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
	35960969	A. BUILDING: _____ B. WING _____	C 03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF NEW PORT RICHEY	7400 TROUBLE CREEK ROAD NEW PORT RICHEY, FL 34653

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N 000	INITIAL COMMENTS A relicensure and complaint survey for complaint number 2025000354 was conducted on to at Life Care Center of New Port Richey. The facility had deficiencies at the time of the survey. Complaint number 2025000354 had no deficiencies.	N 000		
N 071 SS=D	59A-4.109(1), FAC Components of Care Plan (1) Each resident admitted to the nursing home facility must have a plan of care. The plan of care must consist of: (a) Physician's orders, diagnosis, medical history, physical exam and rehabilitative or restorative potential. (b) A preliminary nursing evaluation with physician's orders for immediate care, completed upon admission. (c) A complete, comprehensive, accurate and reproducible assessment of each resident's functional capacity which is standardized in the facility, and is completed within 14 days of the resident's admission to the facility and every twelve months, thereafter. The assessment must be: 1. Reviewed no less than once every 3 months; 2. Reviewed promptly after a significant change, which is a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem, in the resident's physical or mental condition; and, 3. Revised as appropriate to assure the continued accuracy of the assessment. This Statute or Rule is not met as evidenced by: Based on observation interview and record	N 071	" Resident # 162 was discharged from	

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N 071	Continued From page 1 review, the facility failed to effectively assess and revise a resident's care plan following a significant ⌄ loss for one resident (#162) of three residents reviewed for comprehensive assessments. Findings included: Review of a facility policy titled Comprehensive Care Plans and Revisions, dated showed: The facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care. Procedure: I. The facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care. 2. When these changes occur, the facility should review and update the plan of care to reflect the changes to care delivery, this can include: a. Additional interventions on existing problems, b. Updating goal or problem statements c. Adding a short-term problem, goal, and interventions to address a time limited condition. Review of a facility document titled Nutrition At Risk dated showed Resident #162 had the following ⌄ recorded: -On the resident ⌄ . (pounds). - On the resident ⌄ . - On the resident ⌄ .	N 071	the facility " Facility residents with significant ⌄ loss have the potential to be affected by not revising the care plan with changes and new interventions. Residents with a significant ⌄ loss will be reviewed by the Registered Dietitian/ Designee to determine if a significant change assessment and or care plan revision/ is needed. Revisions and updates will be completed as indicated. " The Director of Nursing / Designee will educate the Registered Dietitian, Dietary Tech, Minimum Data Set Coordinators on the need to complete an assessment, and revise the care plan with new interventions for residents with a significant change in status in ⌄ loss so that the care plan accurately reflects the resident " The Director of Nursing/Designee will complete 3 random weekly audits on residents with a significant ⌄ loss to determine if the care plan accurately reflects the residents significant ⌄ loss and / or if revisions are needed. The results of the audits will be tracked, trended and reported to the monthly Quality Assurance Performance Improvement meeting until sustained compliance achieved.	

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N 071	Continued From page 2 The review showed a 10.53% ⌄ loss. Review of a care plan last updated on showed resident #162 - has nutritional problem related to Advanced age, Right with hemi- , , , , ⌄ on altered diet consistency, , , and variable intake with refusals at times. The goal section showed - The resident will maintain adequate nutritional status as evidenced by maintaining ⌄ # with no significant change through the review date. Interventions included: RD (Registered Dietician) to evaluate and make diet change recommendations PRN (as needed). Administer medications as ordered. Lab/diagnostic work as ordered. Report results to MD (Medical Doctor) and follow up as indicated. Invite the resident to activities that promote additional intake. Observe and report PRN (as needed) any signs/symptoms of , , ⌄ : Pocketing, Choking, Coughing. Review of this care plan did not show updated interventions related to the significant ⌄ loss noted on .. On at 10:38 a.m., Resident#162 was observed in the dayroom visiting with family members. The family members stated the resident had lost a lot of ⌄ and did not eat very much anymore. Review of the admission record for Resident #162 revealed the resident was admitted to the facility on with diagnoses to include , , ⌄, , , ⌄ phase and unspecified protein - calorie and unspecified . Review of an order summary report dated showed active orders for Resident #162 included	N 071		

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N 071	Continued From page 3 a regular diet - mechanically altered texture, thin consistency, 2 cal. (calorie) Med Pass supplement two times a day, 120 ml (milliliters) and nutrition consult. Review of a nutritional progress note for Resident #162 dated revealed CBW (current body) reflects -10.6% . ( ) loss x 1 week which is significant however reflects residents previous range of 97.0-111.0 in 2022. 20.1 WNL. Staff to encourage PO fluids per orders. Potential for loss/decreased appetite r/t (related to) ABT (activity based) . Variable PO (by) meal intake noted along with refusal of meals per % PO intake documentation. Resident at risk for loss/nutritional decline r/t advanced age and process of . Recommend 2.0 Medpass 120 cc (twice daily) between meals. Will monitor weekly and f/u (follow up) prn (as needed). On at 1:10 p.m. Resident #162 was observed in bed with her closed. The resident did not respond to an interview. An immediate interview was conducted with Staff Q, Certified Nursing Assistant (CNA). She stated ( ) had assisted the resident with her meal earlier. She stated the resident had had an early tray for observation. She said, "this resident does not eat much. We set up her tray." She stated Resident #162 was not assisted with her meal. Staff Q stated the resident ate less than 25% of her meal almost all the time. On at 3:15 p.m., an interview was conducted with the facility's Diet Technician, (DT). The DT stated when a resident was admitted she did nutritional assessments, got nutrition intake and the initial assessment. She stated she set up	N 071		

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N 071	Continued From page 4 meal preferences. She stated the dietician monitored ⌄ loss and initiated the triggers. She stated she did not know this resident had a significant ⌄ loss. She stated if she did, it would be documented in an assessment or the plan of care. On at 11:20 a.m., an interview was conducted with the facility's Registered Dietician, RD. The RD stated she saw residents once a month. She stated for Resident #162, she had documented on her ⌄ loss last week. She said the resident was on , , and staff should be encouraging her to eat her meals. She stated they should be documenting if she refused. She confirmed she had reviewed the resident's ⌄ record and identified a significant ⌄ loss. She stated she had recommended her for supplements. She stated she had not seen the resident in person. She stated if the resident was losing a lot of ⌄ , there should be a follow -up. She stated majority of times the IDT (interdisciplinary team) would meet to discuss a plan for the change, and it would be documented. She stated they would discuss if the resident needed 1:1 assistance. The RD stated at the time the resident only required tray set up. She stated if her intake had changed, the CNA should be letting the nurse know and possibly obtain another ⌄ . She stated as the RD, she would see them weekly and obtain weekly ⌄ for monitoring. The RD confirmed the resident's assessment had not been updated. She confirmed the care plan should have been updated with new interventions. She confirmed the team had not met to address this resident's significant ⌄ loss. On at 11:51 a.m., an interview was	N 071		

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N 071	Continued From page 5 conducted with Resident #162's Occupational , ( ). She stated they had been working on strengthening , standing and toileting. She stated related to the resident's meal intake, she was able to independently scoop the meal and drink from the cup. She stated she had not assessed the resident for meal consumption. She said, " intake was not the focus, but the ability to eat independently." She stated usually the dietician would come and speak with the DOR if there were loss concerns. She stated it should be documented in the notes and assessments. The stated the Director of Rehab (DOR) had been notified of the loss to see if there was any trouble with feeding. Class III	N 071		
N 201 SS=D	400.022(1)(i), FS Right to Adequate and Appropriate Health Care (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to follow-up on a physician order with a black box warning for one (#264) of fifty-one residents sampled, and did not ensure activities of daily living (ADLs) were completed and maintained for one resident (#91)	N 201	• Resident #264 had his medication, (HCl) discontinued by order from the Advanced Registered Nurse Practitioner. • Residents with black box medication	

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N 201	Continued From page 6 related to meals and three residents (#91, #16 and #49) related to hydration for three out of 23 residents sampled. Findings included: Review of the facility policy titled, "Medication Shortages/ Unavailable Medications, Revision date , showed Applicability Policy 7.0 sets forth procedures relating to medication shortages and unavailable medication. Procedures 6. If the medication is unavailable from Pharmacy due to formulary coverage, contraindications, drug-drug interactions, drug- interaction, or other clinical reason, Facility should collaborate with Pharmacy and Physician/Prescriber to determine a suitable therapeutic alternative. On at 9:00 am., an observation was made revealing Staff P, License Practical Nurse (LPN) on the phone with the pharmacy ordering medication for Resident #264. On at 9:21 am, an interview was conducted with Staff P. She stated Resident #264 was out of his (HCl) 400 Milligram (MG), a medication he took for . Staff P stated she believed Resident #264 was only out of the medication today, that was why she called in a STAT (immediate) order for the medication. She stated she would fax the request over to pharmacy as soon as possible. Review of Resident #264's Admission Record revealed he was admitted to the facility on	N 201	warnings have the potential to be affected by not following up on a physician order. Residents with black box sever interactions were reviewed for any missing, late, ordered or not available medications. Physicians will be notified if indicated. • Director of Nursing/Designee will in-service the licensed staff on the facility process if a medication is unavailable from Pharmacy due to formulary coverage, contraindications, drug-drug interactions, drug interaction, black-box warnings or other clinical reason. The facility will collaborate with the Pharmacy and physician/prescriber to determine a suitable therapeutic alternative if needed. This in-service will also have a focus on reporting medications not available in Grand Rounds and in the morning clinical meeting. • The Unit Managers/Designee will complete 5 random weekly audits on residents with black box sever interactions to ensure follow up with the physician has been completed and the medication is available if medication is approved for the resident. Results of the audits will be tracked trended and reported to the monthly Quality Assurance Performance Improvement meeting until sustained compliance achieved. Resident # 91 was discharged from the facility. Resident #16 and 49 were assessed with no negative outcomes. · Residents that are dependent on staff for hydration that spend time in the activity day rooms are at risk of not being offered	

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N 201	Continued From page 7 with diagnoses to include but not limited to , , Presence of . Review of the Medication Administration Record (MAR) dated - , showed an order for (HCl) Oral Tablet 400 Milligram (MG)- Give 1 tablet by two times a day for , , order start date - discontinued on . On at 3:02 p.m., an interview was conducted with the Director of Nurses, DON. The DON stated that the resident had ordered on admission from the hospital for . She said the pharmacy did not send the medication when the facility initially put a request in for the medication on , . She stated when she found out today Resident # 264 was out of his medication, she reached out to pharmacy to find out why they did not send the medication. She stated pharmacy responded that there was a black box warning related to this type of medication, and they were waiting for a response from the facility. The DON stated she reached out to the Primary Care Provider to notify him that Resident #264 did not receive his medication since admission. She stated she also told him what the pharmacy said about the black box warning for the medication . The DON stated the Primary Care Provider (PCP), stated he did not feel comfortable deciding to discontinue Resident #264's . The DON stated the PCP told her to reach out to the resident's because he or she would be more qualified to provide direction regarding whether to discontinue the use of the medication or to keep the resident on this medication. The DON stated she reached out to their Advanced Registered	N 201	and assisted hydration. Residents' whose Activities of Daily Living are dependent on staff for hydration that spend time in the activity rooms were reviewed to ensure the necessary assistance and fluids are being provided while in the activity day rooms. Residents who have scheduled , , or outings have the potential to be affected by not having staff arrange, provide and complete alternative options for meals and / or snacks to accommodate the outing. Current residents with , , since were evaluated for negative consequences from not being provided a meal or snack with a scheduled outing. · The Director of Nursing/Designee in-serviced the licensed and certified nursing staff on the hydration policy including offering and providing assist with fluids, meals and snacks based on the residents needs and plan of care. This training includes the facility process for residents who have scheduled , , including communicating to the kitchen for timely tray delivery to accommodate the resident needs and preferences with meals, hydration and snacks with the residents on outings as needed. The Dietary Director will educate kitchen staff on the facility process for communicating and accommodating meal or snack delivery for residents with , , . · The Director of Nursing / Designee will complete 5 weekly activity day room observations of resident's dependent on staff for hydration to ensure appropriate assist and hydration is being offered to meet the resident's hydration needs. The	

