement and dated read, "The facility will: 1. Maintain documentation and demonstrate evidence of it's ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events, and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities . . . 3. Present documentation and evidence of it's ongoing QAPI program's implementation and the facility's compliance with the requirements to a State Survey Agency, Federal Surveyor, or CMS (Centers for Medicare & Medicaid Services) upon request." Class III Widespread	N 906		

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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 000	INITIAL COMMENTS Recertification survey was conducted in conjunction with complaint #2025000968. The complaint was not substantiated, but Avante at Melbourne was not in compliance with 42 CFR Part 483 and 488, Requirements for Long Term Care Facilities.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to conduct medication self-administration assessments to ensure safety for 2 of 2 residents reviewed for self-administration of medications, of a total sample of 43 residents (#49, and #305). Findings: 1. Resident #49 was admitted on and readmitted on . His diagnoses included hypertensive urgency, , , , and , of the . A review of the Minimum Data Set (MDS) quarterly assessment with an assessment reference date of revealed resident #49 had a ( ) score of 15 out of 15, which indicated he was . On at 12:27 PM, resident #49 was	F 554	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. Avante at Melbourne maintains the alleged deficiencies do not individually jeopardize the health and/or safety of its residents nor are they if such character as to limit the provider's capacity to render adequate resident care. Furthermore, Avante at Melbourne asserts that it is in substantial compliance with regulations governing the operation of long-term care facilities, and this Plan of Correction in its entirety constitutes the provider's credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/2025

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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	105671	A. BUILDING _____ B. WING _____	C 02/14/2025

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F 554	Continued From page 1 observed sitting upright in bed. His bedside table was over his , , with personal items, including a 30-ounce jar of herbal blend "Randy Ease", D3-K2, Elderberry capsule 1000 milligrams (mg), C tablet 400 mg, tablet 10 mg, Sea Moss, Turmeric-Curcumin capsule 1500 mg, Ultra- , capsule, "Vital Grow" male enhancement gummies, N 2 boosters capsules, E capsules, Super Reds capsules, and Super Greens capsules. The resident stated he stopped taking , because the herbal blend Randy Ease worked better. On at 10:11 AM, Primary Registered Nurse (RN) F, observed the resident's bedside table. She acknowledged the 30-ounce jar of herbal blend Randy Ease, D3-K2, Elderberry capsule 1000 milligrams (mg), C tablet 400 mg, tablet 10 mg, Sea Moss, Turmeric-Curcumin capsule 1500 mg, Ultra- , capsule, "Vital Grow" male enhancement gummies, N 2 boosters capsules, E capsules, Super Reds capsules, and Super Greens capsules. A review of the resident's physician orders with RN F revealed no orders for , or the above items found on the resident's bedside overbed table. The RN explained that for someone to self-administer medications, they must have a physician order and a self-administration evaluation completed. RN F stated there was no order for herbs, supplements, and and that the resident had not completed a self-administration evaluation. 2. Resident #305 was admitted to the facility on with diagnoses including a from a motorized mobility scooter, type 2	F 554	A) What corrective action(s) will be accomplished for those residents found to have been affected by this practice? a. On DON completed self-administration assessment for resident number 49. Reviewed with physician, physician declined self-admin order/ to add supplements to MAR stated the herbs may have contraindication with scheduled medication. b. Resident number 305 discharged from facility , readmitted declined self- administration assessment. B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? a. On Audit completed on residents to ensure any resident who wished to self-administer medications has a self-administration screen completed along with a physician order to self-administer. C) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? a. By Director of Nursing/designee to complete education with Licensed Nurses to ensure residents who wish to self-administer medications have an assessment, lock box, MAR, and physician order. D) How will the corrective actions be monitored to ensure the practice will not reoccur; what quality measures will be put	

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F 554	Continued From page 2 with , , and . A review of the admission the MDS admission assessment with an assessment reference date of revealed resident #305 had a score of 12 out of 15, which indicates he was moderately , cognition. On at 11:21 AM, resident #305 was observed standing next to his bed. The nightstand was observed with a bottle of 300 mg/100 caplets , 8 hour , . The resident stated he keeps the , at his bedside because he has , in the . On at 12:08 PM, the resident's nightstand was observed with (RN) F Primary care nurse. She acknowledged the bottle of 300 mg/100 caplets , 8 hr , . A review of the resident's physician orders with RN F revealed no orders for , found on the resident's nightstand. The RN explained that for someone to self-administer medications, they must have a physician order and a self-administration evaluation completed. RN F stated there was no order for , and that the resident did not have a completed medication self-administration evaluation. On at 2:30 PM, the Director of Nursing (DON) stated residents should not have medications at the bedside to prevent overdose. She also explained a "self-administration assessment" must be completed to ensure residents could safely self-administer medication. She confirmed residents #49 and #302 were not evaluated for medication self-administration.	F 554	into place? a. Director of Nursing/designee to complete random audit of residents who wish to administer medications by themselves have an assessment, lock box, MAR and physician order to do so weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved. b. Findings will be reported monthly at the QA/Risk management meeting until such time substantial compliance has been determined.	

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F 554	Continued From page 3 A review of the facility's policy and procedure for Self-Administration of Medication Program dated revealed, "It is the policy of the facility to allow the resident and or the legal representative of the resident the right to self-administer medications when it has been deemed by the interdisciplinary team that it is clinically appropriate."	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a call light device was within reach for 1 of 3 residents reviewed for accommodation of needs, of a total sample of 43 residents, (#52). Findings: Review of the medical record revealed resident #52, a female was admitted to the facility on with diagnoses that included type 2 , major , persistent , Affect (uncontrollable crying/laughing), and communication The most recent Minimum Data Set Quarterly	F 558	A) What corrective action(s) will be accomplished for those residents found to have been affected by this practice? a. On resident number 52 call light was picked up and clipped to the resident bedsheet, so the bulb was within reach of the resident`s . B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? a. On Director of Nursing/designee completed an audit to ensure resident call lights are within reach. C) What measures will be put into place or what systemic changes will you take to	

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F 558	Continued From page 4 Assessment with an Assessment Reference Date of revealed during the look-periods, resident #52 had , vision, was rarely/never understood, and unable to complete the . Staff assessed the resident had short term and long term memory problems, was severely , , had continuous inattention and disorganized thinking that did not fluctuate, , and was dependent on staff to complete all Activities of Daily Living (ADL). The resident did not walk, required a wheelchair, was always of and functions, required scheduled and as needed , medication, a mechanically altered diet, and received high-risk . and , medications. The Order Summary Report included active physician's medication orders for , (blocker) 10 Milligrams (MG) at bedtime for , , (hormone) 112 Micrograms once daily for , (agent) 20-10 MG every twelve hours for Affect, (, ,) 50 MG three times daily for , , and (,) 25 MG at bedtime for , . The Comprehensive Care Plan included focuses for , , , , risk for , , communication and hearing, risk for , with behaviors, high-risk medication adverse effects monitoring, , , required staff assistance for all ADLs, and Long Term Care (LTC) with a goal to assure maintenance of the resident's safety and comfort, and observance of distress.	F 558	ensure that the practice does not reoccur? a. By Director of Nursing/designee completed education with staff to ensure residents call lights are within reach of the resident. D) How will the corrective actions be monitored to ensure the practice will not recur; what quality measures will be put into place? a. Director of Nursing/designee to complete random audit to ensure resident call lights are within reach compliance with federal regulation F558 weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved. b. Findings will be reported monthly at the QA/Risk management meeting until such a time substantial compliance has been determined.	

