STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056330	A. Building B. Wing	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reo Vista Healthcare Center	6061 Banbury St. San Diego, CA 92139

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42644 Based on interview and record review, the facility failed to obtain informed consent prior to administering psychotropic medications (a medication which affects the mind) for two of three sampled residents reviewed for informed consents (54, 72). As a result, the residents may not have been fully informed of the risks and benefits of the psychotropic medications. Findings: 1. Resident 54 was admitted to the facility on [DATE] with diagnoses which included anxiety (a mental disorder characterized by excessive worrisome), per the facility's Resident Face Sheet. Per facility's Physician Order, on 6/8/21 the physician wrote an order for Resident 54 for lorazepam (medication for anxiety) twice a day and every six hours as needed for anxiety and agitation (state of nervous excitement). 2. Resident 72 was readmitted to the facility on [DATE] with diagnoses which included anxiety (a mental disorder characterized by excessive worrisome), per the facility's Resident Face Sheet. Per facility's Physician Order, on 6/30/21 the physician wrote an order for Resident 72 for lorazepam (medication for anxiety) three times a day for anxiety and agitation. On 7/21/21 at 4:35 P.M., a concurrent interview and record review with LN 1 was conducted. LN 1 stated she was not able to locate Resident 72's informed consent for lorazepam. On 7/22/21 at 12:12 P.M., a concurrent interview and record review with LN 2 was conducted. LN 2 confirmed Resident 54 and 72 did not have informed consent for lorazepam. LN 2 stated informed consent should have been obtained by the resident or the family prior to administering the psychotropic medication. On 07/22/21 at 2 P.M., an interview with the DON was conducted. The DON stated hospice (end of life care) might had Resident 54 and 72's informed consents, but the facility should have the consents in the facility's medical record. The LNs should have verified the informed consents before starting the psychotropic medication. The DON further stated informed consent was important because the resident or family needed to be informed regarding the risks and benefits of the medications. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility's policy, titled Psychotropic Medication Use revised March 2018, . 7. Prior to administration of Psychotropic medication, the prescribing clinician will obtain informed consent from the resident (or as appropriate, the resident representative), and document the consent in the medical record. a. The informed consent obtained by the prescribing clinician is verified by the facility, with verification documented in the medical record .

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on interview and record review, the facility failed to conduct a quarterly (every 92 days) MDS, assessment for one of two (26), reviewed for Resident Assessment, as required by Federal regulation 42 CFR 483.20 (d). This failure had the potential for Resident 26's ongoing clinical status to go unrecognized and unmonitored. Findings: Resident 26 was admitted to the facility on [DATE], with diagnoses which included wedge compression fracture of the lumbar vertebra (fracture in the lower back), per the facility's annual MDS, dated [DATE]. On 7/21/21 at 3:31 P.M., an interview was conducted with the MDSN, regarding Resident 26's MDS data completion. The MDSN stated she would investigate the missing quarterly assessment and get back to me. On 7/22/21 at 8:35 A.M., the MDSN stated Resident 26's quarterly MDS was supposed to be completed in May 2021, and it was overlooked. The MDSN stated she normally printed out a list of all resident's monthly MDS required assessments and then complete the reports. The MDSN stated she assumed Resident 26 was on her May 2021 list, and she overlooked it. The MDSN stated she realized the error in June 2021, so she completed an annual MDS assessment on 7/16/21, to replace the quarterly that was due in May 2021. The MDSN stated by not conducting a quarterly assessment for Resident 26, the resident's regular assessments were out of sequence and any deteriorations or improvements in resident's status would have gone unrecognized. The MDSN stated all residents should be assessed every three months in order to monitor changes in their condition. On 7/22/21 at 9:07 A.M., an interview was conducted with the DON. The DON stated quarterly assessments were a requirement for CMS (Centers for Medicare and Medicaid Services) reimbursements. The DON stated quarterly assessments were important to recognize any changes in the resident's condition. The DON stated if a quarterly assessment was not completed, there was the potential for resident changes to be missed or overlooked. According to CMS's Resident Assessment Instrument (RAI) 3.0 Manual, dated October 2019, .2.4 Responsibility of Nursing Homes for Reproducing and Maintaining Assessments: The Federal regulatory requirement .at nursing homes to maintain all resident assessments completed . 2.5 .Quarterly Item Set .This item set is used for a standalone [sic] Quarterly assessment .