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N 201	Continued From page 8 Nurse Practitioner, ARNP, to explain the situation and review Resident #264's medications. She stated the ARNP instructed them to stop the medication. The DON stated she could not speak to why her nurses did not reach out to her early on to discuss the resident not receiving his medication. The DON stated the nurses kept reaching out to pharmacy, but they did not notify Resident #264 doctor to get further instruction on whether the doctor wanted to provide the resident with an alternative medication. The DON stated the nurse should have called the pharmacy to find out why they did not send the medication. Then notify the physician to get further directions on what to do about the resident's medication, document why the medication was not available, and the physician's response. On at 4:00 pm, an interview was conducted with the Advanced Registered Nurse Practitioner (ARNP). She stated she received a call from the unit manager today because Resident #264's Primary Care Provider wanted the facility to reach out to her about the resident's medication. The ARNP stated if the facility had reached out to her ahead of time, she would have recommended them to discontinue the medication on admission. On at 4:30 pm, an interview was conducted with the pharmacist. She stated the facility should have contacted the pharmacy to see why the medication order was not completed. She stated there are many medications with black box warnings so the nurses should have contacted the physician who prescribed the medication to see if the physician felt the resident could continue with the medication or if they would like to administer an alternative medication.	N 201	Director of Nursing/ Designee will also complete 3 random weekly interviews and/ or observations to ensure residents are being provided an earlier meal/snack or meal/snack upon return based on resident need or preference. Results of the audits will be tracked, trended and reported to the monthly Quality Assurance Performance Improvement meeting until sustained compliance achieved.	

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N 201	Continued From page 9 2. Review of the facilities policy titled Hydration and Nutrition dated revealed: Policy: Each resident receives a sufficient amount of food and fluids to maintain acceptable parameters of nutritional and hydration status. Procedure: 2. A minimum of three meals are provided each day. If a meal or food is refused, the resident is offered a substitute or a similar nutritive value. 4. Fluid is always available to residents. A hydration cart may be utilized. During an interview on at 10:53 a.m., Resident #91 was observed lying bed dressed for the day. Resident #91 stated she had had some ˬ loss, but had lost more because she had not felt like eating. During an observation on from 10:45 a.m. to 12:45 p.m., Resident #91 was observed sitting in a wheelchair in the activities room of the 100 unit. Resident #91 was observed to have no hydration. Resident , were noted to be dry and cracked. During an observation on at 12:48 p.m., Resident #91 was observed sitting in a wheelchair in the hallway. Staff was observed telling Resident #91 that she had a doctors , , and they needed to get her ready to leave the facility. During an interview on at 4:34 p.m., Resident #91 stated she had not eaten lunch before her , , and was not given anything to eat while away from the facility for her , , . Resident #91 stated she had not been offered anything to eat when she returned to the facility after her , , and was waiting	N 201		

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N 201	Continued From page 10 for dinner. Review of Resident #91's admission record revealed an admission date of . Resident #91 was admitted to the facility with diagnoses to include but not limited to , Type 2 , unspecified protein calorie , iron deficiency, and unspecified . Review of Resident #91's Admission Minimum Data Set (MDS) dated , revealed Section C. , a ( ) score of 15 out of 15 which indicated intact cognition. Section GG. Functional limitations revealed Resident #91 needed eating set up or clean up assistance. During an interview on at 12:53 p.m., Staff A, Certified Nurses Assistant (CNA) stated she did restorative and several other things like accompanying residents to , , . She stated she was not sure when Resident #91 had breakfast, and that Resident #91's lunch tray would be saved for her to eat when she got . She was not sure how long they would be gone for her , , . She stated she had not thought of getting her a snack or bringing something with them for Resident #91 to eat since she was not getting her lunch tray. During an interview on at 4:45 p.m., Staff B, CNA, stated he was told the resident did not eat lunch and might be hungry when she got from her , , . He stated she returned to the facility around 3:15 p.m. and he had not offered her a meal or snack. During an interview on at 5:02 p.m., Certified Dietary Manager (CDM), stated when a	N 201		

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N 201	Continued From page 11 resident had an , , the nurses usually notified her so she could arrange to send the food tray early so the resident could eat before their , , . She was not aware of a resident having an , , today, . During an interview on at 5:10 p.m., Staff C, RN, stated she was aware Resident #91 went out to an , , and returned to the facility around 3:15 p.m., she stated she was not aware Resident #91 did not receive lunch. She stated she would expect the CNA to have offered the resident something to eat when she returned to the facility. During an interview on at 5:13 p.m., Staff D, Licensed Practical Nurse (LPN) Unit Manager, stated when residents had an , , the nurse was responsible for notifying the kitchen the day of so they could send their food tray out early. She stated she was not aware Resident #91 did not receive her lunch. She stated she would expect the nurse to share this report with the oncoming nurse. During an observation on from 10:45 a.m. to 12:45 p.m., Resident #16 was observed sitting in the activities room of the 100 hall. Resident #16 was observed with no hydration during this observation. Review of Resident #16's admission record revealed an admission date of . Resident #16 was admitted to the facility with diagnoses to include but not limited to (Generalized), Other Specified And , , , Following , , Severe, with Disturbance, and	N 201		

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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) COMPLETE DATE
N 201	Continued From page 12 Unspecified Protein-Calorie . Review of Resident #16's MDS Section C. Cognition revealed Resident is rarely/never understood. Section GG. Functional Limitations revealed Resident #16 needs substantial maximal assistance with eating. During an interview on at 1:00 p.m., Staff F, CNA, stated she was the CNA for Resident #16, and she constantly checks on her residents. She stated "Resident #16 does not drink anything but Gatorade and just got up at 10 a.m." She was not sure how often she provides hydration to Resident #16. During an observation on from 10:45 a.m. to 12:45 p.m., Resident #49, was observed sitting in the activities room of the 100 hall. Resident #49 was observed to not have hydration during this observation. Review of Resident #49's admission record revealed and admission date of with an initial admission date of . Resident #49 was admitted to the facility with the diagnosis of ,Unspecified, , , , , , , Phase, Unspecified , Unspecified Severity, Without Behavioral Disturbance, Unspecified, , , Without , , . Review of Resident #49's quarterly MDS dated revealed Section. C. , a Brief Mental for Interview Status ( ) of 00 indicated a severe . Section GG. Functional limitations revealed Resident #49 required substantial maximal assistance with	N 201		

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	35960969	A. BUILDING: _____ B. WING _____	C 03/05/2025

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N 201	Continued From page 13 eating. During an interview on at 10:50 a.m., Staff E, Registered Nurse (RN) stated residents should all have water at bedside. She stated signs a resident needs hydration are signs like dry and cracks in the , . She stated if she saw a resident with any of these symptoms, she would encourage more fluids and would ask the aides to include hydration with their care of the residents. She stated, "I would think the CNAs should come in and check on resident's hourly." During an interview on at 10:51 a.m., Director of Nursing (DON) stated she would expect residents to be offered hydration at least once an hour and would expect residents in the activities room to either have a cup for hydration or staff to periodically check on the residents. She stated if a resident has an , , at mealtime or if the resident is out for a meal, Dietary should be notified to get an early tray so that they can eat before they go out. If the residents are alert and oriented, they ask them if they would like to have a snack or a bagged lunch with them so they could have something to eat while they are gone. During an interview on at 1:45 p.m., the Regional Director of Clinical services stated they do not have anything that monitors resident hydration intake unless there are physician's orders. Class III	N 201		

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F 000	INITIAL COMMENTS A recertification and complaint survey for complaint number 2025000354, was conducted on to at Life Care Center of New Port Richey. The facility was not in compliance with 42 CFR, Part 483, Requirements for Long Term Care Facilities. Complaint number 2025000354 had no deficiencies.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-( )(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. ( ) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.	F 565		

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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F 565	Continued From page 1 §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure resident council grievances were fully and promptly acted upon, for ten of ten resident council members who regularly attend the resident council meetings. Findings included. On at 11:10 a.m., a resident council meeting was held with ten participants. The group confirmed on-going complaints related to the following: - Related to call lights - "Sometimes it takes a while for them to answer, depending on who's on duty. Day shift is great, second shift is good, third shift is not so great. We have told the nurses ...They don't have enough staff. When one pushes the bubble, no one comes. This has been discussed in council meetings." - "They keep saying they are short of help. We have reported to staff. When they are short they pull restorative staff, which means restorative is not offered that day ..." - "Call lights take too long to answer at night. They refuse to wear name tags, so you don't identify them." _ "They said they will give us more TV stations.	F 565	On , the Executive Director reviewed the last 3 months of resident council meeting minutes with the Resident Council President and wrote a grievance for the identified concerns. All residents have the potential to be affected. Appropriate notice and invitations were provided for a Resident Council meeting. The Resident Council meeting was held on , with, Long Term Care Certified Ombudsman present and residents report satisfaction with facility response to the previously cited grievances. On , the facility Executive Director/Nursing Home Administrator educated the Activities Director on the Resident Council policy and procedures as well as the facility Grievance policy and procedures. A Resident Council concern/grievance follow up form was created and incorporated to ensure that the Executive Director and Resident Council President confirm each month that follow up to grievances brought forth in the Resident Council meeting is appropriate. Results of the Resident Council	

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F 565	Continued From page 2 10 or more they said. We voted which ones we wanted ... there are not enough channels, the cable cuts in and out, we spoke to maintenance about it, spoke to [NHA]. They say it comes from direct TV. It is not resolved." - Residents requested to learn Spanish because the staff don't speak English. Discussed with [NHA] at the last meeting. Review of the Resident Council meeting minutes revealed the following: On the residents held a resident council meeting and addressed unresolved grievances/complaints related to staff not wearing name tags, education for diets, getting a second rod in closets for low wheelchair users, learning Spanish, and making sure someone is covering for nursing staff when they go on breaks. The review showed these grievances were not logged in the grievance log and had not been documented as addressed. On a resident council meeting was held with the following issues raised: Residents asked to be provided names of department heads and what they do. Kitchen staff not wearing name tags, visitors not wearing name tags, visitors not signing in and out. The review showed these grievances were not logged in the grievance log and had not been documented as addressed. On a resident council meeting was held with the following issues raised: concerns on going outside on the patio, and nursing staff to assist. No garbage bags in restrooms, ice water on each shift, residents requested a resident council rule book. The review showed these grievances were not logged in the grievance log and had not been documented as addressed.	F 565	concern/grievance follow up forms will be tracked and trended and reported monthly to the Quality Assurance Performance Improvement Committee until sustained compliance achieved.	