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F 558	Continued From page 5	F 558		

On at 10:45 AM and 3:56 PM, resident #52 was observed in her room awake and lying in bed. The call light cord with a squeeze bulb activator was lying on the floor under the resident's bed on the left side. On at 3:12 PM, the resident's door was closed; the call light cord and bulb were observed on the floor in the same location.

On at 3:40 PM, Certified Nursing Assistant (CNA) J said she knew resident #52 well, as she was often included in her assignment. The CNA explained the resident was able to use her and arms to activate a call light bulb.

In a , observation on at 3:43 PM, CNA J and Licensed Practical Nurse (LPN) K observed resident #52's call light cord and squeezable bulb lying on the floor under the bed. LPN K picked up the device and clipped it to the resident's bed sheet so the bulb was within reach of the resident's . LPN K explained, staff were expected to check and make sure the device was within reach so the resident could use it if needed. The LPN said when the room door was closed, staff were unable to hear her yell out and confirmed the call light shouldn't be on the floor.

On at 3:55 PM, the Unit Manager explained she expected staff to check residents' call lights and ensure they were safely within reach every time before they exited a room. She said CNAs typically checked on bedbound residents every two hours for care and repositioning and stated, "they shouldn't leave the room with a call light on the floor."

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F 558	Continued From page 6 Review of the Facility Assessment dated noted the facility provided person-centered care for persons with , staff responded to residents' requests for assistance promptly in order to promote resident dignity, and staff training and competency included resident call lights.	F 558		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)( );	F 584		

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F 584	Continued From page 7 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after , must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to provide a homelike environment for residents who ate in the dining rooms on the two (North and South) nursing units. This affected all residents who chose to eat in the nursing unit's dining areas, which varied from approximately residents per meal of the 98 residents at the facility. Findings: On at 12:35 PM, four staff were observed serving trays to residents on the North unit from the food cart. There were seven residents sitting at tables in the North unit dining room waiting to be served. There were no tablecloths or centerpieces on the tables and the dishes were left on the serving trays. On at 1:38 PM, lunch was provided to approximately thirteen residents in the South unit dining room. There were no tablecloths or centerpieces on the tables. All the dishes, flatware, cups and food items were left on the resident's trays while they ate.	F 584	A) What corrective action(s) will be accomplished for those residents found to have been affected by this practice? a. On table clothes and centerpieces were provided on the tables for North and South wing. b. On dishes, flatware, cups and food items were removed from the serving tray B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? a. On the Director of Nursing/designee completed an audit to ensure North and South dining room tables have table clothes and centerpieces on the tables. b. On the Director of Nursing/ designee completed an audit to ensure all dishes, flatware, cups, and food are removed from the tray unless the resident declines to have items removed per their plan of care.	

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F 584	Continued From page 8 On at 5:59 PM, residents were observed eating in the South unit room dining room from their trays. The undecorated tables held newspapers and pieces of paper with word puzzles on them that had been used earlier in the day. On at 1:18 PM, during the lunch service on the South and North unit's dining rooms the residents ate from their trays on undecorated tables as they did the previous day. On at 5:21 PM, resident #77 described the dining area felt like a cafeteria, and could be made nicer with tablecloths or decorations. On at 10:28 AM, the Registered Dietetic Technician (DTR) stated she thought everyone would enjoy a little more decoration in the dining room, like centerpieces in the area in which they dine. On at 1:10 PM, the Administrator observed all residents in the South unit dining room ate from trays. She acknowledged that serving all residents on trays could be considered a dignity issue because it was more institutional, than home-like.	F 584	C) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? a. By Director of Nursing/designee completed education with staff to ensure North and South unit tables have table clothes and center pieces. b. By the Director of Nursing/ designee completed education with staff to remove dishes, flatware, cups, and food removed from the tray unless the resident prefers to have items on the tray per the plan of care. D) How will the corrective actions be monitored to ensure the practice will not recur; what quality measures will be put into place? a. Director of Nursing/designee to complete random audit to ensure North and South wings tables have table clothes and center pieces compliance with federal regulation F584 weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved. b. Director of Nursing/designee to complete random audit to ensure to remove dishes, flatware, cups, and food removed from the tray unless the resident prefers to have items on the tray per the plan of care compliance with federal regulation F584 weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved. c. Findings will be reported monthly at the QA/Risk management meeting until such a time substantial compliance has been determined.	

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F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental , intellectual , or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to complete a new Preadmission Screening and Resident Review (PASSAR) level I screen to ensure additional mental health services were not required for 1 of 5 residents reviewed for PASSAR, of a total sample of 43 residents, (#62). Findings: Resident #62 was admitted to the facility on with diagnoses that included , communication , generalized , and . Other diagnoses were added later and included Schizophreniform on , persistent on	F 644	A) What corrective action(s) will be accomplished for those residents found to have been affected by this practice? a. On PASSR resubmitted for resident # 62. No other deficient practice noted. B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? a. On A full house audit was completed for PASSR□s needing resubmission due new diagnosis. No other deficient practice noted.	

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F 644	Continued From page 10 , and major , on . Resident #62's Quarterly Minimum Data Set assessment dated , revealed he was severely , , and required substantial to for activities of daily living. Review of resident #62's medical record revealed a PASSAR Level I had been completed on with diagnosis of listed. The facility could not provide evidence of a new screening. Review of , note dated , revealed that resident #62 was being treated for , , , , , , , and schizophreniform . The , consult noted that the resident had exhibited behaviors such as and sleeping issues. On at 2:00 PM, the Director of Nursing (DON) jointly with the Regional Director of Clinical Services said she was not aware resident #62 had a new diagnosis that required a new PASSAR screen. The Regional Director of Clinical Services said she assisted the DON with PASSARs but was unaware a new screening was required for resident #62 after the new diagnoses.	F 644	C) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? a. On the DON/designee conducted education with social services and DON on ensuring request for new submission of PASSR is completed with new diagnosis meeting criteria, with an emphasis on the components of Federal regulation F644. D) How will the corrective actions be monitored to ensure the practice will not reoccur; what quality measures will be put into place? a. The DON/Designee will conduct an audit of residents with new diagnosis meeting criteria for resubmission of PASSR to ensure compliance with federal regulation F644 weekly X 4 weeks then monthly for 2 months or until substantial compliance is achieved. b. Findings will be reported monthly at the QA/Risk management meeting until such a time substantial compliance has been determined.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		