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42910 Based on observation, interview, and record review, the facility failed to ensure one of four residents (69), reviewed for shower ADL care. As a result, there a was potential for Resident 69 to feel unclean and to have unidentified skin issues. Findings: Resident 69 was readmitted to the facility on [DATE] with diagnoses which included idiopathic peripheral autonomic neuropathy (occurs when the nerves that control involuntary bodily functions are damaged), per the facility's Resident Face Sheet. A review of Resident 69's MDS, dated [DATE], had a BIMS (a cognitive assessment) score of 15 (13-15 indicated cognitively intact). The ADL assessment indicated, Resident 69 needed one person assist with bathing. An interview was conducted on 7/20/21 at 10 A.M., Resident 69 stated she did not get her scheduled shower on 7/19/21. Resident 69 stated had scheduled shower with CNA 6. Resident 69 was informed by CNA 6 that she was the only CNA on the floor working and was unable to provide the scheduled shower. Resident 69 stated that CNA 6 returned at 10 P.M., to assist her with the shower and Resident 69 denied because she was tired. A record review of the facility's South Station shower schedule indicated, Resident 69 had scheduled shower on Mondays and Thursdays at PM (3-11) shift. A record review of Resident 69's Point of Care History, dated 7/19/21 through 7/31/21, CNA 6 documented that Resident 69 had a shower on 7/19/21 at 10:54 P.M. On 7/21/21 at 8:23 A.M., a subsequent interview with Resident 69 was conducted. Resident 69 stated she was never offered a shower after she declined on 7/19/21, and she felt sad about not having her scheduled shower. On 7/21/21 at 4:17 P.M., an interview with CNA 6 was conducted. CNA 6 stated the other CNAs were on break therefore was unable to give Resident 69 a shower. CNA 6 further stated that she documented that the shower was provided but was not. On 7/21/21 at 9:11 A.M., an interview with the DON was conducted. The DON stated if a resident requested a shower, one should have been provided. Per the facility's policy and procedure, dated 5/18, titled Shower and Bathing, .1. Staff will honor shower and/or bathing .preferences such as frequency of shower schedule .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42250 Based on observation, interview and record review, the facility failed to ensure that one of one sampled resident (211), received quality of care when the surgical sutures were not removed. This failure had the potential for Resident 211 to develop an infection post operatively due to not receiving continuity of care. Findings: Resident 211 was admitted to the facility on [DATE] with diagnoses that include surgical amputation of the right AKA and diabetes (abnormal blood sugar), per the facility's Resident's Face Sheet. On 7/20/21, a review of Resident 211's MDS, dated [DATE], indicated Resident 211's BIMS Score (test for cognitive function) was 14 out of 15, which indicated cognitively intact. On 7/21/21 at 11:03 A.M., a joint observation and interview with Resident 211 was conducted. Resident 211 was observed to have had a right AKA with seventeen (17) black sutures to the skin surface that were clean and dry without signs of infection. Resident 211 stated he had surgery in the middle of June 2021 and had asked the nursing staff at the facility when would the sutures be removed to his right AKA site. Resident 211 stated he was told by the hospital doctor prior to discharge (7/1/21) that the sutures would be removed in two weeks. Resident 211 stated he had an appointment with the Podiatrist (foot doctor) on 7/13/2021, and was told by the Podiatrist that she would not be the one to take out the sutures to the right AKA site he would have to ask the Orthopedic (bone) doctor. Resident 211 stated, he had been asking the nursing staff when the sutures to his right AKA would be removed, but never received an answer from them to date. A review of Resident 211's Orthopedic Note, dated 6/25/21, indicated Orthopedic plan: .Follow up with Special Care Nurse Clinic in 2 weeks for suture removal. Follow Up Appointments: .1. Special Care Nurses 2 weeks for suture removal. A review of Resident 211's Discharge to SNF Summary and Transfer Orders, dated 7/1/21, indicated .Follow Up appointment: Special Care Nurses Clinic in two (2) weeks for wound check and suture removal On 7/21/21 at 1:22 P.M., a concurrent interview and record review was conducted during Resident 211's wound check with the TN 1. TN 1 stated Resident 