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F 565	Continued From page 3	F 565		

On a resident council meeting was held with the following issues raised: Staff not wearing name tags. Staff not knocking on doors. Residents raised individual concerns. DON would educate nursing staff. Other concerns noted concerns with remotes, "there should be more help. The review showed these grievances were not logged in the grievance log and had not been documented as addressed.

Review of resident council meting minutes dated showed "will continue to remind staff to wear their name tags, "There should be more help" ... The review showed these grievances were not logged in the grievance log and had not been documented as addressed.

Review of a resident council meeting minutes revealed: Name tags - who holds staff accountable. Residents feel a member of management needed to come at night to verify staff are wearing their name tags. No team work. "Had to wait 25 minutes for assistance because a CNA (Certified Nursing Assistant) came in to check call light stated she would find her aide instead of helping", " staff telling a resident they will be right and then does not return or you are waiting for long periods of time" "Staff introducing themselves at the beginning of shift." The review showed these grievances were not logged in the grievance log and had not been documented as addressed.

On at 3:14 p.m., an interview was conducted with the Activities Director (AD). The AD stated she did not know she should initiate grievances from resident council meetings. She stated they talked about them in the meetings.

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F 565	Continued From page 4	F 565		

The Department heads should address them. She stated they did not log them or document specific follow-up. She stated they reviewed previous' meeting minutes during council meetings. She stated some of the resident's grievances were on-going, such as name tags and staff taking too long to answer call lights.

On at 08:26 a.m., an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated the AD documents resident's grievances from the resident council meeting minutes. He stated by the next day, most of them were addressed. He stated the AD reviewed them with the IDT (interdisciplinary) team, and the department heads addressed the issues. He stated some of the resident's concerns were generalized, but they investigated and let the AD know to document the resolution in the resident council meeting minutes. He stated responses were reviewed at the next meeting and discussed with the residents to see if it was better. The NHA stated the outcome should be documented on the council form. The NHA reviewed on-going documented grievances and said, "I see there is an opportunity for education. we should be documenting the grievances, adding to the log, and following up on resolutions."

Review of a facility policy titled Resident Council, dated showed the facility will assist residents all their families whenever they wish to organize the facility will provide space privacy for meetings and staff support. 3. The activities director of social services director will facilitate follow-up on all complaints, suggestions and ideas presented at the council meeting and will report results at the next meeting for the

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F 565	Continued From page 5 residents information. This information will be included in the minutes. 4. Each department director will be responsible for filling out a comment and concern form prior to the next meeting to provide his or her input. Review of a facility policy titled Grievance Program (Concern and Comment), revised showed residents and their families have the right to file a complaint without fear of reprisal. ... the facility must make prompt efforts to resolve grievances the resident may have. The executive Director and / or designee is responsible for 2. Ensuring that all grievances and concerns and comment reports have been reviewed and addressed in a timely and appropriate manner and that concerned individuals feel that some type of resolution has been communicated.	F 565		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard -related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to complete a significant	F 637	" Resident # 162 was discharged from the facility	

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F 637	Continued From page 6 change assessment within 14 days of determining a ⌄ loss for one (#162) of four residents reviewed for nutrition. Findings included: Review of a facility document titled Nutrition At Risk dated , showed Resident #162 had the following ⌄ recorded: -On the resident ⌄ . (pounds). -On the resident ⌄ . -On the resident ⌄ . The review showed a 10.53% ⌄ loss. Review of the Minimum Data Assessments (MDS) section showed there were no documented assessments relate to a change in status for Resident #162. On at 10:38 a.m., Resident#162 was observed in the dayroom visiting with family members. The family members stated the resident had lost a lot of ⌄ and did not eat very much anymore. Review of the admission record for Resident #162 revealed the resident was admitted to the facility on with diagnoses to include ⌄ , ⌄ , ⌄ , ⌄ ⌄ phase and unspecified protein - calorie and unspecified . Review of an order summary report dated , showed active orders for Resident #162 included a regular diet - mechanically altered texture, thin consistency, 2 cal. (calorie) Med Pass supplement two times a day, 120 ml (milliliters), and nutrition consult.	F 637	" Facility residents with a significant ⌄ loss are at risk of being affected by not having a significant change assessment. Residents with significant ⌄ loss were reviewed by the interdisciplinary team to determine if a significant change was indicated. A significant change assessment will be completed if needed. " The Director of Nursing / Designee will educate the Minimum Data Set Coordinators, Registered Dietitian and Dietary Tech on the criteria for determining a significant change with ⌄ loss and the need to complete a significant change assessment if the criteria is met. The Director of Nursing / Designee will complete 3 random weekly audits on residents with significant ⌄ loss to determine if a significant change Minimum Data Set assessment was completed. Results of the audits will be tracked and trended and reported to the monthly Quality Assurance Performance Improvement meeting until sustained compliance achieved.	

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F 637	Continued From page 7 Review of a nutritional progress note for Resident #162 dated revealed CBW (current body) reflects -10.6% ( ) loss x 1 week which is significant however reflects residents previous range of 97.0-111.0 in 2022. 20.1 WNL. Staff to encourage PO fluids per orders. Potential for loss/decreased appetite r/t (related to) ABT (activity based) . Variable PO (by) meal intake noted along with refusal of meals per % PO intake documentation. Resident at risk for loss/nutritional decline r/t advanced age and process of . Recommend 2.0 Medpass 120 cc (twice daily) between meals. Will monitor weekly and f/u (follow up) prn (as needed). This review did not show a change in condition was submitted or the physician was notified of the significant loss. On at 1:10 p.m., Resident #162 was observed in bed with her closed. The resident did not respond to an interview. An immediate interview was conducted with Staff Q, Certified Nursing Assistant (CNA). She stated ( ) had assisted the resident with her meal earlier. She stated the resident had had an early tray for observation. She said, "this resident does not eat much. We set up her tray." She stated Resident #162 was not assisted with her meal. Staff Q stated the resident ate less than 25% of her meal almost all the time. Review of a care plan last updated on , showed resident #162 - has nutritional problem related to Advanced age, Right with hemi- on altered diet consistency,	F 637		

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F 637	Continued From page 8	F 637		

, and variable intake with refusals at times. The goal section showed - The resident will maintain adequate nutritional status as evidenced by maintaining ⌄ # with no significant change through the review date. Interventions included: RD (Registered Dietician) to evaluate and make diet change recommendations PRN (as needed). Administer medications as ordered. Lab/diagnostic work as ordered. Report results to MD (Medical Doctor) and follow up as indicated. Invite the resident to activities that promote additional intake. Observe and report PRN (as needed) any signs/symptoms of , , ⌄ : Pocketing, Choking, Coughing.

On at 3:15 p.m., an interview was conducted with the facility's Diet Technician, (DT). The DT stated when a resident was admitted she did the initial nutritional and intake assessments. She stated she set up meal preferences. She stated the dietician monitored ⌄ loss and initiated the triggers. She stated she did not know this resident had a significant ⌄ loss. She stated if she did, it would be documented in an assessment or the plan of care.

On at 11:20 a.m., an interview was conducted with the facility's Registered Dietician, RD. The RD stated she saw residents once a month. She stated for Resident #162, she documented on her ⌄ loss last week. She said the resident was on , , and staff should be encouraging her to eat her meals. She stated they should be documenting if she refused. She confirmed she had reviewed the resident's ⌄ record and identified a significant ⌄ loss. She stated she had recommended her for supplements. She stated she had not seen the resident in person. She

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stated if the resident was losing a lot of ␣ , there should be a follow -up. She stated the majority of times the IDT (interdisciplinary team) would meet to discuss a plan for the change, and it would be documented. She stated they would discuss if the resident needed 1:1 assistance. The RD stated the resident only required tray set up. She stated if her intake had changed, the CNA should let the nurse know and possibly obtain another ␣ . She stated as the RD, she would see them weekly and obtain weekly ␣ for monitoring. The RD confirmed the resident's assessment had not been updated. She confirmed the care plan should have been updated with new interventions. She confirmed the team had not met to address this resident's significant ␣ loss.

On at 11:51 a.m., an interview was conducted with Resident #162's Occupational , ( ). She stated they had been working on strengthening, standing, ␣ and toileting. She stated related to the resident's meal intake, she was able to independently scoop the meal and drink from the cup. She stated she had not assessed the resident for meal consumption. She said, "intake was not the focus, but the ability to eat independently." She stated usually the dietician would come and speak with the DOR if there were ␣ loss concerns. She stated it should be documented in the notes and assessments. The stated the Director of Rehab (DOR) had been notified of the ␣ loss to see if there was any trouble with feeding.

On at 12:11 p.m., an interview was conducted with the Director of Nursing (DON). She stated the RD had identified ␣ loss, initiated med pass 120 cc twice daily, and initiated

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F 637	Continued From page 10 the "NAR" (nutrition at risk) assessment with recommendations for med pass on . She stated they had requested labs on with concerns related to low Hemoglobin, low and elevated ( ). The DON said, "We should have contacted the physician, done a change in condition, updated care plan." Review of a facility policy titled, "Changes in Resident's Condition or Status.", dated showed - This facility will notify the resident, his/her primary care provider, and resident/resident representative of changes in the resident's condition or status. Notification of Changes: (I) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is - (B) A significant change in the resident's physical, mental, or , , status (that is, a deterioration in health, mental, or , , status in either life- threatening conditions or clinical complications).	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the comprehensive Minimum Data Set (MDS) assessments were accurately coded for two (#108 and #110) of fifty - six sampled residents.	F 641	" Resident (#108) and Resident (#110) Minimum Data Sets were modified to reflect the accurate discharge status " Residents that were discharged from the facility have the potential to be affected. Residents discharged from the	

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F 641	Continued From page 11 Findings included: 1. Resident #108 was admitted to the facility on with diagnoses to include but not limited to Type 2 without Complications, Acute and , Failure with , Major , Recurrent, Moderate Review of Resident #108's Minimum Data Set (MDS) dated , Section A- Identification Information revealed section A2105- Discharge Status was coded number 01 which indicated the resident discharged to home/ community. Review of a change in condition dated revealed Resident # 108 was transferred to the hospital for further evaluation and treatment for , increased , no output. Record review revealed Resident #108 Minimum Date Set (MDS) dated was coded inaccurately revealing the resident was coded to discharge home/ community and not the hospital. 2. Resident # 110 was admitted to the facility on with diagnoses to include but not limited to Acute , Failure with , Type 2 without Complications, , Unspecified. Review of Resident #110 Minimum Data Set (MDS) dated , section A - Identification Information, section A2105 -Discharge Status was coded number 04 which indicated Resident #110 was discharged to short - term general hospital.	F 641	facility in the last 30 days were reviewed by the Minimum Data Set coordinator/ designee to ensure accurate coding of the discharge on the minimum data set. Those found to be inaccurate will be modified to accurately reflect the residents discharge location. " The Director of Nursing / Designee provided education to the Minimum Data Set coordinators, Case Manager and Social Service Director on the process for identifying the discharge location and accurate coding of the Minimum Data Set. The Director of Nursing / Designee will complete 3 random weekly audits on discharged residents to ensure residents discharged status was coded accurately Results of the audits will be tracked and trended and reported to the monthly Quality Assurance Performance Improvement meeting until sustained compliance achieved.	