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F 684	Continued From page 11 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility failed to ensure nurses followed physician's orders to monitor for 1 of 1 resident reviewed for change of condition, of a total sample of 43 residents, (#93). Findings: Review of the medical record revealed resident #93, a male was admitted to the facility from an acute care hospital on with diagnoses that included, and (partial), generalized (difficulty swallowing), (high), ( ) status, (abnormal rhythm), ( ), and . The most recent Minimum Data Set 5-day Assessment with an Assessment Reference Date of noted during the look-back periods, resident #93 had difficulty swallowing, required a for nutrition and hydration, received injections for 7 out of 7 days, and high risk ( ), and (lowering) medications. The Order Summary Report noted active physician's medication orders included Diabetisource AC (before meals) (feeding	F 684	A) What corrective action(s) will be accomplished for those residents found to have been affected by this practice? a. On an assessment was completed on resident number 93 no signs or symptoms of hyper or were noted. b. On Staff member received education on entering physician orders in the medical record when received orders for abnormal lab results. B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? a. On the Director of Nursing/designee completed an audit to ensure resident with order changes related to abnormal results ensure all orders are followed. C) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? a. By the Director of Nursing/designee completed education with licensed nurses when orders are received related to abnormal results a physician order is placed in the resident medical record.	

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F 684	Continued From page 12 tube) formula 60 milliliters per hour from 8:00 PM to 6:00 AM, 6.25 Milligrams (MG) twice daily for , , , 1 MG at bedtime for , , , 45 Units (U) twice daily for , Lispro 4 U four times daily for , and Lispro , dosage per stick results before meals for . The Comprehensive Care Plan included focuses for with interventions for nurse monitoring of and risk of complications, and dependence on feeding for nutrition with interventions for nurse monitoring of functioning/maintenance and risk of complications. During a medication administration observation on at 11:32 AM, Licensed Practical Nurse (LPN) E collected resident #93's stick with a result of 175 milligrams per deciliter (mg/dl). The nurse said physician's orders were to give the resident an extra 2 units of Lispro . She explained, she was unable to locate resident #93's Lispro in the medication cart. The nurse explained the facility's on emergency medication kit did not contain Lispro. At 12:04 PM, LPN E said she contacted the physician and obtained orders to hold the Lispro and re-check resident #93's every hour until the refill arrived from the pharmacy. Review of a nurse progress note completed by LPN E on at 12:17 PM, read, " unavailable at the moment awaiting pharmacy to deliver STAT [immediately/urgently] MD [physician] notified and said to keep checking bs [ ] once every hour until gets here."	F 684	D) How will the corrective actions be monitored to ensure the practice will not recur; what quality measures will be put into place? a. Director of Nursing/designee to complete random audit to ensure resident with order changes related to abnormal results ensure all orders are followed compliance with federal regulation F684 weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved. b. Findings will be reported monthly at the QA/Risk management meeting until such a time substantial compliance has been determined.	

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On at 3:25 PM, LPN L said LPN E had left for the day and she received off-going report from her. The nurse said LPN E had not mentioned resident #93 was out of nor that the doctor had given orders to check his every hour until the refill arrived.

Review of the and Vitals Summary Report noted a struck-out entry by LPN L on at 3:31 PM, of a stick measurement of 157 mg/dl and an additional measurement of 137 mg/dl at 4:30 PM.

On at 10:47 AM, LPN E recalled on at lunchtime, she obtained doctor's orders to re-check resident #93's once an hour. She said she completed re-checks every hour until the end of her shift at 3:00 PM and stated, "it was in a good range."

On at 12:46 PM, the Unit Manager recalled on , LPN E obtained a doctors order to hold resident #93's lunchtime and re-check the until the was delivered because it wasn't in the emergency medication kit. The Unit Manager checked the medical record and was unable to locate any re-checks by LPN E on . She acknowledged there were no re-checks until LPN L's was recorded at 4:30 PM, four hours after LPN E received physician's orders. The nurse stated, "she didn't check it every hour per the MD [physician] order; it's important for them to re-check, especially if it was a brittle person."

On at 10:13 AM, the Director of Nursing (DON) explained nurses were expected to follow doctor's orders and monitor residents for

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F 684	Continued From page 14 abnormal to prevent re-hospitalization and complications. The DON stated, "the nurse should have monitored the resident." Review of the facility's standards and guidelines titled Change in Condition Process dated noted nurses were expected to evaluate the resident's status and document findings in the electronic medical record. The Facility Assessment noted the facility provided nursing services and care including management of medication and medical conditions including .	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso- and tubes, both , and , endoscopic , , , and 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 or desirable body 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	F 692		

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F 692	Continued From page 15 provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to monitor identified loss and nutrition risk for 2 residents (#52, #15); and failed to properly monitor the clinical condition for 1 resident, (#34), out of 7 residents reviewed for nutrition, of a total sample of 43 residents. Findings: 1. Review of the medical record revealed resident #52, a female was admitted to the facility on with diagnoses that included type 2 , major , persistent , Affect (uncontrollable crying/laughing), and communication . The most recent Minimum Data Set (MDS) Quarterly Assessment with an Assessment Reference Date (ARD) of revealed during the look- periods, resident #52 had vision, was rarely/never understood, and unable to complete the ( ). Staff assessed the resident had short term and long term memory problems, was severely , had continuous inattention and disorganized thinking that did not fluctuate, , and she was dependent on staff to complete all Activities of Daily Living (ADL). The resident did not walk, required a wheelchair, had no loss or gain, required scheduled and as needed medication, a mechanically altered diet, and she received	F 692	A) What corrective action(s) will be accomplished for those residents found to have been affected by this practice? a. On RD completed review to assess nutritional status of resident numbers, 15, 52, and 34. B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? a. On Audit completed to ensure nutritional status of residents has been assessed. b. On Audit completed to ensure nutritional status of resident with have been assessed. C) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? a. By Director of Nursing/designee to complete education with RD and nurse management team to ensure nutritional status is reviewed and assessed. D) How will the corrective actions be monitored to ensure the practice will not reoccur; what quality measures will be put into place? a. Director of Nursing/designee to complete random audit to ensure nutritional status of residents has been assessed to ensure compliance with federal regulation F692 weekly x4 weeks	

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F 692	Continued From page 16 high-risk , and , medications. The Order Summary Report included active physician's orders for monthly . Medication orders included , (blocker) 10 Milligrams (MG) at bedtime for , (, hormone) 112 Micrograms once daily for , , (agent) 20-10 MG every twelve hours for Affect, (, ,) 50 MG three times daily for , , and (,) 25 MG at bedtime for , . The Comprehensive Care Plan included focuses for , , , risk for , , communication and hearing, risk for , with behaviors, high-risk medication adverse effects monitoring, , , required staff assistance for all ADLs, and Long Term Care (LTC) with a goal to assure maintenance of the resident's safety and comfort, and observance of distress. On at 10:45 AM, resident #52 was observed awake and lying in bed in her room. The resident did not answer questions and was unable to participate in an interview. On at 3:43 PM, Certified Nursing Assistant (CNA) J said resident #52 was often included in her assignment, required staff assistance to eat, and needed cues and reminders to ensure she was eating enough. Review of the Dietary Progress Note dated noted resident #52 was evaluated for loss, insufficient intake, and a low Body	F 692	then monthly for 2 months or until substantial compliance is achieved. b. Findings will be reported monthly at the QA/Risk management meeting until such time substantial compliance has been determined.	