211's surgical wound of the right AKA was monitored daily for signs of infection and documented in the treatment flow sheet. TN 1 stated she did not know when the sutures had been placed. TN 1 stated she did not know when the sutures would be removed as there was no physician's order for the removal of the sutures. TN 1 reviewed Resident 211's Discharge to SNF Summary and Transfer Orders, dated 7/1/21, which indicated .Follow Up appointment: Special Care Nurses Clinic in two (2) weeks for wound check and suture removal (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	TN 1 stated, she did not know anything about the follow up appointment with special care nurses clinic for suture removal. TN 1 further stated Resident 211 still had the sutures intact to his right AKA, this should have been taken out already. TN 1 stated I guess we did not set this up, it looks like we missed this follow up for the resident. ON 7/21/21 at 2:31 P.M., a concurrent interview and record review was conducted with LN 11. LN 11 stated she had initiated the admission process for Resident 211 on the day of his admission to the facility on [DATE]. LN 11 stated, she transcribed all orders for Resident 211 from the transfer orders received. LN 11 reviewed Resident 211's Discharge to SNF Summary and Transfer Orders, dated 7/1/21, which indicated . Follow Up appointment: Special Care Nurses Clinic in two (2) weeks for wound check and suture removal LN 11 stated, she must have missed this order for the follow up appointment and did not set this up, therefore, Resident 211 did not get his sutures removed and he should have. On 7/21/21 at 3:22 P.M., a concurrent interview and record review was conducted with CM. The CM stated she was familiar with Resident 211. The CM stated she was not aware that Resident 211 had an order for a follow up appointment for suture removal as this was not communicated to her by nursing. The CM stated she would assist with facilitating follow up appointments when there was an order, and that nursing would communicate this to her. The CM reviewed the Discharge to SNF Summary and Transfer Orders, dated 7/1/21, which indicated .Follow Up appointment: Special Care Nurses Clinic in two (2) weeks for wound check and suture removal The CM stated, this should have been done for the resident, he did not receive this care for suture removal to his right AKA as far as she knows. On 7/21/21 at 3:55 P.M., a concurrent interview and record review with LN 12 was conducted. LN 12 stated she was familiar with Resident 211 and his care. LN 12 stated, she had made arrangements for a follow up appointment for Resident 211, the most recent was for 7/13/21 with Podiatry for suture removal. LN 12 reviewed the Discharge to SNF Summary and Transfer Orders, dated 7/1/21, which indicated .Follow Up appointment: Special Care Nurses Clinic in two (2) weeks for wound check and suture removal LN 12 stated she was not aware of this order for follow up appointment with the Special Care Nurses Clinic for Resident 211; and stated she did not set this up. LN 12 stated when she had made the appointment for Resident 211 to follow up with Podiatry on 7/13/21, she thought that the Podiatrist would take out the sutures, she did not know that Resident 211 had sutures to both his left toe and right AKA site. LN 12 further stated she did not make arrangements for a follow up appointment with Special Care Nurses Clinic for the suture removal to the right AKA. On 7/22/21 at 10:41 A.M., a concurrent interview and record review was conducted with the NP. The NP stated she was familiar with Resident 211 and was aware that he had a right AKA done but was not sure of the date. The NP stated she was aware that Resident 211 still had the sutures intact. The NP stated, she would not be the one to remove the sutures, Orthopedic had been following Resident 211; they would be the ones to remove the sutures. The NP stated she was not aware of any order for Resident 211 to have the sutures removed. The NP reviewed the Discharge to SNF Summary and Transfer Orders, dated 7/1/21, which indicated .Follow Up appointment: Special Care Nurses Clinic in two (2) weeks for wound check and suture removal The NP stated, nursing would be setting this up, it doesn't look like this was done. On 7/21/21 at 11:21 A.M., an interview was conducted with Resident 211's Physician. The Physician stated he was aware that Resident 211's sutures where still intact to his right AKA site. The Physician further stated Orthopedic would be the one to makes the decision when the sutures would