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F 641	Continued From page 12 Review of Resident #110's Discharge Summary dated revealed Resident #110 discharged home in stable conditions with his daughter. Record review revealed Resident # 110 Minimum Date Set (MDS) dated was coded inaccurately revealing the resident was coded to discharged to the hospital and not home. An Interview was conducted on at 3:00 p.m. with Staff O, the Minimum Data Set (MDS) Coordinator. Staff O stated MDS used the discharge calendar to know if a resident had a planned discharge to go to the community or home. They also looked at the dashboard in the Electronic Medical Record, and progress notes to see if a resident had been discharged to the hospital to know how to code the MDS accurately. Staff O stated Resident 108's MDS should have been coded to show the resident went out to the hospital and Resident #110 MDS should have been coded to show the resident was discharged home or to the community. Staff O stated both residents MDS was coded inaccurately An Interview was conducted on at 3:30 p.m. with the Director of Nurses, DON. The DON stated that her expectation was the Minimum Data Set (MDS) should be accurate to reflect the residents' discharge locations. The facility did not have a policy to include with this citation because they use the Resident Assessment Instrument, (RAI) to ensure the Minimum Date Set (MDS) is code accurate.	F 641		
F 645 SS=E	PASARR Screening for MD & ID	F 645		

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F 645	Continued From page 13 CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental and individuals with intellectual . §483.20(k)(1) A nursing facility must not admit, on or after , any new residents with: (i) Mental as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual , as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual or authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual . §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission	F 645		

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F 645	Continued From page 14 to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental if the individual has a serious mental defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual , if the individual has an intellectual , as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete/update the Pre-admission Screening and Resident Reviews (PASRRs) for residents with a mental and individuals with intellectual , following qualifying mental health diagnoses for six (#12, #57, #66, #30, #73, and #84) of 23 residents reviewed for PASRRs.	F 645	A new screening was completed on or before for Resident #12, #57, #66, #30, #73, and #84 to accurately capture applicable diagnoses. For any that resulted in Resident Review Evaluation Requests through the Preadmission Screening and Resident Review Form third party vendor, requested documentation has been	

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F 645	Continued From page 15 Findings included: 1. Review of a level I PASRR for Resident #12 dated , showed the resident was screened upon admission for (mental illness) or suspected . The review showed the resident had diagnoses of , , , and , . The review showed diagnoses of , and were not indicated and the level I PASRR was not revised. Review of a level II screening and determination summary report showed during the time of submission, on the diagnoses of , , and major , were not included for consideration. 2. Review of a level I PASRR for Resident #57 dated , showed the resident was not screened upon admission for (mental illness) or suspected . The review showed a blank PASRR, and the qualifying diagnoses were not submitted for consideration. Review of a level II screening and determination summary showed during the time of submission, on the diagnoses of generalized , and major , were not included for consideration. 3. Review of the admission record showed Resident #66 was admitted to the facility on and readmitted on with diagnoses to include - , , , - , major , , - , , , , and	F 645	submitted and is pending third party vendor review. Current residents have the potential to be affected. Current resident Preadmission Screening and Resident Review Forms will be reviewed by to ensure accuracy. For any inaccurate Preadmission Screening and Resident Review Form identified, a new screening will be completed and Resident Review Evaluation Requests through the Preadmission Screening and Resident Review Form third party vendor if applicable. The facility process will be to review new admission Preadmission Screening and Resident Review Forms in the facility clinical meeting and submit revisions or requests for Resident Review Evaluation if applicable. Director of Nursing / Nursing Home Administrator / or Designee will educate Social Services Department staff, Nursing Administration staff, and Admissions Department Staff on Preadmission Screening and Resident Review Form accuracy, specific to ensuring that the Preadmission Screening and Resident Review Form captures applicable diagnoses referenced on the Preadmission Screening and Resident Review Form screening form. Director of Nursing / Nursing Home Administrator / or Designee will audit 8 Preadmission Screening and Resident Review Forms per week for accuracy. For any inaccurate Preadmission Screening and Resident Review Form identified, a new screening will be completed and Resident Review Evaluation Requests	

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F 645	Continued From page 16 Review of level I PASRR for Resident #66 dated , showed qualifying diagnoses of , , and and were not checked. The review showed the Level I PASRR was incomplete, and a Level II was not submitted for consideration following qualifying diagnoses. 4. Review of the admission record showed Resident #30 was admitted to the facility on with diagnoses to include , , and . Review of a level I PASRR for Resident #30 dated showed a blank PASRR and the qualifying diagnoses were not checked. The review showed the Level I PASRR was incomplete, and a level II was not submitted for consideration following qualifying diagnoses. 5. Review of the admission record showed Resident #73 was admitted to the facility on and readmitted on with diagnose to include ( ), , , and . Review of a level I PASRR for Resident #73 dated , showed the qualifying diagnosis of was not documented. The review showed the Level I PASRR was incomplete, and a level II was not submitted for consideration following qualifying diagnoses. 6. Review of Resident #84's admission record revealed an admission date of .	F 645	through the Preadmission Screening and Resident Review Form third party vendor if applicable. Results of the audits will be tracked and trended and reported to the monthly QAPI meeting until sustained compliance achieved.	

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F 645	Continued From page 17 Resident #84 was admitted to the facility with diagnosis to include 's without dyskinesia, without mention of fluctuations ( ), major , recurrent (/224), post- stress , unspecified ( ), and generalized , ( ). Review of Resident #84's Level I PASRR, dated , showed the Level I PASARR was incomplete, and a level II was not submitted for consideration following qualifying diagnoses. Review of the facilities policy titled Pre-admission Screening and Resident Review PASRR), reviewed showed the following: Policy: The facility will ensure that potential admissions are screened for possible serious mental or and related conditions. This initial pre-screening is referred to as PASARR level I, and is completed prior to admission to a nursing facility. A negative level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental or intellectual , arises later. A positive level I screen necessitates an in-depth evaluation of the individual by the state designated authority, known as PASARR level II, which must be conducted prior to admission to the nursing facility. Procedure: 1. Ensure level I PASARR screening has been completed on potential admissions prior to admission. 2. A negative level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental or intellectual , arises later. 3. A record of the pre-screening should be	F 645		

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retained in the residence medical record.
4. A positive level I screen necessitates an in-depth evaluation of the individual by the state designated authority, known as PASARR level II, which must be conducted prior to admission to a nursing facility. God
5. When a level II PASARR Screening is warranted, it must be obtained as well as the termination letter prior to admission. The level 2 PASARR cannot be conducted by the nursing facility.
6. With respect to the responsibilities under the PASARR program, the state is responsible for conducting the screens, preparing the PASRR report, and providing or arranging the specialized services that are needed as a result of conducting the screens.
a. The State is required to provide a copy of the PASARR report to the facility. This report must list the specialized services that the individual requires and that are the responsibility of the State to provide. All other needed services are the responsibility of the facility to provide.
7. The level II PASARR determination and the evaluation report specify services to be provided by the facility and/ so or specialized services defined by the State.
8. Recommendations from PASARR level II determination and PASARR evaluation report are to be incorporated into the person-centered care plan as well as in transitions of care.
9. As part of the PASARR process, the facility is required to notify the appropriate state mental health authority or state intellectual , authority when a resident with a mental (MD) or intellectual , (ID) has a significant change in their physical or mental condition. This will ensure that residents with a mental condition or intellectual , continue

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F 645	Continued From page 19 to receive the care and services they need in the most appropriate setting. 10. Referral to the SMH/ ID authority should be made as soon as the criteria indicative of a significant change are evident. a. Each State Medicaid Agency might have specific processes and guidelines for referral, and which types of significant changes should be referred. Therefore, facilities should become acquainted with their own state requirements. 11. Facilities should look at their state PASARR programs requirements for specific procedures. PASARR contact information for the SMH/ ID authorities and the State Medicaid Agency. 12. The State must provide or arrange for the provision of specialized services to all nursing facility residents MD or ID in accordance with §483.120, whose needs are such that continuous supervision, treatment and training by qualified mental health or intellectual , personnel is necessary, as identified in the resident's PASARR level II. a. Specialized services provided or arranged by the State may be provided in nursing facility or through off-site visits arranged by the nursing facility, while the resident lives in the facility. 13. Any resident with newly evident are possible serious mental , ID or a related condition must be referred, by the facility to the appropriate state designated mental health or intellectual , authority for review ... 14. Referral for level II resident review evaluation is required for individuals previously identified by PASSARR to have a mental , intellectual , or a related condition who experience a significant change.	F 645		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

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F 657	Continued From page 20 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation interview and record review, the facility failed to effectively assess and revise a resident's care plan following a significant ⌄ loss for one resident (#162) of three residents reviewed for comprehensive assessments. Findings included:	F 657	" Resident # 162 was discharged from the facility " Facility residents with significant ⌄ loss have the potential to be affected by not revising the care plan with changes and new interventions. Residents with a significant ⌄ loss will be reviewed by the Registered Dietitian/ Designee to determine if a	

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F 657	Continued From page 21 Review of a facility document titled Nutrition At Risk dated showed Resident #162 had the following recorded: -On the resident . (pounds). - On the resident . - On the resident . The review showed a 10.53% loss. Review of a care plan last updated on showed resident #162 - has nutritional problem related to Advanced age, Right with hemi- on altered diet consistency, , and variable intake with refusals at times. The goal section showed - The resident will maintain adequate nutritional status as evidenced by maintaining # with no significant change through the review date. Interventions included: RD (Registered Dietician) to evaluate and make diet change recommendations PRN (as needed). Administer medications as ordered. Lab/diagnostic work as ordered. Report results to MD (Medical Doctor) and follow up as indicated. Invite the resident to activities that promote additional intake. Observe and report PRN (as needed) any signs/symptoms of : Pocketing, Choking, Coughing. Review of this care plan did not show updated interventions related to the significant loss noted on .. On at 10:38 a.m., Resident#162 was observed in the dayroom visiting with family members. The family members stated the resident had lost a lot of and did not eat very much anymore. Review of the admission record for Resident	F 657	significant change assessment and or care plan revision/ is needed. Revisions and updates will be completed as indicated. " The Director of Nursing / Designee will educate the Registered Dietitian, Dietary Tech, Minimum Data Set Coordinators on the need to complete an assessment, and revise the care plan with new interventions for residents with a significant change in status in loss so that the care plan accurately reflects the resident " The Director of Nursing/Designee will complete 3 random weekly audits on residents with a significant loss to determine if the care plan accurately reflects the residents significant loss and / or if revisions are needed. The results of the audits will be tracked, trended and reported to the monthly Quality Assurance Performance Improvement meeting until sustained compliance achieved.	

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F 657	Continued From page 22 #162 revealed the resident was admitted to the facility on with diagnoses to include phase and unspecified protein - calorie and unspecified . Review of an order summary report dated showed active orders for Resident #162 included a regular diet - mechanically altered texture, thin consistency, 2 cal. (calorie) Med Pass supplement two times a day, 120 ml (milliliters) and nutrition consult. Review of a nutritional progress note for Resident #162 dated revealed CBW (current body) reflects -10.6% ( ) loss x 1 week which is significant however reflects residents previous range of 97.0- 111.0 in 2022. 20.1 WNL. Staff to encourage PO fluids per orders. Potential for loss/decreased appetite r/t (related to) ABT (activity based) . Variable PO (by) meal intake noted along with refusal of meals per % PO intake documentation. Resident at risk for loss/nutritional decline r/t advanced age and process of . Recommend 2.0 Medpass 120 cc (twice daily) between meals. Will monitor weekly and f/u (follow up) prn (as needed). On at 1:10 p.m. Resident #162 was observed in bed with her closed. The resident did not respond to an interview. An immediate interview was conducted with Staff Q, Certified Nursing Assistant (CNA). She stated (.) had assisted the resident with her meal earlier. She stated the resident had had an early tray for observation. She said, "this resident does not eat much. We set up her	F		

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tray." She stated Resident #162 was not assisted with her meal. Staff Q stated the resident ate less than 25% of her meal almost all the time.

On at 03:15 p.m., an interview was conducted with the facility's Diet Technician, (DT). The DT stated when a resident was admitted she did nutritional assessments, got nutrition intake and the initial assessment. She stated she set up meal preferences. She stated the dietician monitored ˬ loss and initiated the triggers. She stated she did not know this resident had a significant ˬ loss. She stated if she did, it would be documented in an assessment or the plan of care.

On at 11:20 a.m., an interview was conducted with the facility's Registered Dietician, RD. The RD stated she saw residents once a month. She stated for Resident #162, she had documented on her ˬ loss last week. She said the resident was on , , and staff should be encouraging her to eat her meals. She stated they should be documenting if she refused. She confirmed she had reviewed the resident's ˬ record and identified a significant ˬ loss. She stated she had recommended her for supplements. She stated she had not seen the resident in person. She stated if the resident was losing a lot of ˬ , there should be a follow -up. She stated majority of times the IDT (interdisciplinary team) would meet to discuss a plan for the change, and it would be documented. She stated they would discuss if the resident needed 1:1 assistance. The RD stated at the time the resident only required tray set up. She stated if her intake had changed, the CNA should be letting the nurse know and possibly obtain another ˬ . She

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stated as the RD, she would see them weekly and obtain weekly ⌄ for monitoring. The RD confirmed the resident's assessment had not been updated. She confirmed the care plan should have been updated with new interventions. She confirmed the team had not met to address this resident's significant ⌄ loss.

On at 11:51a.m., an interview was conducted with Resident #162's Occupational , ( ). She stated they had been working on strengthening , standing ⌄ and toileting. She stated related to the resident's meal intake, she was able to independently scoop the meal and drink from the cup. She stated she had not assessed the resident for meal consumption. She said,
" intake was not the focus, but the ability to eat independently." She stated usually the dietician would come and speak with the DOR if there were ⌄ loss concerns. She stated it should be documented in the notes and assessments. The stated the Director of Rehab (DOR) had been notified of the ⌄ loss to see if there was any trouble with feeding.

Review of a facility policy titled Comprehensive Care Plans and Revisions, dated showed: The facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care.

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F 657	Continued From page 25 Procedure: I. The facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care. 2. When these changes occur, the facility should review and update the plan of care to reflect the changes to care delivery, this can include: a. Additional interventions on existing problems, b. Updating goal or problem statements c. Adding a short-term problem, goal, and interventions to address a time limited condition.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, grooming, and oral care,	F 676		

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F 676	Continued From page 26 §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility did not ensure activities of daily living (ADLs) were completed and maintained for one (#91) of three residents sampled related to meals/snacks and three (#91, #16 and #49) of 23 residents sampled for hydration. Findings included: 1. During an interview on at 10:53 a.m., Resident #91 was observed lying in bed dressed for the day. Resident #91 stated she had had some loss, but had lost more because she had not felt like eating. During an observation on from 10:45 a.m. to 12:45 p.m., Resident #91 was observed sitting in a wheelchair in the activities room of the 100 unit. Resident #91 was observed to have no hydration. Her were noted to be dry and cracked. During an observation on at 12:48 p.m., Resident #91 was observed sitting in a	F 676	Resident # 91 was discharged from the facility. Resident #16 and 49 were assessed with no negative outcomes. · Residents that are dependent on staff for hydration that spend time in the activity day rooms are at risk of not being offered and assisted hydration. Residents' whose Activities of Daily Living are dependent on staff for hydration that spend time in the activity rooms were reviewed to ensure the necessary assistance and fluids are being provided while in the activity day rooms. Residents who have scheduled or outings have the potential to be affected by not having staff arrange, provide and complete alternative options for meals and / or snacks to accommodate the outing. Current residents with since were evaluated for negative consequences from not being provided a meal or snack with a scheduled outing. · The Director of Nursing/Designee in-serviced the licensed and certified nursing staff on the hydration policy	

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F 676	Continued From page 27 wheelchair in the hallway. Staff was observed telling Resident #91 that she had a doctors , , and they needed to get her ready to leave the facility. During an interview on at 4:34 p.m., Resident #91 stated she had not eaten lunch before her , , and was not given anything to eat while away from the facility for her , , . Resident #91 stated she had not been offered anything to eat when she returned to the facility after her , , and was waiting for dinner. Review of Resident #91's admission record revealed an admission date of . The resident was admitted to the facility with diagnoses to include but not limited to, Type 2 , unspecified protein calorie , iron deficiency, and unspecified . Review of Resident #91's Admission Minimum Data Set (MDS) dated , revealed Section C. , a Brief Interview Mental Status ( ) of 15 out of 15 which indicated intact cognition. Section GG. Functional limitations revealed Resident #91 needed eating set up or clean up assistance. During an interview on at 12:53 p.m., Staff A, Certified Nurses Assistant (CNA) stated she did restorative and several other things like accompanying residents to , , . She stated she was not sure when Resident #91 had breakfast, and that Resident #91's lunch tray would be saved for her to eat when she got . She was not sure how long they would be gone for her , , . She stated she had not thought of getting her a snack or bringing	F 676	including offering and providing assist with fluids, meals and snacks based on the residents needs and plan of care. This training includes the facility process for residents who have scheduled , , including communicating to the kitchen for timely tray delivery to accommodate the resident needs and preferences with meals, hydration and snacks with the residents on outings as needed. The Dietary Director will educate kitchen staff on the facility process for communicating and accommodating meal or snack delivery for residents with , , . · The Director of Nursing / Designee will complete 5 weekly activity day room observations of resident's dependent on staff for hydration to ensure appropriate assist and hydration is being offered to meet the resident's hydration needs. The Director of Nursing/ Designee will also complete 3 random weekly interviews and/ or observations to ensure residents are being provided an earlier meal/snack or meal/snack upon return based on resident need or preference. Results of the audits will be tracked, trended and reported to the monthly Quality Assurance Performance Improvement meeting until sustained compliance achieved.	

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something with them for Resident #91 to eat since she was not getting her lunch tray.

During an interview on at 4:45 p.m., Staff B, CNA, stated he was told the resident did not eat lunch and might be hungry when she got from her , , . He stated she returned to the facility around 3:15 p.m. and he had not offered her a meal or snack.

During an interview on at 5:02 p.m., the Certified Dietary Manager (CDM), stated when a resident had an , , the nurses usually notified her so she could arrange to send the food tray early so the resident could eat before their , , . She was not aware of a resident having an , , for today.

During an interview on at 5:10 p.m., Staff C, Registered Nurse (RN), stated she was aware that Resident #91 went out to an , , and returned to the facility around 3:15 p.m., she stated she was not aware that Resident #91 did not receive lunch. She stated she would expect the CNA to have offered the resident something to eat when she returned to the facility.

During an interview on at 5:13 p.m., Staff D, Licensed Practical Nurse (LPN) Unit Manager, stated when residents had an , , the nurse was responsible for notifying the kitchen the day of so they could send their food tray out early. She stated she was not aware Resident #91 did not receive her lunch. She stated she would expect the nurse to share this report with the oncoming nurse.

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2. During an observation on from 10:45 a.m. to 12:45 p.m., Resident #16 was observed sitting in the activities room of the 100 hall. Resident #16 was observed with no hydration during this observation.

Review of Resident #16's admission record revealed an admission date of . Resident #16 was admitted to the facility with diagnoses which included but not limited to (Generalized), Other Specified And , Major Following , Severe, With Disturbance and Unspecified Protein-Calorie .

Review of Resident #16 MDS Section C. Cognition revealed Resident is rarely/never understood. Section GG. Functional Limitations revealed Resident #16 needs substantial maximal assistance with eating.

During an interview on at 1:00 p.m., Staff F, CNA, stated she was the CNA for Resident #16, and she constantly checks on her residents. She stated "Resident #16 does not drink anything but Gatorade and just got up at 10 a.m." She was not sure how often she provides hydration to Resident #16.

3. During an observation on from 10:45 a.m. to 12:45 p.m., Resident #49, was observed sitting in the activities room of the 100 hall. Resident #49 was observed to not have hydration during this observation.

Review of Resident #49's admission record revealed an admission date of with an

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F 676	Continued From page 30 initial admission date of . Resident #49 was admitted to the facility with diagnoses which included but not limited to , , , Phase, Unspecified , Unspecified Severity, Without Behavioral Disturbance, Unspecified, Unspecified, Without , , Review of Resident #49's quarterly dated revealed Section. C. , a Brief Mental Interview Status ( ) of 00 which indicated severe . Section GG. Functional limitations revealed Resident #49 require substantial maximal assistance with eating. During an interview on at 10:50 a.m., Staff E, Registered Nurse (RN) stated residents should all have water at the bedside. She stated signs a resident needed hydration were a dry and cracks in the , . She stated if she saw a resident with any of these symptoms, she would encourage more fluids and would ask the aides to include hydration with their care of the residents. She stated, "I would think the CNAs should come in and check on resident's hourly." During an interview on at 10:51 a.m., Director of Nursing (DON) stated she would expect residents to be offered hydration at least once an hour and would expect residents in the activities room to either have a cup for hydration or staff to periodically check on the residents. She stated if a resident had an , , at mealtime or if the resident was out for a meal, Dietary should be notified to get an early tray so that they can eat before they go out. If the residents were alert and oriented, they asked	F 676		

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F 676	Continued From page 31 them if they would like to have a snack or a bagged lunch with them so they could have something to eat while they were gone. During an interview on at 1:45 p.m., the Regional Director of Clinical services stated they do not have anything that monitors resident hydration intake unless there are physician's orders. Review of the facilities policy titled Hydration and Nutrition dated revealed: Policy: Each resident receives a sufficient amount of food and fluids to maintain acceptable parameters of nutritional and hydration status. Procedure: 2. A minimum of three meals are provided each day. If a meal or food is refused, the resident is offered a substitute or a similar nutritive value. 4. Fluid is always available to residents. A hydration cart may be utilized.	F 676		
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 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, record review, and interview, the facility failed to follow-up on a physician order with a black box warning for one resident (#264) of fifty-one residents sampled.	F 684	• Resident #264 had his medication, (HCl) discontinued by order from the Advanced Registered Nurse	

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F 684	Continued From page 32 Findings included: On at 9:00 am., an observation was made revealing Staff P, License Practical Nurse (LPN) on the phone with the pharmacy ordering medication for Resident #264. On at 9:21 am, an interview was conducted with Staff P. She stated Resident #264 was out of his (HCl) 400 Milligram (MG), a medication he took for . Staff P stated she believed Resident # 264 was only out of the medication today, that was why she called in a STAT (immediate) order for the medication. She stated she would fax the request over to pharmacy as soon as possible. Review of Resident #264's Admission Record revealed he was admitted to the facility on with diagnoses to include but not limited to , Presence of . Review of the Medication Administration Record (MAR) dated - , showed an order for (HCl) Oral Tablet 400 Milligram (MG)- Give 1 tablet by two times a day for , order start date - discontinued on . On at 3:02 p.m., an interview was conducted with the Director of Nurses, DON. The DON stated that the resident had ordered on admission from the hospital for . She said the pharmacy did not send the medication when the facility initially put a request in for the medication on .	F 684	Practitioner. • Residents with black box medication warnings have the potential to be affected by not following up on a physician order. Residents with black box sever interactions were reviewed for any missing, late, ordered or not available medications. Physicians will be notified if indicated. • Director of Nursing/Designee will in-service the licensed staff on the facility process if a medication is unavailable from Pharmacy due to formulary coverage, contraindications, drug-drug interactions, drug interaction, , black-box warnings or other clinical reason. The facility will collaborate with the Pharmacy and physician/prescriber to determine a suitable therapeutic alternative if needed. This in-service will also have a focus on reporting medications not available in Grand Rounds and in the morning clinical meeting. • The Unit Managers/Designee will complete 5 random weekly audits on residents with black box sever interactions to ensure follow up with the physician has been completed and the medication is available if medication is approved for the resident. Results of the audits will be tracked trended and reported to the monthly Quality Assurance Performance Improvement meeting until sustained compliance achieved.	

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She stated when she found out today Resident # 264 was out of his medication, she reached out to pharmacy to find out why they did not send the medication. She stated pharmacy responded that there was a black box warning related to this type of medication, and they were waiting for a response from the facility. The DON stated she reached out to the Primary Care Provider to notify him that Resident #264 did not receive his medication since admission. She stated she also told him what the pharmacy said about the black box warning for the medication . The DON stated the Primary Care Provider (PCP), stated he did not feel comfortable deciding to discontinue Resident #264's . The DON stated the PCP told her to reach out to the resident's because he or she would be more qualified to provide direction regarding whether to discontinue the use of the medication or to keep the resident on this medication. The DON stated she reached out to their , Advanced Registered Nurse Practitioner, ARNP, to explain the situation and review Resident #264's medications. She stated the ARNP instructed them to stop the medication. The DON stated she could not speak to why her nurses did not reach out to her early on to discuss the resident not receiving his medication. The DON stated the nurses kept reaching out to pharmacy, but they did not notify Resident # 264 doctor to get further instruction on whether the doctor wanted to provide the resident with an alternative medication. The DON stated the nurse should have called the pharmacy to find out why they did not send the medication. Then notify the physician to get further directions on what to do about the resident's medication, document why the medication was not available, and the physician's

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F 684	Continued From page 34 response. On at 4:00 pm, an interview was conducted with the ,, Advanced Registered Nurse Practitioner (ARNP). She stated she received a call from the unit manager today because Resident #264's Primary Care Provider wanted the facility to reach out to her about the resident's medication. The ARNP stated if the facility had reached out to her ahead of time, she would have recommended them to discontinue the medication on admission. On at 4:30 pm, an interview was conducted with the pharmacist. She stated the facility should have contacted the pharmacy to see why the medication order was not completed. She stated there are many medications with black box warnings so the nurses should have contacted the physician who prescribed the medication to see if the physician felt the resident could continue with the medication or if they would like to administer an alternative medication. Review of the facility policy titled, "Medication Shortages/ Unavailable Medications, Revision date , showed Applicability Policy 7.0 sets forth procedures relating to medication shortages and unavailable medication. Procedures 6. If the medication is unavailable from Pharmacy due to formulary coverage, contraindications, drug-drug interactions, drug- interaction, ,, or other clinical reason, Facility should collaborate with Pharmacy and Physician/Prescriber to determine a suitable therapeutic alternative.	F 684		

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F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and . ˬ well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure competent staff were available to provide skilled nursing care and services related to (1.) Failure to monitor resident's access to food ˬ for two	F 726	Resident # 163 was discharged from the facility. Resident # 66 was assessed with no negative outcome. Resident #73 ˬ was changed by our Nurse with no negative outcome.	

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LIFE CARE CENTER OF NEW PORT RICHEY	7400 TROUBLE CREEK ROAD NEW PORT RICHEY, FL 34653

(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 726	Continued From page 36 residents (#163 and #66), 2. Failure to ensure were dated for one resident (#73), 3. Failure to follow up on a physician order with a black box warning for one resident (#264), 4. Failure to provide nutrition services for one resident (#91), and 5. Failure to provide hydration for three residents (#91, #16, and #49) of 58 sampled residents. Findings included: 1. On at 8:31 a.m., Resident #163 was observed in her room eating breakfast. The resident stated she was served wheat, and she was . She said, "this is not the first time. last night I was served milk. I am ." The resident stated she had requested an alternate, almond milk and had not received it. Observation of the resident's plate revealed the resident ate approximately of pureed bread and one scoop of cream of wheat. Review of an Admission Record for Resident #163 revealed an admission date of with diagnoses to include , , . Review of the Resident Information showed under : , , , milk and wheat. Review of the Resident #163's care plan revealed prior to the observation and interview, the resident did not have a focus related to food . A focus initiated on showed the resident has nutritional problem related to advanced age, food to wheat and milk ...Interventions included - detailed food preferences obtained, CDM (Certified Dietary Manager) assisting with daily menu selection. Review of physician orders for Resident #163	F 726	Resident # 91, 16, and 49 were assessed with no negative outcomes. Resident #264 had his medication, (HCI) discontinued by order from the Advanced Registered Nurse Practitioner. · Residents with food have the potential to be affected. Residents with food will be reviewed to ensure no related consequences. Residents with have the potential to be affected by not being dated. Residents with will be reviewed to ensure are dated. Residents with medications with black box warnings have the potential to be affected. They will be reviewed to ensure no black box medication related negative effects. Current residents with , , since will be evaluated for negative consequences from not being provided a meal or snack with a scheduled outing. Residents' whose Activities of Daily Living are dependent on staff that spend time in the activity day rooms for hydration were reviewed to ensure the necessary assistance and fluids are being provided according to the resident needs and plan of care. · The Director of Nursing / Staff Development Coordinator will complete training to the Licensed nurses and Certified Nursing Assistants on the process for ensuring food items that residents are to are not accessible, the facilities hydration policy and process with a focus on the residents that are dependent upon staff to meet	

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F 726	Continued From page 37 dated , showed : , milk, wheat. Regular diet - puree texture, nectar/mildly consistency - must use almond milk, family to supply ( ) On at 09:09 a.m., an interview was conducted with Staff R, Cook. He stated for breakfast this morning, the residents were served sausage gravy, biscuits, bread, scrambled eggs/boiled eggs and juice and/or milk. He reviewed the tray for Resident #163 and stated she was served pureed bread, scrambled eggs and cream of wheat. He reviewed the resident's meal ticket and confirmed the wheat . He stated, she should not have been served that. He stated the dietary aides were responsible for ensuring the meal tickets were accurate. On at 9:12 a.m., an interview was conducted with Staff S and Staff T, Dietary Aides. They both confirmed it was their responsibility to review meal tickets and ensure the resident's preferences were honored and were prevented. The dietary aides confirmed Resident #163 was served items that she was to. They stated it was an error on their part. On at 9:14 a.m., an interview was conducted with the Certified Dietary Manager (CDM). She confirmed the resident was served cream of wheat and bread, items she was to. The CDM reviewed the meal ticket and said, "she is to that. I know it because I spoke with her. I put the down on the tickets." She stated the resident should not be served items they were to. The CDM said, "It can lead to ." She stated she would let the nurse know. The CDM confirmed the resident was also to milk. She stated	F 726	their hydration needs. The training will also review the process for communicating resident , , to the kitchen and ensuring residents receive a snack or meal according to resident preferences. The Director of Nursing/ Staff Development Coordinator will educate licensed nurses on the need to ensure are dated and follow up on physician ordered black box warnings is completed timely. · The Director of Nursing / Designee will complete 5 random weekly audits of day rooms to ensure residents do not have access to food to verify staff understanding of the education provided. The Director of Nursing / Designee will complete 5 random observations of to ensure they are labeled and 5 random audits of residents with black box warning to ensure physician orders are followed up on. In addition, the Director of Nursing / Designee will interview 3 residents per week to determine if residents who have , , have been offered and/or provided a meal or snack and complete 5 random observations of dependent residents in the activity day rooms to ensure they are being provided and assisted with hydration. These audits, interviews and observations will validate staff competency and knowledge of the facility processes. The results of the audits will be tracked, trended and reported to the monthly Quality Assurance Performance Improvement meeting until sustained compliance achieved.	

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they were waiting for the truck to deliver almond milk. she stated they did not have any.

On at 9:18 a.m., an interview was conducted with the Director of Nursing (DON). She stated the resident should not have been served items she was ˘ to. She confirmed the resident was ˘ to milk, wheat. She stated the family was supposed to bring Resident #163 some almond milk.

On at 3:15 p.m., an interview was conducted with the facility's Diet Technician (DT). The DT stated she assessed residents upon admission for meal preferences and/ or ˘ . She stated she updated meal tickets if there were changes. The DT said, "I ask for ˘ , sometimes if it is not listed in their record, I let the DON know." The DT confirmed it was her responsibility to add the ˘ to the meal profile. The DT said she heard about Resident #163 being served items she was ˘ to. The DT said, "I don't understand it. They should review each ticket and pay attention to ˘ ."

Review of a progress note dated showed, "Writer spoke with resident regarding her food ˘ . Resident stated she is ˘ to milk which causes breathing difficulty. She was ˘ tested for this and does not have a Lactose intolerance. Resident prefers Silk brand Almond milk in vanilla sweetened version. Resident stated she is ˘ to wheat which causes breathing difficulty. She was ˘ tested for this and does not have a intolerance or Celiac's . She reports that she purchases ˘ free bread because then she knows it doesn't have wheat in it. Resident stated she does eat oatmeal regularly at home, she purchases the instant packets."

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F 726	Continued From page 39 On at 9:46 a.m., the CDM stated she and the DT were responsible for ensuring staff competencies for dietary staff. They stated they educated the staff and observed if they were following the expectations. During an observation and interview on at 9:30 a.m., Resident #66 said he ate a staff member's apple and his ⌄ "swell a little." Review of admission summary showed Resident #66 was admitted on and readmitted on and showed ⌄ to include apple, apple juice, applesauce, and apple peel. Review of Resident # 66's health status note dated at 7:33 a.m. showed, ", took Certified Nursing assistants' ([CNA's]) lunch bag and started to eat an apple a few bites." During an interview on at 9:08 a.m. Staff L, CNA said on hire, she was told to store her lunch in the facility's employee lunchroom. During an interview on at 3:15 P.M. the Director of Nursing (DON) said while Resident # 66 was in the day room he removed an apple from a staff member's lunch bag. She said during orientation staff have been instructed to keep personal items in their lockers. 2. On at 11:56 a.m., during observation and interview with Resident #73, three ⌄ located on the left and both ⌄ were undated. Photographic Evidence Obtained. Review of admission record showed Resident	F 726		

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F 726	Continued From page 40 #73 was admitted to the facility on and readmitted on with diagnoses to include of part of and of with . Review of order summary report, active orders as of showed Resident #73 had care orders for both and left to be changed daily and as needed. During an interview on at 9:54 a.m., Staff I, Licensed Practical Nurse (LPN) said after were changed the nurses were required to write the date and their initials on the bandage. During an interview on at 3:25 p.m., the Director of Nursing (DON) said were expected be dated and initialed, "so staff knows when it was last changed." During an interview on at 1:11 p.m., Staff H, Registered Nurse (RN) Care , said nurses were expected to date bandages when were changed, "that's how I know when they were put on." Review of a facility policy titled, Documentation and Assessment of , reviewed showed the following: Policy-to guide the associates and licensed nurses ... consistent with professional standards of practice, to promote healing, prevent ...	F		

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3. On at 9:00 am., an observation was made revealing Staff P, License Practical Nurse (LPN) on the phone with the pharmacy ordering medication for Resident #264.

On at 9:21 am, an interview was conducted with Staff P. She stated Resident #264 was out of his (HCl) 400 Milligram (MG), a medication he took for . Staff P stated she believed Resident #264 was only out of the medication today, that was why she called in a STAT (immediate) order for the medication. She stated she would fax the request over to pharmacy as soon as possible.

Review of Resident #264's Admission Record revealed he was admitted to the facility on with diagnoses to include but not limited to , Presence of .

Review of the Medication Administration Record (MAR) dated - , showed an order for (HCl) Oral Tablet 400 Milligram (MG)- Give 1 tablet by two times a day for , order start date - discontinued on .

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On at 3:02 p.m., an interview was conducted with the Director of Nurses, DON. The DON stated that the resident had ordered on admission from the hospital for . She said the pharmacy did not send the medication when the facility initially put a request in for the medication on . She stated when she found out today Resident # 264 was out of his medication, she reached out to pharmacy to find out why they did not send the medication. She stated pharmacy responded that there was a black box warning related to this type of medication, and they were waiting for a response from the facility. The DON stated she reached out to the Primary Care Provider to notify him that Resident #264 did not receive his medication since admission. She stated she also told him what the pharmacy said about the black box warning for the medication . The DON stated the Primary Care Provider (PCP), stated he did not feel comfortable deciding to discontinue Resident #264's . The DON stated the PCP told her to reach out to the resident's because he or she would be more qualified to provide direction regarding whether to discontinue the use of the medication or to keep the resident on this medication. The DON stated she reached out to their Advanced Registered Nurse Practitioner, ARNP, to explain the situation and review Resident #264's medications. She stated the ARNP instructed them to stop the medication. The DON stated she could not speak to why her nurses did not reach out to her early on to discuss the resident not receiving his medication. The DON stated the nurses kept reaching out to pharmacy, but they did not notify Resident # 264 doctor to get further instruction on

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whether the doctor wanted to provide the resident with an alternative medication. The DON stated the nurse should have called the pharmacy to find out why they did not send the medication. Then notify the physician to get further directions on what to do about the resident's medication, document why the medication was not available, and the physician's response.

On at 4:00 pm, an interview was conducted with the Advanced Registered Nurse Practitioner (ARNP). She stated she received a call from the unit manager today because Resident #264's Primary Care Provider wanted the facility to reach out to her about the resident's medication. The ARNP stated if the facility had reached out to her ahead of time, she would have recommended them to discontinue the medication on admission.

On at 4:30 pm, an interview was conducted with the pharmacist. She stated the facility should have contacted the pharmacy to see why the medication order was not completed. She stated there are many medications with black box warnings so the nurses should have contacted the physician who prescribed the medication to see if the physician felt the resident could continue with the medication or if they would like to administer an alternative medication.

On at 4:40 p.m. an interview was conducted with the Staff Developer, SD and the Director of Nurses, DON. The SD stated he used the annual education calendar for staff education. He stated the calendar was divided into different types of topics each month. He stated he also used a nursing manual to help provide education

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pertaining to nursing topics. He stated he ensured staff competencies were maintained by doing chart reviews, he looked at documentation, observations, and conducted audits. He stated medication filling out orders would not be in the nursing manual he used for education. He stated filling physician orders was a standard of nursing practice. The DON stated the nurses were provided with education on their standard when it came to completing orders. The DON stated their standards were if a medication was not available the nurse would call the pharmacy, notify the physician of what the pharmacy said about the medication not being available. The nurses would document their conversation with pharmacy and the doctor and any changes that was made to the order and the follow through process.

Review of the Registered Nurse (RN) Unit Registered Nurse, Job Description Revision Date , showed Position Summary, The RN Unit Registered Nurse delivers quality nursing care to patients through interpersonal contact and provides care and services to assure patient safety and attain or maintain the highest practicable physical, mental and , well-being of each patient in accordance with all applicable laws, regulations, and Life Care Standards. Reports to Director of Nursing (DON).

Specific Requirements must perform proficiently in all applicable competency areas.

Essential Functions must be able to knowledgeably and competently deliver quality nursing care to patients.

Review of the License Practical Nurse (LPN)

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F 726	Continued From page 45 Unit License Practical Nurse Job Description Revision Date , showed Position Summary, The LPN Unit License Practical Nurse delivers quality nursing care to patients through interpersonal contact and provides care and services to assure patient safety and attain or maintain the highest practicable physical, mental and , , well-being of each patient in accordance with all applicable laws, regulations, and Life Care Standards. Reports to the Director of Nursing (DON) or other nursing supervisor. Specific Requirements must perform proficiently in all applicable competency areas. Essential Functions, must be able to knowledgeably and competently deliver quality nursing care to patients. Review of the Certified Nursing Aid (CNA) Job Description Revision Date , showed Position Summary, The Certified Nursing Aid is responsible for providing routine daily nursing care to assigned patients to assure patient safety and attain or maintain the highest practicable physical, mental, and , , well-being of each patient in accordance with all applicable laws, regulations, and Life Care standards. Specific Requirements must perform proficiently in all applicable competency areas. 4. During an observation on at 12:48 p.m., Resident #91 was observed sitting in a wheelchair in the hallway. Staff A, Certified Nurse Assistant (CNA) was observed telling Resident #91 that she had a doctor's , , and transportation was there to get her.	F 726		

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During an interview on at 4:34 p.m., Resident #91 stated she had not eaten lunch before her , , and was not given anything to eat while away from the facility for her , , . Resident #91 stated she had not been offered anything to eat when she returned to the facility after her , , and was waiting for dinner. Resident #91's , were observed to be pale, dry, and cracked.

During an interview on at 12:53 p.m., Staff A, Certified Nurses Assistant (CNA) stated she does restorative and several other things like accompanying residents to , , . She stated she was not sure when Resident #91 had breakfast, and that Resident #91's lunch tray will be saved for her to eat when she gets . She was not sure how long they would be gone for her , , . She stated she had not thought of getting her a snack or bringing something with them for Resident #91 to eat since she was not getting her lunch tray.

During an interview on at 4:45 p.m., Staff B, CNA, stated he was told the resident did not eat lunch and might be hungry when she got from her , , . He stated she returned to the facility around 3:15 p.m. and he had not offered her a meal or snack.

During an observation on from 10:45 a.m. to 12:45 p.m., Resident #91, Resident #16 and Resident #49 were observed sitting in the activities room of the 100 Hall. During the observation residents were observed not to have hydration. No staff were observed entering the room and offering hydration to the residents.

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5. During an interview on at 1:00 p.m., Staff F, CNA, stated she was the CNA for Resident #16, and she constantly checks on her residents. She stated "Resident #16 does not drink anything but Gatorade and just got up at 10 a.m." She was not sure how often she provided hydration to Resident #16.

During an interview on at 10:51 a.m., Director of Nursing (DON) stated she would expect residents to be offered hydration at least once an hour and would expect residents in the activities room to either have a cup for hydration or staff to periodically check on the residents. She stated if a resident had an , , at mealtime or if the resident was out for a meal, Dietary should be notified to get an early tray so that the resident could eat before they go out. If the residents were alert and oriented, they asked them if they would like to have a snack or a bagged lunch with them so they could have something to eat while they were gone.

Review of the facilities policy titled, Education and Training Requirements, dated
revealed:
The facility will maintain an effective in service and orientation program for:
a. all associates
b. individuals providing direct care services under contractual arrangements
c. volunteers consistent with their roles

Procedure
1. The staff development coordinator or designee plans and directs an effective orientation, training, and evaluation program.
2. General orientation is required for all new or

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F 726	Continued From page 48 rehired associates, agency or contract staff, and volunteers. 7. Competencies and skill sets will for all new and existing staff, be consistent with their expected roles. This would include the following: a. facility associates b. Individuals providing services under contractual arrangement c. Volunteers 8. The facility will need to ensure staff are trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program. 10. In service education topics related to specific needs of the facility, its residents and associates will be determined by the facility assessment, annual skills evaluations, associate request, and other items determined by the quality assurance performance improvement committee (QAPI). 12. In service, training, competencies can be completed using various forms including: a. In person instruction b. Live training/webinars c. HCA or other learning management systems d. Lippincott procedures including associated competency checklist or skill test e. Supervised practical training	F 726		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 759		

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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 759	Continued From page 49 Based on observation, record review, and interview, the facility failed to ensure the medication error rate was less than 5%. Twenty-nine medication opportunities and 3 errors were identified for two residents (#102 and #361) of four observations, resulting in an error rate of 10.34% Findings included: On at 8:12 a.m., during medication administration observation Staff J, Licensed Practical Nurse (LPN) was observed administering the following medications to Resident #361, ER 100MG, 100 mg, 5MG, 600mg, 1000 UNIT, 5% patch, 50 mg, ER 625mg, Multiple with 1 tablet, with C 1 tablet, C 250 mg and 81 mg low dose 1 tablet. A review of the order summary report dated showed Resident #361 did not receive 81 mg Delayed Release and as ordered. On at 8:49 a.m., during medication administration observation Staff E, Registered Nurse (RN) administered the following medications to Resident #102, 1000-unit, 81 mg low dose 1 tablet, tablet 3.125 MG, DS 800-160 mg, ER 40 MEQ, and 50 mg tablet. A review of the order summary report dated	F 759	Residents # 102 and #361 were evaluated for any negative consequences with none noted. The physicians and resident representatives were notified with no new orders received. Facility residents that receive medications have the potential to be affected. The Director of Nursing/ Staff Development Coordinator will complete medication administration competencies on each licensed nurse to validate staff competency related to medication administration with focus on preventing medication errors. The Director of Nursing/ Staff Development Coordinator will educate licensed nurse on the policy and procedure for medication administration including following physician orders and preventing medical errors. The Director of Nursing/ Staff Development Coordinator will complete 5 random weekly random medication administration observations to ensure medications are provided as ordered. Observations will be completed on each shift and weekends. Results of the audits will be tracked, trended and reported to the monthly Quality Assurance Performance Improvement meeting until sustained compliance achieved.	

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	106049	A. BUILDING _____ B. WING _____	C 03/05/2025

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F 759	Continued From page 50 for Resident #102 showed , 81 mg delayed release was not administered as ordered. During an interview, record review, and medication container observation on at 8:27 a.m. with Staff E, RN, Unit Manager, , , 81 mg delayed release and , were verified as not administered as ordered. During an interview on at 12:50 P.M. the DON said Staff E, RN, UM had informed her of the medication administration concerns and it is expected for nurses to administer medications as ordered. Review of a facility policy titled, Administration of Medications, reviewed showed the following: Policy-The facility ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms. Procedure- 2 Staff who are responsible for medication administration will adhere to the 10 rights of medication administration. 2a. Right Drug-Every drug administered must have an order from the provider. Compare the order with the medication administration record (MAR) for accuracy. Compare the label on the drug to the information on the MAR three times. i) Before removing the container from the drawer ii) as the drug is removed from the container and iii) At the bedside before administering it to the resident.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		

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F 761	Continued From page 51 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Prevention and Control Act of 1976 and other drugs subject to , except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility did not ensure medications were inaccessible to unauthorized staff, residents, and visitors for five (#265, #63, #12, #164 and #18) of 58 sampled residents. Findings included: 1. On at 11:32 a.m., an observation in Resident #265's room revealed a medication bottle, labeled Custom medication crafted for (Resident #265). The medication name was /MAG/MENTH /89 %, apply to treatment area one to two times daily. The medication was	F 761	Residents #265, #63, #12, #164 and #18 medications were removed and properly stored with the permission of the resident/ or resident representative. Facility residents have the potential to be affected by medications being accessible to unauthorized staff, residents and visitors. The Director of Nursing and Unit Mangers completed 100% observation of each resident's room to ensure medications are not accessible to unauthorized staff, residents and visitors. Residents that had medications not stored appropriately were removed and stored in	

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F 761	Continued From page 52 observed on a table in the resident's room. Review of the Admission Record for Resident #265 showed the resident was admitted to the facility on with a primary diagnosis of atherosclerotic of native , without protectors. Review of active physician orders for Resident #265 dated did not show an order to administer the medication. 2. On at 10:20 a.m. an inhaler was observed on Resident #63's bedside table. The resident stated it was her rescue inhaler, and she self-administered as needed. Review of the Admission Record for Resident #63 showed the resident was re- admitted to the facility on with diagnoses to include (,). Review of active physician orders for Resident #63 dated did not show an order to self-administer the medication, nor was this medication on the list. The order showed the resident received , , - solution 0. .5 MG/ML (Milligram/milliliter) inhale orally via every 4 hours as needed for . 3. On at 10:31 a.m., Resident #12 was observed in bed. An cream was observed on the bedside table. The resident could not answer if and when the cream was applied. Review of the Admission Record for Resident #12 showed the resident was admitted to the facility	F 761	the medication carts or residents locked drawer, if a physician order is in place for self- administration, with the resident or resident representatives' permission. The Director of Nursing / Designee will complete 5 random weekly observations of resident rooms to ensure there are no medications that are accessible to unauthorized staff, residents and visitors. The results of the audits will be tracked, trended and reported to the monthly Quality Assurance Performance Improvement meeting until sustained compliance achieved.	

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F 761	Continued From page 53 on with a primary diagnosis of . Review of active physician orders for Resident #12 dated did not show an order to administer the medication. 4. On at 11:38 a.m., an observation was made of a cream at Resident #164's bedside table. The resident did not respond to the interview. Review of the Admission Record for Resident #164 showed the resident was admitted to the facility on with a primary diagnosis of unspecified intracapsular of right . Review of active physician orders for Resident #164 dated did not show an order to administer the medication. 5. On at 12:59 p.m., Resident #18 was observed in her room. An observation was made of a white basket placed on her bed with a cream and bio freeze. The resident stated she used the bio freeze for her hurting . She stated she received the itching cream from the facility, and she applied it herself due to itching. Review of the Admission Record for Resident #18 showed the resident was re-admitted to the facility on with a primary diagnosis of of unspecified site of left female . Review of active physician orders for Resident #18 dated did not show an order to self-administer the medications, and the medications	F 761		

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F 761	Continued From page 54 were not on the order list. On at 9:25 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated medications should be stored in the treatment cart or medication cart at all times. She stated nursing staff should apply and administer all medications unless there was a self-administration assessment. The DON said, "even so, they should still be locked and handed to them at the time of application or administration." The DON stated there were no residents with self-administration orders. She stated medications should not be left at bedside. Review of a facility policy titled, Storage and Expiration Dating of Medications and Biologicals, revised on showed: 1. The facility should ensure that only authorized facility staff, as defined by facility should have possessions of the keys access card electronic codes or combinations which open medication storage areas. 5. Facility should ensure all medications and biologicals including treatment items are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. 19.2 Facility should store bedside medications or biologicals in a locked compartment within the resident's room.	F 761		
F 806 SS=D	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;	F 806		

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F 806	Continued From page 55 §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; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility did not ensure food that accommodates resident ˘ , intolerances, and preferences was served for one (#163) of four residents reviewed for nutrition. Findings included: On at 8:31 a.m., Resident #163 was observed in her room eating breakfast. The resident stated she was served wheat, and she was ˘ . She said, "this is not the first time. last night I was served milk. I am ˘ ." The resident stated she had requested an alternate, almond milk, and had not received it. Observation of the resident's plate revealed the resident ate approximately of pureed bread and one scoop of cream of wheat. Review of an Admission Record for Resident #163 revealed an admission date of with diagnoses to include ´ , ˘ . Review of the Resident Information showed under ˘ : ' ´ , milk and wheat. Review of the Resident #163's care plan revealed prior to the observation and interview, the resident did not have a focus related to food ˘ . A focus initiated on showed the resident has nutritional problem related to advanced age, food ˘ to wheat and milk ...Interventions included - detailed food	F 806	Resident #163 was discharged from the facility. Residents with food ˘ , intolerances and preferences have the potential to be affected by not honoring ˘ , intolerances and preferences. The Registered Dietician/ diet tech will review residents with food ˘ and intolerances to ensure the residents tray ticket and care plan are accurate. The diet tech/ food service director will interview residents to ensure their food preferences are accurate and are correct on residents tray ticket. The facility added a food tray checker at the end of the tray line to verify the tray is accurate honoring the resident ˘ , intolerances and food preferences of the resident. The Registered Dietitian / Designee will in-service the food and nutrition staff on the process for ensuring residents with ˘ and intolerances are not served those food items and that food preferences are honored. This training will include the process for checking the tray prior to serving. The Director of Nursing / Designee will in-service licensed Nurses, Certified Nursing Assistants and Activity Staff on the need to ensure that the items on the tray match the tray ticket and that food items that the residents are ˘ to or have intolerances to are not served those items and that food preferences are	

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F 806	Continued From page 56 preferences obtained, CDM (certified Dietary Manager) assisting with daily menu selection. Review of physician orders for Resident #163 dated , showed : , milk, wheat. Regular diet - puree texture, nectar/mildly consistency - must use almond milk, family to supply ( ) On at 9:09 a.m., an interview was conducted with Staff R, Cook. He stated for breakfast this morning, the residents were served sausage gravy, biscuits, bread, scrambled eggs/boiled eggs and juice and/or milk. He reviewed the tray for Resident #163 and stated she was served pureed bread, scrambled eggs and cream of wheat. He reviewed the resident's meal ticket and confirmed the wheat . He stated, she should not have been served that. He stated the dietary aides were responsible for ensuring the meal tickets were accurate. On at 9:12 a.m., an interview was conducted with Staff S and Staff T, Dietary Aides. They both confirmed it was their responsibility to review meal tickets and ensure the resident's preferences are honored and are prevented. The dietary aides confirmed Resident #163 was served items that she was to. They stated it was an error on their part. On at 9:14 a.m., an interview was conducted with the Certified Dietary Manager (CDM). She confirmed the resident was served cream of wheat and bread, items she was to. The CDM reviewed the meal ticket and said, "she is to that. I know it because I spoke with her. I put the down on the tickets." She stated the resident should not be served	F 806	provided. The Registered Dietitian/ Designee will complete 5 random weekly meal observations to ensure that residents are not served items they are to or have intolerances to and are provided their food preferences. The results of the audits will be tracked, trended and reported to the monthly Quality Assurance Performance Improvement meeting until sustained compliance achieved.	

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F 806	Continued From page 57 items they were ⌄ to. The CDM said, "It can lead to , , ." She stated she would let the nurse know. The CDM confirmed the resident was also ⌄ to milk. She stated they were waiting for the truck to deliver almond milk. she stated they did not have any. On at 9:18 a.m., an interview was conducted with the Director of Nursing (DON). She stated the resident should not have been served items she was ⌄ to. She confirmed the resident was ⌄ to milk, wheat. She stated the family was supposed to bring Resident #163 some almond milk. On at 3:15 p.m. an interview was conducted with the facility's Diet Technician (DT). The DT stated she assessed residents upon admission for meal preferences and or ⌄ . She stated she updated meal tickets if there were changes. The DT said, "I ask for ⌄ , sometimes if it is not listed in their record, I let the DON know." The DT confirmed it was her responsibility to add the ⌄ to the meal profile. The DT said she heard about Resident #163 being served items she was ⌄ to. The DT said, "I don't understand it. They should review each ticket and pay attention to ⌄ ." Review of a progress note dated showed, "Writer spoke with resident regarding her food ⌄ . Resident stated she is ⌄ to milk which causes breathing difficulty. She was ⌄ tested for this and does not have a Lactose intolerance. Resident prefers Silk brand Almond milk in vanilla sweetened version. Resident stated she is ⌄ to wheat which causes breathing difficulty. She was ⌄ tested for this and does not have a intolerance or Celiac's .	F 806		

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F 806	Continued From page 58	F 806		

She reports that she purchases ˬ free bread because then she knows it doesn't have wheat in it. Resident stated she does eat oatmeal regularly at home, she purchases the instant packets."

On at 9:46 a.m., The CDM stated she and the DT were responsible for ensuring staff competencies for dietary staff. They stated they educated the staff and observed if they were following the expectations.

Review of a facility policy titled Food ˬ and Intolerances dated showed under policy - The Director of Food and Nutrition Services obtains food preferences, including any food ˬ and intolerances upon admission.
Procedure:
1. The Director of Food and Nutrition Services/Designee conducts food preference interviews with all new residents on admission.
2. Food ˬ or intolerances are communicated to Nursing Services and indicated on the resident tray card and resident diet profile.
3. The information is also recorded in the electronic medical record, including the nutrition assessment and care plan.
4. The Director of Food and Nutrition Services identifies menu items that contain the food item(s) related to the ˬ/intolerances and ensures those items are not used in foods prepared and served to identified residents.
5. Food service and nursing associates are educated on residents with food ˬ and intolerances.