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Index ( ). Orders for calorically dense supplements twice daily between meals and fortified foods were implemented for loss and low .

The and Vitals Report showed on , resident #52 had a 8.7% or , loss over two months. Additional were not completed after , for three months.

In a , interview with the Dietary Technician (DT) and Registered Dietician (RD) on at 12:09 PM, the DT said she visited the facility once weekly to complete evaluations for new admissions and concerns when she was informed by nursing. She said loss was tracked from a facility provided report and was acted on for identified loss. She explained that typically, nutritional supplements were added to help avoid nutritional complications of loss and were often re-checked more frequently with loss in , aging residents.

On at 1:56 PM, the Unit Manager said all residents were on admission, and at least monthly and it was assigned by the Director of Nursing (DON). She explained the facility's Dietician monitored residents for any loss concerns.

In a , interview with the DT, RD, and DON, the DT checked resident #52's medical record and said the last progress note dated showed the resident triggered for significant loss. She said orders were added for Med Pass (supplement) and fortified foods. She checked the medical record and said no

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had been completed for the resident since , so she was not aware of the resident's status since that time. The RD stated, " maintenance is important because it affects healing and optimal health and well-being."

2. Review of the medical record revealed resident #15, a female was admitted to the facility on with diagnoses that included , , , (clot of), major , , , and D deficiency.

The most recent MDS Quarterly Assessment with an ARD of revealed during the look-periods, resident #15 scored 1 out of 15 on the which indicated she was severely . The assessment showed the resident had range of motion functional limitations in both upper extremities (, , ,), and she was fully dependent on staff to complete all ADLs, including eating. The resident did not walk, required a wheelchair, had no loss or gain, and she received high-risk ( ) and ( ) medications.

The Care Plan Report included focuses for staff dependence to complete all ADLs including eating related to limitations in both with a goal to receive assistance necessary to improve/maintain quality of life, and an intervention for physician notifications for significant intake changes. Additional focuses included, , risk for , and , risk for , , cognition and thought processes/memory loss,

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high-risk medication adverse effects monitoring, , with interventions to monitor diet and intake, missing natural , expected LTC needs due to limitations with a goal to assure maintenance of the resident's safety and comfort, and observance of distress and nutritional problems related to conditions, varied intake, and deficiency with an intervention for the RD to evaluate, monitor, and make recommendations.

On at 9:22 AM, resident #15 was observed in her room lying in bed. She did not respond to questions and her uneaten breakfast tray was observed on the bedside table.

On at 3:43 PM, Licensed Practical Nurse (LPN) K said resident #15 required staff assistance to eat her meals. The nurse said the resident was and was dependent on staff to make sure she ate enough.

Review of the and Vitals Summary noted the resident was , , , , and . In two months, the resident had a , . The resident was not again until , for three months and showed a , or 12.6%. Since the resident was admitted to the facility, she had a total , , or 15.8%, over 5 months.

Active physician's orders included monthly .

The Nutrition Comprehensive Evaluation/Risk Screen dated noted resident #15 had abnormal nutrition related labs, other risk factors, a low ( ), and she was at

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nutritional risk. The dietician recommended increased larger protein portions at breakfast to meet nutritional needs.

A Dietician progress note dated showed resident #15 was re-evaluated for significant loss over 90 days with recommendations to increase protein portions for all three meals.

In a interview with the DT, RD, and DON on at 2:05 PM, the DT said she completed a comprehensive nutritional assessment for resident #15 when she was admitted in that showed some nutritional risks, so she recommended additional protein intake at breakfast. She explained the facility did not report any loss in the monthly reports she received until and a re-evaluation was completed on for significant loss. The Dietary Technician explained, resident #15's loss wasn't reported for three months because the medical record showed the resident wasn't and a re-evaluation would have been completed if the facility had reported it. She checked the medical record and confirmed resident #15 triggered for loss and required another assessment and possibly additional interventions.

On at 2:15 PM, the DON said the facility's policy was to weigh all residents at least monthly by the 8th of every month, and more frequently when needed. She explained reports were generated monthly and CNAs completed for all residents due, as directed by the DON. The DON said she could not explain why there were no monthly resident completed between and and stated, "it's important to get to make sure they're

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not losing , to maintain nutrition and monitor underlying medical conditions or that may affect their health and well-being."

Review of the facilities standards and guidelines titled Management and dated noted all residents were at least every month, monitored by "Dietary", and re- were obtained for any gain or loss of from the previous .

3. Resident #34 was admitted to the facility on with diagnoses which included ( ) with dependence on , , , , secondary of , , without behavioral disturbance, and primary . The Admission Evaluation completed on indicated the resident's initial (not taken). This evaluation also indicated the resident's skin had some redness but was intact without any , and had no issues with her appetite.

Resident #34's care plan indicated she had a , on her , with interventions to monitor nutritional status and obtain weekly skin checks, document, and notify Medical Doctor (MD) of any changes in skin integrity (initiated). The Care Plan also indicated this resident had nutritional problem related to , , , , therapeutic diet, and varied oral intake with a goal of resident tolerating diet and not having significant loss through review date. One of the interventions was to provide and serve supplements as ordered (initiated).

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The Nutrition Comprehensive Evaluation dated indicated resident #34's food intake varied between 25-100% of meals and was inadequate to meet her needs which were estimated to be between 2400-2800 calories and 96-112 grams protein/day. The nutritional assessment indicated the resident did not have any skin issues/ , which was obtained from the resident's nursing admission assessment. This was in conflict with the care plan which indicated the upon admission. The assessment indicated her current body ( ) or (.) from the recorded during her recent hospital stay, the resident reported her appetite was diminished and she was not interested in the food being served. A recommendation for one , oral nutritional supplement was made due to varied food intake and .

Resident #34's medical record revealed a physician order dated , which indicated nurses were to complete a weekly skin observation every night shift on every Wednesday. The Weekly Skin Observation nursing reports dated , , and all indicated the resident had no old or new skin conditions.

On at 9:23 AM, resident #34 stated she had a on her backside that hurt.

On at 10:28 AM, the DTR stated the initial admission used by the facility for the nutritional assessment was from a prior hospital admission because there was no initial obtained when resident was admitted to the facility. She acknowledged that use of a

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measurement completed by another facility was not best practice for assessments or for projected ⌄ change in the future. The DTR stated obtaining an initial ⌄ at the facility was important. She stated she routinely emailed recommendations to nursing to obtain initial ⌄ if they were missing from a resident's record, but confirmed she had not requested one for resident #34 to be ⌄ . The DTR verified she forgot to put in the order for the nutrition supplement she had recommended, which she acknowledged was her responsibility. She indicated her email to nursing should also have indicated the start of , daily for varied food intake on , . The DTR confirmed that no food preferences were obtained to assist the resident to improve her food intake through alternative meal choices and trying to mimic the meals the resident normally liked to eat. At that time, the Regional Director of Clinical Services (Regional Nurse) reviewed the resident's " and Initial Assessment" which she confirmed did not contain an initial ⌄ upon admission.

On at 9:30 AM, the Regional Nurse stated when nursing identified a ⌄ loss or , they would make the RD or DTR aware through emails. She added after the RD/DTR assessed a resident and decided on supplements, they sent their recommendations to nursing via email. The RD/DTR would keep that resident on their caseload and follow them until their issues were resolved. She added the physician oversaw the RD/DTR recommendations and orders and decided whether they were appropriate or not. The Regional Nurse was not able to provide email communication from nursing to the RD/DTR that made them aware of for resident

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F 692	Continued From page 24 #34. The RD/DTR Progress Note dated reported resident #34's ˘ ˘ or ., which was a . ˘ difference, and a 13% ˘ loss from her ˘ reported during the initial nutrition assessment on , one month prior. This significant ˘ loss could not be verified as accurate since the initial ˘ used was taken from a different facility's record, but it did reinforce the high risk nature of this resident's nutritional status, and the importance for obtaining an initial ˘ for each resident upon admission. The facility's policy entitled, " ˘ Management," dated indicated all residents admitted to the facility would be ˘ upon admission and dietary staff would evaluate all ˘ each month. The policy described the facility would attempt to obtain ˘ at the same time of the day, preferably in the morning, and with the same scale to ensure accuracy and that the physician and resident or resident's representative would be notified by the nurse of any significant unexpected or unplanned ˘ changes. The facility's policy entitled, "Food and Nutritional Services," dated indicated the facility would ensure facility staff supported the nutritional well-being of the residents while respecting their right to make choices about his or her diet. In addition the facility would employ sufficient staff with the appropriate competencies and skill sets to carry out the functions of food and nutrition services, taking into consideration resident assessments, individual plans of care	F		

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AVANTE AT MELBOURNE INC	1420 SOUTH OAK STREET MELBOURNE, FL 32901

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F 692	Continued From page 25 and the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment. A member of the Food and Nutrition Services staff must also participate on the Interdisciplinary team.	F 692		
F 695 SS=D	, ,/ , Care and Suctioning CFR(s): 483.25(i) § 483.25(i) , care, including , care and suctioning. The facility must ensure that a resident who needs , care, including care and 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: Based on observation, interview, and record review, the facility failed to provide emergency equipment available for accidental extubation for a resident on with a , ( ) per nursing standards of practice for 1 of 1 residents reviewed for , of a total sample of 40 residents, (#22). Findings: Resident #22 was initially admitted on and re-admitted on with diagnoses which included , failure with , , (low ,), anoxic damage, , , (trouble swallowing), hypertensive , and , status. A" , (also called a ,) is an	F 695	A) What corrective action(s) will be accomplished for those residents found to have been affected by this practice? a. On an extra tube (emergency kit) was placed at bedside for resident number 22. B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? a. On Director of Nursing/designee completed an audit to ensure extra tube kept at bedside (Emergency kit). C) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? a. By the Director of	

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F 695	Continued From page 26 opening surgically created through the into the (windpipe) to allow air to fill the . After creating the , opening in the , surgeons insert a tube through it to provide an airway and to remove from the . The person with a , breathes through the , tube (tube or obturator) rather than through the and ." An extubation (when the tube is displaced) creates an emergency that requires an obturator be readily available and staff are knowledgeable to reinsert it, (retrieved on from www.hopkinsmedicine.org). On at 10:09 AM, resident #22 was observed in bed, calm, and awake with , tubing connected to the , concentrator. The , tubing and the suction tip which was bedside were undated. A bag valve mask (BVM) or Ambu bag was in a clear plastic bag on the wall directly over the of the resident's bed, but there was no emergency kit in the clear plastic bag nor at the bedside. The assigned Licensed Practical Nurse (LPN) G was in resident #22's room at that time and validated the observations. LPN G stated it was the night shift nurses' responsibility to change and date the , tubing along with the suction tip but she did not know how often the tubing needed to be changed. LPN G explained she thought the night shift set up the equipment. She explained she knew how to perform care and suction the resident, but was unsure about what to do if there was an emergency and was unaware of the need for an emergency kit at bedside. LPN G was unsure who was responsible for the emergency supplies at bedside but felt it was possibly Central Supply.	F 695	Nursing/ designee completed education with licensed Nurses on ensuring we have extra tube is kept at bedside (Emergency Kit). D) How will the corrective actions be monitored to ensure the practice will not reoccur; what quality measures will be put into place? a. Director of Nursing/designee to complete random audit extra tube is stored at bedside (emergency kit) ensure compliance with federal regulation F695 weekly x 4 weeks then monthly for 2 months or until substantial compliance is achieved. b. Findings will be reported monthly at the QA/Risk management meeting until such time substantial compliance has been determined.	

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F 695	Continued From page 27	F 695		

A review of the resident #22's medical record revealed physician orders for care to be done every day and as needed, mask tubing /humidifier mask to be changed every week, on night shift every Friday. The physician's orders did not contain an order for emergency supplies including replacement obturator needed for resident #22. A review of the resident's Care Plan identified the resident had a but did not contain interventions for emergency supplies at bedside.

On at approximately 10:45 AM, the Unit Manager (UM), Central Supply staff and a Regional Nurse were in resident #22's room and verified there was no emergency kit at the bedside. The Central Supply staff confirmed it was her responsibility to place the emergency kit at the bedside. The UM confirmed that emergency supplies were supposed to be at bedside and said, "this is not what is done here, [she was] not sure what happened..."

On at 1:47 PM, the UM said she helped with the education of staff and participated in in-services because the facility did not have a Staff Educator. She verified the importance of having the emergency kit at bedside for residents with a and stated the assigned nurse LPN G could get nervous at times but thought she knew what to do in an emergency. The UM explained that the Director of Nursing (DON) was responsible for staff orientation after hire.

On at 1:51 PM, LPN H said that she had worked with resident #22 and knew the importance of having the emergency kit at bedside because, "if [the tube] accidentally

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F 695	Continued From page 28 dislodged they can use items in kit to replace the ." She explained at least once a shift she should ensure that the emergency supplies were at bedside. On at 2:16 PM, the DON who was working on the floor because of a nurse call out, explained the training process for new staff nurses. She said upon hire; she would go over the facility's policy then place the new nurse with a . She explained that new staff were oriented depending on how experienced they were, she would get feedback from the , and proceed accordingly. The was responsible for showing the orientee most tasks and would have referred to her "if they were not comfortable with something." The DON stated she had a plan to do an in-service on care because one nurse reached out to her specifically. On at 11:51 AM, the DON stated the expectation was for the nurses to have verified that resident #22 had an emergency kit at the bedside in case of an accidental dislodgement. The Facility's Policy and Procedure for / Care and Suctioning revised indicated, "the facility will ensure that residents who need care, including care and suctioning is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences."	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		

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F 755	Continued From page 29 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to obtain medications timely for 1 of 26 residents reviewed for medication administration, of a total sample of 43 residents, (#93).	F 755	A) What corrective action(s) will be accomplished for those residents found to have been affected by this practice? a. On DON ordered from the pharmacy STAT for resident number 93.	

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F 755	Continued From page 30 Findings: Review of the medical record revealed resident #93, a male was admitted to the facility from an acute care hospital on with diagnoses that included unspecified , generalized , , , , (difficulty swallowing), high , , , ( ) status, (abnormal rhythm), , , , ( ), , and . The most recent Minimum Data Set 5-day Assessment with an Assessment Reference Date of noted during the look- periods, resident #93 had difficulty swallowing, required a for nutrition and hydration, received injections for 7 out of 7 days, and high risk , , , , , , , , ( ), , , , (lowering), and ( ) medications. The Order Summary Report noted active physician's medication orders included Diabetisource AC ( ) formula 60 milliliters per hour from 8:00 PM to 6:00 AM, 45 Units (U) twice daily for , Lispro 4 U four times daily for , and Lispro , dosage per stick results before meals for . The Comprehensive Care Plan included focuses for with interventions for nurse monitoring of and risk of complications. On at 11:32 AM, Licensed Practical	F 755	B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? a. On Audit completed on residents who require to ensure is available. C) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? a. By Director of Nursing/designee to complete education with Licensed Nurses to ensure residents who receive have on . D) How will the corrective actions be monitored to ensure the practice will not reoccur; what quality measures will be put into place? a. Director of Nursing/designee to complete audit of residents who received to ensure is available and on for ordered use ensure compliance with federal regulation F755 weekly x 4 weeks then monthly for 2 months or until substantial compliance is achieved. b. Findings will be reported monthly at the QA/Risk Management meeting until such time substantial compliance has been determined.	

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Nurse (LPN) E was observed obtaining a level from resident #93. She said the resident required 2 U of Lispro per physician's orders. She checked the medication cart and said the resident didn't have any Lispro . She then left to check the facility's emergency medication kit. At 12:17 PM, LPN E explained the emergency kit did not contain Lispro . She said she called the physician who said none of the emergency medications on could be used as an alternate, so an order was placed with the pharmacy for delivery expected later that afternoon. LPN E said the physician wanted hourly until the arrived.

On at 3:25 PM, LPN L said LPN E had left for the day and she received oncoming report for the 3:00 PM to 11:00 PM shift. The nurse explained that LPN E had not mentioned resident #93 was out of Lispro and the afternoon pharmacy delivery had not arrived yet.

On at 12:46 PM, the Unit Manager recalled on , LPN E asked her to assist with locating Lispro for resident #93 because he didn't have any, and there was none in the emergency kit. She explained medication re-orders were a simple electronic process and nurses were expected to ensure adequate was available. She said nurses should have ordered the when it was low before it ran out. The Unit Manager conveyed resident's was very important to keep on , especially for brittle to ensure treatment interventions were available at the facility to avoid possible re-hospitalization and stated, "it must've not been ordered on time."

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F 755	Continued From page 32 On at 10:13 AM, the Director of Nursing (DON) explained she expected nurses to re-order medications from the pharmacy before the supply was depleted to ensure timely delivery. She conveyed supplies were important to maintain so nurses could administer doses if needed to avoid possible serious complications. The DON did not explain why resident #93's supply was not ordered timely. Review of the facility's standards and guidelines titled Reordering, Changing, and Discontinuing Medication Orders dated noted medication reorders could be made electronically, in writing, by phone, or facsimile. Review of the facility's standards and guidelines titled Medication Shortages/Unavailable Medications dated noted when insufficient medication supplies were observed, nurses were expected to immediately reorder from the pharmacy to ensure receipt by the next scheduled delivery and obtain it from the Emergency Medication Supply and/or arrange for an emergency delivery.	F 755		
F 806 SS=F	Resident , Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident , intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;	F 806		

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F 806	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide food to accommodate residents' preferences for 4 of 43 sampled residents, (#77, #403, #34, and #59). Findings: 1. Resident #77 was admitted to the facility on with the diagnoses of right , , major , , and . Her physician orders revealed a regular diet was prescribed. On at 9:01 AM, resident #77 stated she was not going to eat her breakfast of a small donut and sausage because she considered these foods to be unhealthy. She added she had been at the facility for three months and was not aware she could request menu items for her meals. Resident #77 explained she had just found out she could eat outside of her room after she had around one morning about a month after she had arrived. She stated no one had asked her what foods she liked to eat or what foods she disliked. On at 11:16 AM, the Dietetic Technician, Registered (DTR) reviewed the nutrition assessment completed for resident #77 on . The DTR confirmed the assessment indicated resident #77 was eating well and met her nutritional needs. The assessment did not included any information about the resident's food preferences. The DTR stated if there was not an issue with a resident's intake, she did not discuss food preferences with the residents.	F 806	A) What corrective action(s) will be accomplished for those residents found to have been affected by this practice? a. On Kitchen manager/designee spoke with residents numbers, 34, 59, 403, and 77 to ensure food preferences were obtained. B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? a. On Audit completed on residents to ensure resident food preferences have been obtained. C) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? a. By Director of Nursing/designee to complete education with CDM to ensure resident food preferences are obtained timely. D) How will the corrective actions be monitored to ensure the practice will not reoccur; what quality measures will be put into place? a. Director of Nursing/designee to complete audit of residents food preferences , ensure compliance with federal regulation F806 weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved. b. Findings will be reported monthly at the QA/Risk management meeting until such time substantial compliance has	

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F 806	Continued From page 34 2. Resident #403 was admitted on with diagnoses of a crushing injury to his right , , in right , , of upper right extremity, and adjustment with mixed , and depressed . His physician orders for , included a regular diet. Review of the nutrition assessment dated indicated resident #403's caloric needs were estimated at 2189-2975 calories/day. On at 9:30 AM, resident #403 stated he only got a sausage, a small donut, and a glass of juice and milk for breakfast, and he was still hungry. He stated he had been at the facility about a week and a half and he was not aware he could make food selections from the menu. Resident #403 added no one from the staff had discussed his food preferences with him. Occupational , ( ) M brought the resident a 2nd meal tray because he told her he wanted more food. M stated the tray she brought was a leftover, untouched tray for another resident who had gone to the hospital. Resident #403 acknowledged the food provided was , but stated he didn't care because he was hungry. On at 11:16 AM, the DTR confirmed resident #403's caloric needs were estimated at 2189-2975 calories/day and acknowledged his nutritional needs could be very difficult to meet when the menu provided approximately 2000-2200 calories per day. She added snacks were available from the nursing stations. The DTR stated the resident seemed fine with the food and confirmed she didn't discuss food preferences with this resident. The DTR acknowledged the facility did not offer resident	F 806	been determined.	