be removed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/21 at 2:37 P.M., a concurrent interview and record review with the DON was conducted. The DON stated it was the expectation that the nursing staff follow through with carrying out the transfer orders and communicating to the care team any follow up appointments for the residents. The DON stated, Resident 211 could have potentially develop an infection to the surgical site if the sutures were not removed; Resident 211 was diabetic and at risk for further infection. The DON stated the nursing staff did not read through all the transfer orders to coordinate the residents' care for the follow up appointment and should have. According to the facility's policy, titled Admission Assessment and Follow Up: Role of the Nurse, revised 9/12, .#11 .Reconcile .admitting orders .discharge summary from the previous institution, according to established procedures.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42910 Based on observation, interview, and record review, the facility failed to ensure a pressure relieving mattress (LAL-low air loss) was programmed based on the resident's weight for one of six residents reviewed for pressure ulcer (18). This failure had the potential for Resident 18's Stage 3 pressure ulcer (Full thickness tissue loss) on the sacral (in the lower back) region to worsen and develop complications. Findings: Resident 18 was admitted in the facility on 9/16/21, which included Stage 3 pressure ulcer of the sacral region, unspecified severe protein-calorie malnutrition, per the facility's Resident Face Sheet. A review of Resident 18's MDS (an assessment tool), dated 4/27/21, indicated, Resident 18 had a BIMS (cognitive assessment) score of 00 which indicated severe cognitive impairment. Section G (functional status), indicated, Resident 18 was totally dependent on staff for activities of daily living. On 7/19/21 at 9:12 A.M., Resident 18 was observed laying on an LAL mattress. The LAL relieving mattress was set for the body weight of 180 lbs. (pounds). On 7/21/21 at 9:36 A.M., Resident 18 was observed laying on her left side on the LAL mattress. The LAL relieving mattress was set for the body weigh of 120 lbs. Resident 18's medical record was reviewed: Per the Monthly Weight, dated 7/5/21, Resident 18 was 85 lbs. Per the Physician's Order, dated 10/1/21, .LAL mattress for skin integrity maintenance . Per the Skin Care Plan, dated 4/12/21, included Approach .use LAL mattress for pressure reduction . mattress setting based of resident's weight . On 7/21/21 at 9:49 A.M., an interview with LN 7 was conducted. LN 7 stated she never touches the settings on the LAL mattress. LN 7 stated she was not sure if the maintenance staff adjusted the settings. On 7/21/21 at 9:57 A.M., an interview with CN 6 was conducted. CN 6 stated the setting of the LAL mattress depends on the resident's weight. CN 6 stated the RN or the CN were responsible for adjusting the settings on the LAL mattress, and the LNs were responsible for checking the settings daily. CN 6 stated the LAL mattress settings of Resident 18 on 7/19/21 and 7/21/21 was not correct. CN 6 stated the importance of adjusting the LAL mattress according to the resident's weight was to maintain the integrity of the skin and to protect the skin. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/21/21 at 2:52 P.M., an interview with TN 2 was conducted. TN 2 stated the LAL mattress was to be adjusted according to the resident's weight and comfort. TN 2 stated she monitored the settings on the LAL mattress and the LN adjust the settings based on the resident's weight. TN 2 stated they did not have a record or a log to monitor the settings of the LAL mattress. TN 2 stated the importance of adjusting the LAL mattress properly was to provide comfort and maintain skin integrity. On 7/22/21 at 9:33 A.M., an interview with the DON was conducted. The DON stated the importance of adjusting the setting of the LAL mattress according to the Resident's weight was to help reduce pressure, provide comfort, maintain the integrity of the skin, and prevention of pressure ulcer from worsening. The DON stated nurses were expected to check the settings frequently and adjust the settings of the LAL mattress according to the resident's weight. A review of the facility's policy, dated 7/17, titled Prevention of Pressure Ulcer/Injuries, .Select appropriate support surfaces based on resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36471 Based on interview and record review, the facility failed to act upon the pharmacist's recommendation for the use of as needed psychotropic medication (a medication which affects the mind) for two of four sampled residents (44, 81) for unnecessary medication. This failure had the potential for missed opportunities to identify the use of unnecessary psychotropic medication for Resident 44 and 81. Findings: 1. Resident 81 was admitted to the facility on [DATE] with diagnoses which included Anxiety, per the facility's Resident Face Sheet. A review of Resident 81's medical record was conducted. Per the Physician Order Report, dated 6/26/20, Resident 81 may receive Alprazolam (a psychotropic medication used to relieve symptoms of anxiety) 0.5 mg one tablet three times a day PRN. There was no end date per the Federal regulation. Per the Medication Regimen Review Binder, dated 6/20 through 6/21, there was no documented evidence Resident 81's psychotropic medication was reviewed by the CP. On 7/22/21 at 1:16 P.M., a joint interview and record review of the CP's Recommendation Notes was provided by the CP. The CP stated psychotropic medications should not be ordered beyond 14 days. The CP stated he wrote recommendations for Resident 81's Alprazolam PRN to the physician multiple times requesting to document the rationale and determine the duration. Per the Consultant Pharmacist's Recommendation Note for Resident 81, dated 9/30/20, 3/31/21, and 6/30/21, the CP wrote, . Patient has been on Xanax (Alprazolam) 0.5 mg PO TID for Anxiety since 6/26/2020. PRN for psychotropic medications, which are NOT antipsychotic medications are limited to 14 days. please assess the continued use of this PRN medication. On 7/22/21 at 3 P.M., an interview with the DON was conducted. The DON stated the CP comes in to the facility and made recommendation. The MRR was then electronically send to her account and she then address it. The DON stated she was unsure what happened to the MRR that the CP recommended for Resident 81 and why it was not in the binder. The DON further stated the CP recommendation should have been given to the physician to address the issue and it was not. 42644 2. Resident 44 was readmitted to the facility on [DATE] with diagnoses which included anxiety (a mental disorder characterized by excessive worrisome), per the facility's Resident Face Sheet, Per the facility's Physician Order, on 12/11/20 the physician wrote an order for Resident 44 for an as needed (PRN) psychotropic medication to treat anxiety. The end date read, Open Ended. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/21 at 1:16 P.M , a telephone interview was conducted with the CP. The CP stated he reviewed medications at least every month at the facility. The CP stated he wrote recommendations for Resident 44 and 81's PRN psychotropic medication to the physician multiple times. He further stated, psychotropic medication should not be ordered beyond 14 days. The CP stated the review of psychotropic medications was important to assess the appropriateness of the medications and to ensure minimum effective dose was ordered. Per the Consultant Pharmacist's Recommendation Note for Resident 44 on 12/31/20, 3/31/21, and 6/30/21, the Pharmacist wrote, . Patient has been on Lorazepam 0.5 mg PO BID for Anxiety since 12/11/2020. PRN for psychotropic medications, which are NOT antipsychotic medications, are limited to 14 days. please assess the continued use of this PRN medication. On 7/22/21 at 2 P.M., an interview with the DON was conducted. The DON stated PRN psychotropic medication should not be ordered beyond 14 days. The DON stated PRN orders for psychotropic medications needed an end date for the prescriber to re-evaluate the continued needs of the medications. She further stated residents could have experienced side effects from the psychotropic medications if the prescriber did not assess the resident timely. According to the facility's policy, titled Psychotropic Medication Use revised March 2018, .18. PRN Psychotropic drug orders (other than PRN Antipsychotics) are limited to 14 days, the Attending Physician or prescribing practitioner shall document the rationale in the medical record and indicate a duration for the PRN order.21. The Attending Physician shall respond appropriately by changing or stopping problematic doses or medications . Per the Medication Regimen Reviews, revised 11/16, titled Medication Regimen Reviews, .The irregularity will be acted upon by the responsible person(s) in a timely manner, consistent with the urgency of the irregularity .