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F 806	Continued From page 35	F		

#403 "large portions" or discuss options for the resident to fill out menus to better meet his hunger and nutritional needs.

On at 9:30 AM, the Regional Nurse stated they expected staff to check the resident's diet order and go to kitchen to get a resident fresh, warm food according to their diet order, if they asked for more food. The DON and the DTR were in agreement, and the DTR added that serving a leftover tray to another resident was not acceptable. The DON stated she would have stopped the staff and told them to get fresh food from the kitchen because any food that was out, could have been touched by someone else.

3. Resident #34 was admitted to the facility on with diagnoses that included ( ) with dependence on , secondary of the , without behavioral disturbance, and primary . The physician orders for for indicated resident #34 was on a diet.

Review of the Nutrition Comprehensive Evaluation dated revealed resident #34's food intake varied between 25-100% of meals and was inadequate to meet her needs which were estimated to be between 2400-2800 calories and 96-112 grams protein /day.

On at 9:23 AM, resident #34, acknowledged she had been at the facility about 4 weeks, and stated she didn't like the food. She explained she had asked her aide to be able to select her meals herself but was never given a

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F 806	Continued From page 36	F 806		

menu to do so.

On at 11:16 AM, the DTR reviewed the nutrition assessment for resident #34 dated . She acknowledged the assessment indicated the resident was not meeting her nutritional needs, her appetite was diminished, and she was not interested in the food served at the facility, but agreed to receive the nutrition supplement, , . The DTR verified there was no indication food preferences were discussed or an attempt to try to provide foods the resident liked to eat. The DTR confirmed the , supplement had not been ordered for the resident which she said was her error. The DTR added she believed someone on the nursing staff explained the option to fill out menus to the residents, but she was not sure who did it.

On at 9:55 AM, the Dietary Services Manager stated when residents got admitted to the facility, he visited them to get their food preferences and let them know they could get menus from the nursing station or their Certified Nursing Assistant (CNA) to select their meals. He added that the DTR or the Registered Dietitian (RD) also then met with residents when they assessed their nutritional status and would communicate any additional preferences to him through email. The Dietary Services Manager checked his computer for residents #77, #403, and #34 and found no preferences, no dislikes, and no documentation that the residents were spoken with about their food requests.

On at 9:08 AM, CNA D stated the 3 PM-11 PM shift CNA's gave menus to residents when they asked for one and put extra menus by the nursing station. She added new CNA's were

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F 806	Continued From page 37	F 806		

trained to tell new residents there were menus available when they got admitted.

On at 5:11 PM, CNA C stated when a resident was first admitted, the CNA's explained there were menus for selecting lunch and dinner meals, but menus were not passed to residents who were on pureed, mechanical soft, or diets. She pointed out a couple of specific residents who received menus to fill out for the next day. She acknowledged that sometimes residents may be overwhelmed when they were first admitted, and she acknowledged it might be helpful if the information was repeated to them.

4. Resident #59 was admitted on with diagnoses of acute , failure with , unspecified injury, type II , protein-calorie , and major . Review of physician orders for indicated she was ordered a regular diet.

Resident #59's Comprehensive Nutrition Assessment dated indicated she had a low ( ) of 21.3, had significant loss in the recent past and ate her meals independently with set-up. The assessment revealed the resident stated she was sometimes hungry between meals and desired beneficial gain. The document described the resident agreed to some large portions and her preferences were discussed.

On at 5:49 PM, CNA A delivered resident #59's dinner tray into her room, set it down and indicated to the resident the meal was there, and left the room. The resident opened the lid from

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F 806	Continued From page 38 her food plate and realized what she received was not what she had ordered, which was corroborated by her menu. A few minutes later CNA A stated staff were supposed to check the resident's menu ticket to ensure they actually received what was on the ticket when they delivered the meals. She added she just dropped the tray off to this resident because she knew the resident could set up her own tray and she figured the resident would ask if something was missing. She then acknowledged she left the resident's room so quickly, the resident hadn't had a chance to look at her meal or request what food items she hadn't received on her ticket. On at 10:28 AM, the Director Of Nursing (DON) stated when CNA's delivered meal trays to residents, she expected them to sanitize their prior to getting their meal, to ensure the meal tickets matched the resident's name and food items on their tray, and the tray included the utensils and drinks listed on the ticket. The facility's policy entitled, "Food and Nutritional Services" dated , indicated the facility would provide a nourishing, palatable, well-balanced diet that met the daily nutritional and special dietary needs of the residents, taking into consideration their preferences. The document continued that the facility employed sufficient staff with appropriate competencies and skill sets to carry out the function of food and nutrition service.	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		

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F 812	Continued From page 39 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to serve food items in accordance with professional standards for food service safety. Specifically, potentially hazardous food items were held and served while in the temperature danger zone having the potential to affect 95 of the 98 residents at the facility. Findings: On at 4:40 PM, the dinner tray line was in process when tuna salad sandwiches were noted to be stacked in a full, deep sheet pan sitting in one of the wells of the steam table being used to plate hot entrees. The heating element for the steamtable well which held the sandwiches along with the well directly adjacent to it, were turned off but were warm to the touch as heat radiated from the other heated wells further down on the table. The Dietary Services Regional Manager took the	F 812	A) What corrective action(s) will be accomplished for those residents found to have been affected by this practice? a. On sandwiches not meeting temperature were immediately removed. B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? a. On Audit completed on prepared food to ensure temperatures were appropriate. C) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? a. By Director of Nursing/designee to complete education	

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F 812	Continued From page 40 temperatures of the sandwiches which recorded at 50 degrees Fahrenheit (F). The evening (PM) cook removed the tuna sandwiches from the tray line and put them in the freezer to re-chill. The Regional Manager removed a 2nd deep full-size steamtable pan of tuna salad sandwiches from the freezer and measured the temperature of random sandwiches, which was found to be 46.7 degrees F, in the danger zone for potentially hazardous foods. The Regional Manager put the 2nd steamtable pan of sandwiches into the freezer and told the cook and kitchen staff that the tray line should stop and was not able to continue until the sandwiches were cooled to a safe serving temperature of at least 41 degrees F. The PM cook stated the pan of sandwiches were usually on a bed of ice in the steamtable wells, but the ice machine was not producing ice at that time, so no ice was available for the tray line. A few minutes later, the Dietary Service Manager provided the temperature log that contained the pre-tray line temperatures of foods from the tray line. The cook stated she had taken the temperatures approximately 20 minutes earlier, at the start of tray line, and the sandwich temperature was recorded at that time as 38 degrees F. The Dietary Services Manager stated he did not have an explanation for how sandwiches whose temperature was recorded at 38 degrees F twenty minutes prior then placed in the freezer had actually warmed to 46.7 degrees F. He stated at approximately 2:30 PM, he talked with the PM cook while she prepared the sandwiches and he witnessed her put the sandwiches in the freezer around that time. On at 12:10 PM, the Dietary Services	F 812	with dietary staff on how to store food. D) How will the corrective actions be monitored to ensure the practice will not reoccur; what quality measures will be put into place? a. Director of Nursing/designee to complete audit of meals daily to ensure food temperatures are appropriate, ensure compliance with federal regulation F812 weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved. b. Findings will be reported monthly at the QA/Risk management meeting until such time substantial compliance has been determined.	

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F 812	Continued From page 41 Regional Manager stated it was common at facilities to put sandwiches into the freezer to chill them quickly then move them into a refrigerator when they were at a safe temperature. He acknowledged the sandwiches that tested 46.7 degrees F in the freezer, must not have been placed there long enough to be chilled, and were not at a safe temperature to be served. The facility's Food and Nutrition Services policy dated detailed the facility would store, prepare, distribute, and serve food in accordance with professional standards for food service safety.	F 812		
F 847 SS=F	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a	F 847		

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F 847	Continued From page 42 language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure that the binding arbitration agreement explicitly granted the resident or their representative the right to rescind the agreement within 30 calendar days of signing it for 18 of 102 current residents who signed arbitration agreements. Findings:	F 847	A) What corrective action(s) will be accomplished for those residents found to have been affected by this practice? a. On NHA notified current, in-house residents or their RP of update to Arbitration Agreement. B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action	

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F 847	Continued From page 43 Review of the log provided by the facility revealed 18 of the current 102 residents signed the facility's arbitration agreement. On at 1:59 PM, the Internal Admissions staff person verified she completed most of the admission packets with residents or their representatives within 48 hours of admission. She stated she usually read the Voluntary Binging Arbitration Agreement to the resident or their representative. She confirmed the agreement was not a requirement for admission. She explained the resident or their representative could change their mind after signing but was not sure of the time frame. The Internal Admissions staff person reviewed the arbitration agreement and confirmed it gave the resident or their representative 30 calendars of the resident's date of admission to rescind the agreement, not from the date of signature. Review of the facility's "Voluntary Binding Arbitration Agreement" revealed the document was voluntary and was not a requirement for admission. The document defined the parameters of an arbitration and indicated the document could be rescinded within 30 days of the resident's date of admission to the facility. On at 2:03 PM, the Regional Vice President of Operations reviewed the "right to change your mind" clause in the Voluntary Binding Arbitration Agreement. She acknowledged the wording did not explicitly grant the resident/resident representative 30 days from the date of signing to rescind the agreement. The Regional Vice President of Operations agreed the resident/resident representative would not have 30 days from date of signature to rescind the	F 847	will be taken? a. No residents were found to be directly affected by this practice. Audit completed on residents admitted on or after to ensure updated Arbitration Agreements are included in admission packets. C) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? a. By the Administrator/designee to complete education with Admissions department to ensure updated Arbitration Agreements are distributed. D) How will the corrective actions be monitored to ensure the practice will not reoccur; what quality measures will be put into place? a. Administrator/designee to complete audit of residents who admitted on or after to ensure updated Arbitration Agreements are distributed. compliance with federal regulation F847 weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved. b. Findings will be reported monthly at the QA/Risk management meeting until such time substantial compliance has been determined.	

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F 847	Continued From page 44 agreement if it differed from the date of admission, but stated she did not think any residents had been affected since no one had requested to rescind the agreement.	F 847		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and	F 865		

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F 865	Continued From page 45	F 865		

evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the , , unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

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F 865	Continued From page 46 §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to maintain records, monitor, and effectively conduct Quality Assurance Performance Improvement (QAPI)/Quality Assurance and Assessment (QAA) activities which could affect facility wide processes impacting quality of care and quality of life for all	F 865	A) What corrective action(s) will be accomplished for those residents found to have been affected by this practice? a. On QAPI meeting was held to complete a system review and new identified PIP were initiated	

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F 865	Continued From page 47 residents. Findings: On at 8:43 AM, in a interview with the Director of Nursing (DON) and Regional Director of Clinical Services, the Director said she initiated a Performance Improvement Plan (PIP) approximately one month prior for Pre-Admission Screening and Resident Review (PASARR). She stated in regards to resident PASARRs, "I would say maybe 25% have been looked at and some were redone." She said she had to locate the documentation and audits to clarify. On at 10:08 AM, the Regional Director of Clinical Services explained she was unable to locate any records for the PIPs and stated, "they're not on record and not organized." On at 11:59 AM, the Nursing Home Administrator (NHA) said she had been the NHA since . She explained she had conducted QAPI meetings on and . She explained the last meeting included discussions concerning regulatory compliance and survey management. She said she initiated a PIP for facility wide environmental concerns and maintenance repairs. The NHA checked previous records that showed a QAPI meeting was conducted in with notes that PIPs were implemented for facility issues with control, , , care, and PASARR. A handwritten log was observed in the binder that noted the titles of PIPs she verbalized. No reports or documents related to the PIPs aside from the environmental/maintenance plans were located in the NHA's QAPI records. The NHA was unable to	F 865	B) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken? a. No residents were found to be directly affected by this practice. A review of current PIPs was completed on to assess the need for modifications or updates. C) What measures will be put into place or what systemic changes will you take to ensure that the practice does not reoccur? a. By Administrator/designee to complete PIP education with department managers to reinforce adherence to identifying trends and concerns proactively. D) How will the corrective actions be monitored to ensure the practice will not reoccur; what quality measures will be put into place? a. Administrator/designee to conduct a weekly review of PIP tracking tools to ensure ongoing compliance is met ensure compliance with federal regulation F865 weekly x4 weeks then monthly for 2 months or until substantial compliance is achieved. b. Findings will be reported monthly at the QA/Risk management meeting until such time substantial compliance has been determined.	

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locate any records for clinical PIPs and said she could not speak to what occurred before she took over. The NHA stated, "there are no records for clinical; QAPI is in place to monitor, analyze, and correct problems so residents get the care and services they need and have the right to."

Review of the Quality Assurance Meeting minutes dated provided by the NHA noted there were no QAA Committee recommendations, and read, "Plan implemented based on recommendations: N/A"

Review of the facility's standards and guidelines titled Quality Assurance and Performance Improvement and dated read, "The facility will: 1. Maintain documentation and demonstrate evidence of it's ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events, and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities . . . 3. Present documentation and evidence of it's ongoing QAPI program's implementation and the facility's compliance with the requirements to a State Survey Agency, Federal Surveyor, or CMS (Centers for Medicare & Medicaid Services) upon request."