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42910 Based on observation, interview, and record review, the facility failed to ensure a medications were secured in a shared bathroom when a medications were found in the a bag labeled for Resident's 69. This failure had a potential for other residents, visitors and unauthorized staff to have access to Resident 69's medications. Findings: Resident 69 was readmitted to the facility on [DATE], per the facility's Resident Face Sheet. A review of Resident 69's MDS, dated [DATE], had a BIMS (a cognitive assessment) score of 15 (13-15 indicated cognitively intact). On 7/19/21 at 8:56 A.M., an observation of Resident 69's shared bathroom was conducted. Inside the bathroom there was a blue plastic bag with several medication container labeled with Resident 69's name that were filled with pills. On 7/19/21 at 8:58 A.M., a concurrent observation and interview was conducted with the CM. The CM confirmed the medications found in the shared bathroom belonged to Resident 69. On 7/19/21 at 8:59 A.M., an interview with Resident 69 was conducted. Resident 69 stated the medications were brought in by a friend. An interview with LN 6 was conducted on 7/19/21 at 9 A.M. LN 6 stated the medications were not in the bathroom yesterday. LN 6 stated she did not know who put Resident 69's medications in the bathroom. On 7/22/21 at 9:22 A.M., an interview with the DON was conducted. The DON stated it was important to properly store the medications for the safety of the residents. The DON stated, storing of medications in a shared bathroom was not safe because other residents might take the medications. The DON stated staff were expected to check and secure medications for proper storage and disposal of medications. A review of the facility's undated policy and procedure, titled Medication Storage in the Facility, .Medications and biologicals are stored safely, securely, and properly .the medication supply is accessible only to licensed nursing personnel .

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	056330	A. Building B. Wing	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Reo Vista Healthcare Center	6061 Banbury St. San Diego, CA 92139

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39220 Based on interview and record review, the facility failed to consistently offer evening snacks to seven of 13 residents (Residents 34, 44, 61, 69, 79, 97, and 111), reviewed for Between Meal Snacks. This failure had the potential for residents to go to bed hungry. Findings: 1. Resident 79 was readmitted to the facility on [DATE], with diagnoses which included cerebral infarction (stroke), per the facility's Resident Face Sheet. Resident 79's BIMS (a cognitive assessment) score, dated 7/10/21, was 11 (score 8-11 indicates moderate impaired cognition). On 7/21/21 at 9:23 A.M., an interview was conducted with Resident 79 in his room. Resident 79 stated he was not offered any snacks in the evening, but he thought that was a good idea, because he would like to have something before he went to bed. 2. Resident 34 was readmitted to the facility on [DATE], with diagnoses which included hemiplegia affecting right dominate side (paralysis on one side of the body), per the facility's Resident Face Sheet. Resident 34's BIMS score, dated 5/24/21, was 15 (13-15 indicates intact cognition). On 7/21/21 at 9:26 A.M., an interview was conducted with Resident 34, as he sat in a wheelchair beside his bed. Resident 34 stated one particular CNA routinely offered him evening snacks, but if that CNA was not working, he would have to request a snack and they usually brought him pudding, which he did not like. 3. Resident 111 was readmitted to the facility on [DATE], with diagnoses which included cerebral ischemic attack (stroke), per the facility's Resident Face Sheet. Resident 111's BIMS score, dated 6/3/21, was 15 (13-15 indicates moderate cognition). On 7/21/21 at 9:34 A.M., an interview was conducted with Resident 111 in her room. Resident 111 stated a particular CNA always provided her with an evening snack when she was working. Resident 111 stated when other staff were working, they did not ask her if she wanted anything to eat in the evening. 4. Resident 69 was readmitted to the facility on [DATE], with diagnoses which included acute respiratory failure (the lungs inability to provide enough oxygen to the bloodstream), per the facility's Resident Face Sheet. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 69's BIMS score, dated 3/17/21, was 15 (13-15 indicates intact cognition). On 7/21/21 at 1:33 P.M., an interview was conducted with Resident 69 in her room. Resident 69 stated, No, staff did not offer her snacks in the evening and she thought that would be a good idea. 5. Resident 61 was admitted to the facility on [DATE], with diagnoses which included congestive heart failure (an inability for the heart to pump effectively), per the facility's Resident Face Sheet. Resident 61's BIMS score, dated 6/4/21, was 10 (8-11 indicates moderately impaired). On 7/21/21 at 1:35 P.M., an interview was conducted with Resident 61 in her room. Resident 61 stated she was never offered an evening snack and she would like to have one. 6. Resident 97 was admitted to the facility on [DATE], with diagnoses which included quadriplegia (inability to move from the neck down), per the facility's Resident Face Sheet. Resident 97's BIMS score, dated 5/18/21, was 15 (13-15 indicates intact cognition). On 07/21/21 at 1:37 P.M., an interview was conducted with Resident 97 in her room. Resident 97 stated, No, I don't get anything in the evening and I would like something to hold me over. 7. Resident 44 was readmitted to the facility on [DATE], with diagnoses which included hemiplegia following cerebral infarction affecting left side (stroke with left sided weakness), per the facility's Resident Face Sheet. Resident 44's BIMS score, dated 5/6/21, was 14 (13-15 indicates intact cognition). On 7/21/21 at 1:42 P.M., an interview was conducted with Resident 44, as he laid in bed. Resident 44 stated he got a snack in the evening if he ask for one, that they were not routinely offered. On 7/21/21 at 4 P.M., an interview was conducted with CNA 16. CNA 16 stated all evening snacks were delivered on a roll cart and dispersed to residents between 8:30 P.M. and 9 P.M. CNA 16 stated all residents should be offered snacks. If a resident refused a snack, the charge nurse would need to be informed so they could document. On 7/21/21 at 4:05 P.M., an interview was conducted with CNA 6. CNA 6 stated evening snacks were distributed according to the name and room number listed on the snack. CNA 6 stated the CNAs were responsible for charting how much of the snack was consumed. CNA 6 stated if a snack was refused, the charge nurse should be informed and it would be charted. CNA 6 stated their evening snacks consisted of sandwiches, crackers, ice cream, pudding, milk, and juice. CNA 6 stated she only passed out snacks to the residents with their with names and room numbers on the snacks. On 7/21/21 at 4:12 P.M., an interview was conducted with CNA 18. CNA 18 stated evening snacks were brought to them between 7 and 8 P.M., on a push cart. The snacks were labeled for residents with diabetes (abnormal blood sugars) with their names and room numbers. CNA 18 stated if all the snacks were passed out and they had extra, they would offer it to other residents. CNA 18 stated if there were no extra snacks left and other residents wanted something, they would provide them with crackers. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/21/21 at 4:16 P.M., an interview was conducted with CNA 19. CNA 19 stated snacks come on a cart from the kitchen and were labeled with resident names and their room numbers. CNA 19 stated the snacks consisted of fruit, sandwiches, jello, pudding and graham crackers. CNA 19 estimated there were 40 snacks on the cart for one unit. On 07/21/21 at 4:23 P.M., an interview was conducted with LN 1. LN 1 stated snacks arrived with the assigned resident names and room numbers on them. LN 1 stated if other residents wanted an evening snack, she would go to the other nurses station to see what they had left on the cart. LN 1 stated the kitchen was closed and she did not have access to get additional snacks if it were requested. LN 1 stated snacks were only provided to those residents that had their names on the specific snacks. On 7/22/21 at 8:40 A.M., an interview was conducted with the RD. The RD stated she expected all residents to be offered snacks. The RD stated if snacks were not offered to all resident's, blood sugars could drop and she did not want any residents to feel hungry, because they did not have access to food. On 7/22/21 at 9:07 A.M., an interview was conducted with the DON. The DON stated she expected all residents to be offered evening snacks. The DON stated if not offered snacks, there was a potential for residents to go too long between meals without eating. According to the facility's policy, titled Snacks (Between Meal and Bedtime), Servings, dated 9/10, Purpose: The purpose of this procedure is to provide the resident with adequate nutrition .Documentation: .1. The date and time the snack was served .3. The amount of snack eaten by the resident .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39220 Based on observation, interview, and record review, the facility failed to maintain one of two freezers (stand alone) reviewed for kitchen sanitation. This failure had the potential for cross-contamination which could result in food-borne illness. Findings: On 7/19/21 at 8:14 A. M., during initial entrance of the kitchen, an observation was conducted with the RD, the RDC, and the DSSA, of the stand-alone freezer. Ice build-up was observed around the interior circumference of the freezer, from the top to the bottom. The freezer contained individual packaged servings of flavored ice cream. The freezer opened from the top with two doors. Multiple small brown and black particles were observed on top of the freezer door gaskets. Inside the freeze, on the base of the top left rack were dark debris items, estimated to be 1/2 inch in size, along with ice cream containers. The left, rear rack had an orange, gelatin like substance smeared on the back-side of the shelf. On 7/19/21 at 8:15 A.M., the RDC stated the freezer looked dirty and ice was built-up. The RDC used a knife to hit the ice build-up and stated, It's about a quarter inch thick. On 7/19/21 at 8:16 A.M., the DSSA stated the freezer was scheduled to be cleaned every Sunday, (would have been on 7/18/21). The DSSA stated they did not currently have a freezer log to document cleaning. On 7/19/21 at 8:17 A.M., the RD stated the freezer looked dirty and needed to be cleaned regularly, to prevent the risk of cross contamination. On 7/22/21 at 9:07 A.M., an interview was conducted with the DON. The DON stated she expected the kitchen and all of its equipment to be cleaned, maintained and documented on a regular basis to prevent cross contamination. According to the facility's policy, dated 2018, titled Refrigerator and Freezer, .1. Refrigerator and freezer should be cleaned on a weekly cleaning schedule .5. Wipe down gaskets with soapy water. 6. Remove all items and clean shelves. Wipe with sanitizer .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42910 Based on observation, interview, and record review, the facility failed to accurately document a shower provided for one of 24 sampled residents (69), reviewed for documentation. As a result, Resident 69's medical record contained inaccurate documentation. Findings: Resident 69 was readmitted to the facility on [DATE] with diagnoses which included idiopathic peripheral autonomic neuropathy (occurs when the nerves that control involuntary bodily functions are damaged), per the facility's Resident Face Sheet. A review of Resident 69's MDS, dated [DATE], had a BIMS (a cognitive assessment) score of 15 (13-15 indicated cognitively intact). The ADL assessment indicated, Resident 69 needed one person assist with bathing. An interview was conducted on 7/20/21 at 10 A.M., Resident 69 stated she did not get her scheduled shower on 7/19/21. Resident 69 stated she had a scheduled shower with CNA 6. Resident 69 was informed by CNA 6 that she was the only CNA on the floor working and was unable to provide the scheduled shower. Resident 69 stated that CNA 6 returned at 10 P.M., to assist her with the shower and Resident 69 declined shower because she was tired. A record review of the facility's South Station shower schedule indicated, Resident 69 had scheduled shower on Mondays and Thursdays at PM (3-11) shift. A record review of Resident 69's Point of Care History, dated 7/19/21 through 7/31/21, CNA 6 documented that Resident 69 had a shower on 7/19/21 at 10:54 P.M. On 7/21/21 at 8:23 A.M., a subsequent interview with Resident 69 was conducted. Resident 69 stated she was never offered a shower after she declined on 7/19/21, and she felt sad about not having her scheduled shower. On 7/21/21 at 4:17 P.M., an interview with CNA 6 was conducted. CNA 6 stated the other CNAs were on break therefore was unable to give Resident 69 a shower. CNA 6 further stated that she documented that the shower was provided but was not. On 7/22/21 at 9:11 A.M., an interview with the DON was conducted. The DON stated, her expectations for staff was to report or communicate to the incoming staff the care to be provided for the residents. The DON stated it was important to be accurate in documenting the care provided to the residents to avoid miscommunication. A review of the facility's policy, revised 7/17, titled Charting and Documentation, .Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate .