STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335695	A. Building B. Wing	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manhattanville Health Care Center	311 W 231st Street Bronx, NY 10463

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351 Based on record review and staff interviews conducted during the Recertification survey from 3/9/23 to 3/16/23, the facility did not ensure that comprehensive person-centered care plans were developed and implemented for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychological needs that are identified in the comprehensive assessment for 2 of 10 residents (Resident #26, Resident #29) reviewed for Accidents out of a total sample of 38 residents. Specifically, a Comprehensive Care Plan (CCP) had not been developed for safety measures related to smoking for Resident #26 and Resident #29. The findings are: The facility's policy and procedure titled Comprehensive Care Planning reviewed 1/23 documented Comprehensive Care Plan (CCP) shall be developed through an interdisciplinary team approach and CCP team review each resident's own unique personal needs in an integrated and coordinated manner. 1. Resident #26 was admitted to the facility with diagnoses of Depression, Non-Alzheimer's Dementia, and Diabetes Mellitus. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #26 had severely impaired cognition and required supervision for locomotion on and off unit. The Social Services progress note dated 6/20/22 documented that the Social Worker reviewed the facility's smoking policy with Resident #26 and resident's signature was obtained. Family was contacted and notified via voicemail. Review of the electronic medical record revealed that there was no documented evidence that a CCP for smoking was developed. 2. Resident #29 was admitted to the facility with diagnoses of Non-Alzheimer's Dementia, Schizophrenia, and Diabetes Mellitus. The Annual Minimum Data Set (MDS) assessment dated [DATE] documented cognition was moderately impaired and required supervision with locomotion on and off the unit. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Service progress note dated 7/20/22 documented Social Worker met with Resident #29 who stated that resident previously smoked years ago and wished to resume smoking again. Smoking policy was reviewed and signed by the resident. Review of the Comprehensive Care Plan (CCP) revised 12/26/22 revealed there was no documented evidence that CCP for smoking was developed. On 3/14/23 at 11:36 AM, Social Worker (SW) #1 was interviewed and stated that they are responsible for initiating and updating care plans for cognition, mood, advance directives, discharge planning, COVID-19, and abuse. For a resident who is identified as a smoker, they will also have a smoking care plan that is initiated and updated by the social worker. SW #1 also stated that when a resident is identified as a smoker, the social worker will review the smoking policy and obtain a signature from the resident to ensure resident agrees to the smoking policy. SW #1 further stated that there are not too many smokers in the facility and therefore, SW #1 did not realize that a care plan had not been created and this was an oversight. On 3/13/23 at 12:50 PM, the Director of Social Work (DSW) was interviewed and stated the care plan for smoking is to be initiated when a resident is identified as a smoker. The resident and their family are educated on the facility's smoking policy and once they agree, signatures are obtained. The DSW was asked to review the smoking care plan for Resident #26, Resident #29 and after reviewing the medical record, the DSW acknowledged that a CCP for should have been developed for both residents once they were identified as smokers. 415.11(c)(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39136 Based on record review and interview conducted during the Recertification survey from 3/9/23 and 3/16/23, the facility did not ensure that resident's comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Specifically, the Comprehensive Care Plans (CCPs) for residents with significant weight loss were not updated and revised. This was evident for 3 of 6 residents reviewed for Nutrition out of 38 sampled residents. (Residents #18, #17, and #22,). The finding is: The facility Policy for Comprehensive Care Planning dated 11/1997, last revised 01/2023 documented that A Comprehensive Care Plan for each resident shall be developed through an interdisciplinary team approach. A Comprehensive Care Plan (CCP) team has been established to review each resident's own unique personal needs in an integrated and coordinated manner. Reviews are conducted on initial admission, readmission, hospital return, significant change of status and quarterly thereafter. 1. Resident #18 was admitted to the facility with diagnoses including Coronary Artery Disease and Dementia. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #18 was severely cognitively impaired, had a weight loss of 5% or more in the last month or a loss of 10% over the previous six months, and was not on a physician prescribed weight loss program. A Dietary Progress Note dated 10/12/22 at 1:16 PM documented that Resident #18 was triggered for undesired/unplanned significant weight loss for three months. The Quarterly MDS assessment dated [DATE] documented that Resident #18 was severely cognitively impaired, had a weight loss of 5% or more in the last month or a loss of 10% in the previous six months, and was not on a physician prescribed weight loss program. The Dietary Progress Note dated 12/28/22 documented that Resident #18 is triggered for unexpected/undesirable significant weight loss for six months. There was no documented evidence that the CCP for nutrition had been reviewed and revised after the MDS assessments on 10/7/22 and 12/30/22 which indicated that resident had a significant weight loss. 2. Resident #71 was admitted to the facility with diagnoses that include Anxiety Disorder, Bipolar Disorder, and Dementia The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that Resident # 71 was severely cognitively impaired, had a weight loss of 5% or more in the last month or a loss of 10% over the previous six months, and was not on a physician prescribed weight loss program. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Dietary Note dated 10/8/22 at 12:59 PM documented that Resident #71 is triggered for undesired/unplanned significant weight loss x 3 month. The Quarterly MDS assessment dated [DATE] documented that Resident #71 was severely cognitively impaired, had a weight loss of 5% or more or loss of 10% or more in last 6 months and was not on a physician-prescribed weight-loss regimen. A Dietary Progress Note dated 12/27/22 at 2:04 PM documented that Resident #71 weight loss is possibly related to disease progression. A Comprehensive Care Plan titled Nutrition Status was initiated on 2/28/17 and was last revised on 2/10/22. There was no documented evidence that the CCP for nutrition had been reviewed and revised when resident was identified with significant weight loss and after MDS assessments on 10/1/22 and 12/21/22. On 03/15/23 at 2:45 PM, an interview was conducted with the Registered Dietician (RD) who stated that care plans are updated after every assessment and when there is a significant nutritional change. The RD also stated Resident #71 was triggered for significant weight loss, so the care plan was updated on 3/13/23 with no new interventions added. On 03/16/23 at 9:55 AM, an interview was conducted with the Director of Nursing (DON) who stated that the Dietician is responsible for updating the nutrition care plan. The DON also stated that the regional consultant is responsible for overseeing the Dietician and the care plans are supposed to be updated every quarter, and after a significant change. 40565 3. Resident #22 was admitted to the facility with diagnoses that included Coronary Artery Disease, Cerebrovascular Accident, Non-Alzheimer's Dementia, and Depression. The Quarterly Minimum Data Set (MDS) dated [DATE] documented the resident had severe impairment in cognition with long and short-term memory problems. The MDS documented the resident is required extensive assistance of staff for most activities of daily living including eating and that the resident holds food in mouth/cheeks. The Annual MDS dated [DATE] and Quarterly MDS dated [DATE] documented that Resident #22 had a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months documented, and was not on a physician-prescribed weight-loss regimen. The Comprehensive Care Plan (CCP) for Nutritional Status dated 12/16/2013, last updated 2/17/2022, documented that Resident is on the therapeutic diet secondary to Significant weight, loss: x 3 months (~ -12. 37%), 6 months (~-14.62%). Goals included: - Resident will be adequately nourished as evidenced by absence of significant weight loss; Resident laboratory report(s) will be clinically stable per MD. Resident will continue to consume >75% of meals served x 90 days. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Long Term Care Survey Process (LTCSP) weight calculator documented On 09/13/2022, the resident weighed 152 lbs. On 03/06/2023, the resident weighed 123 pounds which is a -19.08 % Loss. This weight loss occurred over a 6 month period. The LTCSP weight calculator also documented On 02/22/2023, the resident weighed 129.6 lbs. On 03/06/2023, the resident weighed 123 pounds which is a -5.09 % loss. This weight loss occurred over a 12-day period. Progress Notes Dietary dated 12/24/2022 documented: Quarterly Assessment: .Current nutritionally pertinent medication includes . mirtazapine, Prilosec. Note: Mirtazapine - may increase appetite. There are no current nutrition related labs.Current Wt:131.5 (12/5) Ht: 66 in. Past Weight: 126.6 lbs. (11/14), 138 lbs. (10/14), 138 lbs. (9/30), 157.8 lbs. (8/16), 157.4 lbs. (7/19), 156 lbs. (6/21), 154.2 lbs. (5/31). Current BMI: 21. 2 - WNL - low for geriatric age. Continues to trigger for unplanned/undesirable weight loss in 3 months ~12. 37% and 6 months ~14.62% There was no documented evidence that the nutrition care plan was reviewed and revised since 2/17/2022 after MDS assessments or to reflect the documented weight loss or interventions to address the weight loss. On 03/14/23 at 11:08 AM, an interview was conducted with the Certified Nursing Assistant (CNA) #1 who stated that Resident #22 had been noted with some weight loss when transferred to the unit a few months ago and this was reported to the nurse. On 03/14/23 at 11:41 AM, an interview was conducted with the Charge Nurse, Licensed Practical Nurse (LPN) #1 who stated that the Resident's meal intake is documented by the CNAs in the CNA Accountability Record (CNAAR). LPN #1 also stated that Resident #22 was noted with some weight loss when transferred to the unit. LPN #1 further stated that any weight loss is discussed with the dietician who is responsible for reviewing and updating the resident's nutrition care plan. On 03/14/23 at 12:03 PM, an interview was conducted with the Registered Dietitian (RD) #1 who stated that the first assessment and quarterly evaluation was done in December 2022. RD #1 stated that when the nurses document the weight in the electronic medical record, at the end of the month, it is checked, and the weight is put in the meal tracker to generate a report. When the meal tracker was checked at the end of January, no changes were identified with Resident 22's weight loss. RD #1 further stated that they had planned to re-assess the resident at the end of the next quarter, which is currently due, and then update the CCP. RD #1 stated that they were not aware that the resident's care plan should be updated at every assessment. On 03/16/23 at 08:55 AM, an interview was conducted with the Registered Nurse Supervisor (RNS) #1. RNS #1 stated that monthly weight is done for a stable resident, and any resident observed with weight loss of 5% from the previous weight is reported to the dietician and then reported to the doctor for further intervention. The resident's weight will be monitored weekly until the weight is stabilized. RNS #1 stated that it is the responsibility of the dietician to update the nutrition care plan whenever there is significant weight change. RNS #1 further stated that they did not know that the resident's CCP for nutrition was not being updated. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/16/23 at 09:21 AM, an interview was conducted with the Director of Nursing (DON) who stated that if a resident is observed with significant weight loss, nursing staff will notify the doctor and the dietician. A calorie count will be recommended and ordered, and depending on the physician, the resident may be given appetite stimulant, and weekly weight monitoring. It will also be discussed by the interdisciplinary team. The DON also stated that the care plan must be updated by the dietician. The DON further stated that every discipline is required to update their care plan based on their clinical areas. 415.11(c)(2)(i-iii)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40565 Based on record review and staff interviews, the facility did not ensure that residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range. Specifically, the facility did not effectively monitor a resident that was at risk for weight loss and weight fluctuations with a weight loss of 19.08 % in 6 months, and 5.09% in less than 1 month. This was evident for 1 of 6 residents reviewed for Nutrition out of a sample of 38 residents investigated. (Resident # 22). The findings are: The facility's policy titled Weights dated 05/06, last revised 01/2023 documented: A loss or gain of 3lbs a week and 5lbs a month will be communicated by CNA to the Charge Nurse and a reweigh will be done in the presence of the Charge Nurse for validation. A confirmed weight loss or gain will be communicated to MD/NP, RD, NOK and documented in the CCP (Comprehensive Care Plan) with corresponding intervention. Resident #22 was admitted with diagnoses that included Cerebrovascular Accident (CVA), Non-Alzheimer's Dementia, and Depression. The Quarterly Minimum Data Set (MDS) dated [DATE] documented the resident had severe impairment in cognition with long and short-term memory problems. The MDS also documented that the resident was extensive assistance of staff for most activities of daily living including eating. The MDS further documented that Resident #22 holds food in mouth/cheeks, and had a loss of 5% or more in the last month or loss of 10% or more in last 6 months and was not on a physician-prescribed weight-loss regimen. The Comprehensive Care Plan (CCP) for Nutritional Status dated 12/16/2013, last updated 2/17/2022, documented that Resident is on therapeutic diet secondary to Significant weight loss: x 3 months. Goals included that Resident will be adequately nourished as evidenced by absence of significant weight loss, resident's laboratory report(s) will be clinically stable per MD, and resident will continue to consume >75% of meals served x 90 days. Interventions included check lab values on a routine basis, monitor intake and tolerance to diet, monitor weight, observe for visual signs and symptoms of poor nutrition or hydration status, and provide diet per MD order (NAS diet, with chopped consistency and honey thick liquids). The Long Term Care Survey Process (LTCSP) weight calculator documented On 09/13/2022, the resident weighed 152 lbs. On 03/06/2023, the resident weighed 123 pounds which is a 19.08 % loss. This weight loss occurred over a 6 month period. The LTCSP weight calculator also documented On 02/22/2023, the resident weighed 129.6 lbs. On 03/06/2023, the resident weighed 123 pounds which is a -5.09 % loss. This weight loss occurred over a 12-day period. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress Notes Dietary dated 12/24/2022 documented: Quarterly Assessment: .Current nutritionally pertinent medication includes . mirtazapine, Prilosec. Note: Mirtazapine - may increase appetite. There are no current nutrition related labs.Current Wt:131.5 (12/5) Ht: 66 in, Past weight: 126.6 lbs. (11/14), 138 lbs. (10/14), 138 lbs. (9/30), 157.8 lbs. (8/16), 157.4 lbs. (7/19), 156 lbs. (6/21), 154.2 lbs. (5/31). Current BMI: 21. 2 - WNL - low for geriatric age. Continues to trigger for unplanned/undesirable weight loss in 3 months ~12. 37% and 6 months ~14.62% Progress Note Medical dated 12/20/2022 documented that resident was seen and examined secondary to exposure to COVID-19, weights documented by MD are 131.5lbs (12/05/22); 126.6lbs (11/14/22); 138lbs (10/14/22, and 157.8lbs (8/16/22). This was a 16.67 % loss between 8/16/22 and 12/5/22. There was no documented evidence of interventions to address the resident's significant weight loss of over 16% in 4 months. Progress note Medical -Physician's Monthly Progress dated 3/13/2023 documented that Resident seen and examined 3/13/2023 for monthly follow up. Weight loss, Aphasia, dementia; At risk for malnutrition secondary to multiple comorbidities, weight 123 pounds. There was no documented evidence of interventions to address the resident's significant weight loss and risk for malnutrition. On 03/14/23 at 11:08 AM, an interview was conducted with Certified Nursing Assistant (CNA) #1 who stated that Resident #22 can feed self with tray set up and has been completing between 25% and 75% of meals served. CNA #1 also stated that resident has been noted with some weight loss when transferred to the unit a few months ago and this was reported to the nurse. On 03/14/23 at 11:41 AM, an interview was conducted with the Charge Nurse, Licensed Practical Nurse (LPN) #1 who stated that Resident #22's meal intake is documented by CNA in the CNA Accountability Record (CNAAR). If a resident consumes less than 25% for 3 days, the dietician is notified to do a calorie count and weekly weights are recommended. LPN #1 also stated that based on the resident's weight, Resident #22 was noted with some weight loss when transferred to the unit. LPN #1 further stated that they do not remember doing a calorie count for the resident recently, and weekly weights had not been recommended by the dietician or by the Physician. On 03/14/23 at 12:03 PM, an interview was conducted with the Registered Dietitian (RD) who stated that per documentation reviewed, resident requires assistance of staff for eating and has been consuming over 75% of the meals based on the data generated from the CNAAR. The RD also stated that they had never observed the resident eating during meals, and the first assessment and quarterly evaluation was done in December. The RD further stated that as per the assessment, resident was triggered for undesired weight loss, probably due to the worsened dementia, as at that time, it was documented that resident was consuming only about 25% of food. The RD stated that they planned to re-assess the resident at the next quarter, which is currently due. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/16/23 at 08:55 AM, an interview was conducted with the Registered Nurse Supervisor (RNS) #1. RNS #1 stated that monthly weight is done for a stable resident, and any resident observed with weight loss of 5% from the previous weight is reported to the dietician and the doctor so necessary interventions can be given. The resident's weight will be monitored weekly until the weight is stabilized. RNS #1 also stated that the dietician should have communicated the significant weight change of the resident to the doctor for new interventions to address the resident's weight loss. RNS #1 stated that they believe that the resident's weight loss was discussed with the dietician by nursing staff, but they did not know why the dietician had not implemented necessary interventions for the weight loss. On 03/16/23 at 09:21 AM, an interview was conducted with the Director of Nursing (DON) who stated that if a resident is observed with significant weight loss, the nursing staff will notify the doctor and the dietician. A calorie count will be recommended and ordered, and depending on the physician, the resident may be given an appetite stimulant, along with weekly weight monitoring. It will also be discussed by the interdisciplinary team. The DON also stated the care plan must be updated by the dietician. The DON further stated that every discipline is required to update their care plan based on their clinical areas. The DON stated that they were not aware that the resident's significant weight loss was not appropriately addressed. On 03/16/23 at 11:53 AM, an interview was conducted with the Medical Director (MD) who stated that when a resident is observed with significant weight loss, we ask dietary to see if we need to offer supplements and appetite stimulant, and to continue monitoring the weight weekly until the resident is stable. The MD also stated that based on the record review, the former dietician had documentation regarding the resident's weight loss in November last year but Resident #22's weight loss had not been properly followed up on by the current dietician and the Attending Physician. The MD further stated that they were surprised that this was not done and the issue will be discussed with the staff and the attending physicians to prevent reoccurrence. 415.12(i)(1)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40565 Based on observation, record review and interview conducted during the Recertification survey from 3/9/23 to 3/16/23, the facility did not ensure that the medical care of each resident was supervised by a physician. Specifically, there was no documented evidence that the physician monitored changes in the resident's health status and provided interventions to address a resident's undesired significant weight loss over the period of 6 months. This was evident for 1 of 6 residents reviewed for Nutrition out of a sample of 38 residents investigated. (Resident # 22) The finding is: The facility's policy titled Physician dated 09/2016, last revised 02/2023, documented: Resident will be seen by Primary Physician/ Nurse Practitioner on Admission/ Readmission; Monthly (every 28-30 days); Significant Change; PRN/ as requested by resident/NOK The facility's policy titled Weights dated 05/06, last revised 01/2023, documented: A loss or gain of 3lbs a week and 5lbs a month will be communicated by CNA to the Charge Nurse and a reweigh will be done in the presence of the Charge Nurse for validation. A confirmed weight loss or gain will be communicated to MD/NP, RD, NOK and documented in the CCP (Comprehensive Care Plan) with corresponding intervention. Resident #22 was admitted with diagnoses that included Cerebrovascular Accident (CVA), Non-Alzheimer's Dementia, Hemiplegia, and Depression. The Quarterly Minimum Data Set (MDS) dated [DATE] documented the resident had severe impairment in cognition with long and short-term memory problems. The MDS also documented that Resident #22 required extensive assistance of staff for most activities of daily living including eating. The MDS further documented that Resident #22 holds food in mouth/cheeks, and had a loss of 5% or more in the last month or loss of 10% or more in last 6 months, and was not on a physician-prescribed weight-loss regimen. The Comprehensive Care Plan (CCP) for Nutritional Status dated 12/16/2013, last updated 2/17/2022, documented that Resident is on therapeutic diet secondary to Significant weight loss: x 3 months. Goals included that Resident will be adequately nourished as evidenced by absence of significant weight loss, resident's laboratory report(s) will be clinically stable per MD, and resident will continue to consume >75% of meals served x 90 days. Progress Notes Dietary dated 12/24/2022 documented: Quarterly Assessment: .Current nutritionally pertinent medication includes . mirtazapine, Prilosec. Note: Mirtazapine - may increase appetite. There are no current nutrition related labs.Current Wt:131.5 (12/5) Ht: 66 in, Past weight: 126.6 lbs. (11/14), 138 lbs. (10/14), 138 lbs. (9/30), 157.8 lbs. (8/16), 157.4 lbs. (7/19), 156 lbs. (6/21), 154.2 lbs. (5/31). Current BMI: 21. 2 - WNL - low for geriatric age. Continues to trigger for unplanned/undesirable weight loss in 3 months ~12. 37% and 6 months ~14.62% (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress Note Medical dated 12/20/2022 documented that resident was seen and examined secondary to exposure to COVID-19, weights documented by physician were 131.5lbs (12/05/22); 126.6lbs (11/14/22); 138lbs (10/14/22, and 157.8lbs (8/16/22) which represented a 16.67 % loss between 8/16/22 and 12/5/22. There was no documented evidence of interventions to address the resident's significant weight loss of over 16% in 4 months. The Long Term Care Survey Process (LTCSP) weight calculator documented On 09/13/2022, the resident weighed 152 lbs. On 03/06/2023, the resident weighed 123 pounds which is a -19.08 % Loss. This weight loss occurred over a 6 month period. The LTCSP weight calculator also documented On 02/22/2023, the resident weighed 129.6 lbs. On 03/06/2023, the resident weighed 123 pounds which is a -5.09 % loss. This weight loss occurred over a 12-day period. Progress note Medical -Physician's Monthly Progress dated 3/13/2023 documented that Resident seen and examined 3/13/2023 for monthly follow up. Weight loss, Aphasia, dementia; At risk for malnutrition secondary to multiple comorbidities, weight 123 pounds. There was no documented evidence of interventions to address the resident's significant weight loss and risk for malnutrition. On 03/14/23 at 11:41 AM, an interview was conducted with the Charge Nurse, Licensed Practical Nurse (LPN) #1 who stated that Resident #22's meal intake is documented by CNA in the CNA Accountability Record (CNAAR). If a resident consumes less than 25% for 3 days, the dietician is notified to do a calorie count and weekly weights are recommended. LPN #1 also stated that based on the resident's weight, Resident #22 was noted with some weight loss when transferred to the unit. LPN #1 further stated that they do not remember doing a calorie count for the resident recently, and weekly weights had not been recommended by the dietician or by the Physician. On 03/14/23 at 12:03 PM, an interview was conducted with the Registered Dietitian (RD) who stated that per documentation reviewed, resident requires assistance of staff for eating and has been consuming over 75% of the meals based on the data generated from the CNAAR. The RD also stated that they had never observed the resident eating during meals, and the first assessment and quarterly evaluation was done in December. The RD further stated that as per the assessment, resident was triggered for undesired weight loss, probably due to the worsened dementia, as at that time, it was documented that resident was consuming only about 25% of food. The RD stated that they planned to re-assess the resident at the next quarter, which is currently due. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/16/23 at 08:55 AM, an interview was conducted with the Registered Nurse Supervisor (RNS) #1 who stated that monthly weight is done for a stable resident, and any resident observed with weight loss of 5% from the previous weight is reported to the dietician and the doctor so necessary intervention can be done. The resident's weight will be monitored weekly until the weight is stabilized. RNS #1 also stated that the dietician should have communicated the significant weight change of the resident to the doctor for new interventions to address the resident's weight loss. The RNS stated that they believe that the resident's weight loss was discussed with the dietician by nursing staff, but they did not know why the dietician had not implemented necessary interventions for the weight loss. On 03/15/23 at 12:47 PM, an interview was conducted with the Attending Physician (AP) #1 who stated that Resident #22 was seen regularly. Resident #22's labs were reviewed, the most recent labs were normal, and resident was stable metabolically. AP #1 also stated that Resident #22's weight loss is due to multiple comorbidities and the last time the resident was seen, the resident was talking, and was noted to be clinically stable. AP #1 was unable to explain why there was no documented evidence of any planned interventions to address the resident's significant weight loss. On 03/16/23 at 09:21 AM, an interview was conducted with the Director of Nursing (DON) who stated that if a resident is observed with significant weight loss, the nursing will notify the doctor and the dietician, calorie count will be recommended and ordered, and depending on the physician, the resident may be given appetite stimulant, and weekly weight monitoring. It will also be discussed by the interdisciplinary team. The DON stated the care plan must be updated by the dietician. The DON further stated that every discipline is required to update their care plan based on their assigned care areas. On 03/16/23 at 11:53 AM, an interview was conducted with the Medical Director (MD) who stated that when a resident is observed with significant weight loss, we ask dietary to see if we need to offer supplements and appetite stimulant, and to continue monitoring the weight weekly until the resident is stable. The MD also stated that based on the record review, the former dietician had documentation regarding the resident's weight loss in November last year but Resident #22's weight loss had not been properly followed up on by the current dietician and the Attending Physician. The MD further stated that they were surprised that this was not done and the issue will be discussed with the staff and the attending physicians to prevent reoccurrence. 415.15(b)(1)(i)(ii)

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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** 45351 Based on observations, record review, and staff interviews during the Recertification survey conducted from 3/9/23 to 3/16/23, the facility did not ensure that a Medication Regimen Review (MRR) performed by the Consultant Pharmacist was reviewed and acted upon by the attending physician or medical director in a timely manner. This was evident for 2 of 5 residents (Resident #26 and Resident #71) reviewed for Unnecessary Medications Review out of a total sample of 38 residents. Specifically, 1). the physician did not act upon the consultant pharmacist's recommendations to attempt a gradual dose reduction (GDR) for residents receiving antidepressant medication, and 2). A pharmacy consultant recommendation for a Psychiatry consult to evaluate symptoms of depression and the therapeutic goals of Cymbalta was not completed. The findings are: The facility's policy and procedure titled Pharmacy Services with last revised date 2/2023 that the medication regimen of each resident must be reviewed at least once a month by licensed pharmacist. The pharmacist must report any irregularities to the Attending Physician, the facility Medical Director and the Director of Nursing and these reports must be acted upon. 1. Resident #26 was admitted to the facility with diagnosis of Depression, Non-Alzheimer's Dementia, and Diabetes Mellitus. The medical order initiated 2/9/22, renewed 2/14/23 documented resident to receive Cymbalta 1 capsule (20 mg) once daily at 10 AM and Cymbalta 1 capsule (60 mg) once daily at 10 PM for Major Depressive Disorder. Medical Order initiated 3/11/22 documented Mirtazapine 15 mg tablet once daily which was discontinued on 8/24/22. The medical order initiated 8/24/22, renewed 2/14/23 documented resident to receive Mirtazapine 7.5 mg tablet by oral route once daily at bedtime at 10 PM for major depressive disorder, recurrent, mild. The Medication Administration Record dated February and March 2023 documented Resident #26 received Cymbalta 1 capsule (20 mg) at 10 AM, Cymbalta 1 capsule (60 mg) at 10 PM, Mirtazapine 0.5 tablet (7.5mg) at 10 PM, during the entire month of February and to current date of March 2023. The pharmacy's Medication Regimen Review (MRR) dated 2/15/23 documented resident has two psychotropic medication orders (Cymbalta, Remeron) for at least 3-12 months that are now potentially due for a Gradual Dose Reduction (GDR) based on CMS guidelines. Recommended to evaluate if resident is a candidate for GDR and consider reduction in the total daily dose of either of the two psychotropic medication orders. The physician's response dated 2/16/23 documented to order a psychiatric consult and have psychiatrist evaluate if resident is a candidate for GDR. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the interdisciplinary notes from 2/16/23 to 3/13/23 revealed there was no documented evidence that resident was evaluated by psychiatrist for Gradual Dose Reduction for the two psychotropic medication orders. On 3/13/23 at 2:15 PM, Pharmacist was interviewed and stated that Resident #26 receives two antidepressant medications. Pharmacist stated last GDR recommendation was made back in August 2022 and it was agreed to decreased Remeron from 15 mg to 7.5 mg. Pharmacist stated the monthly pharmacy reviews are emailed immediately to Director of Nursing, Assistant Director of Nursing, Medical Director, and the Administrator. Pharmacy stated that another GDR was recommended for Resident #26's MRR dated 2/15/23. Pharmacist did not know if it was considered and ordered since March Medication Regimen Review was not done as of 3/13/23. On 3/14/23 at 10:56 AM, Attending Physician (AP #2) was contacted and stated that they will call back but did not return the call. On 3/15/23 at 11:05 AM, the Psychiatric Nurse Practitioner (PNP) was interviewed and stated that once they receive a referral, the referred resident will be seen and evaluated within 3 days of receiving referral. It is electronically submitted and recorded in the electronic medical record. The PNP also stated that Resident #26 was referred to evaluate capacity on 1/14/23 and the resident was seen/evaluated on 1/16/23 according to their record. The PNP further stated that there was no other pending consult for Resident #26 since 1/16/23. On 3/14/23 at 9:57 AM, the Medical Director (MD) was interviewed and stated that they also provide care for residents and was the physician responsible to review the MRR for month of February for Resident #26. The MD stated that they reviewed the pharmacist's recommendation on 2/16/23 and planned to discontinue Remeron for Resident #26. The MD further stated that it was an oversight and that Remeron was just discontinued as an attempt for GDR on 3/14/23. 39136 2. Resident #71 was admitted to the facility with diagnoses that include Anxiety Disorder, Bipolar Disorder, and Major Depressive Disorder. The Minimum Data Set 3.0 (MDS) assessment dated [DATE] documented Resident #71 had severely impaired and received antidepressants on five of seven days. A Medical Doctor Order (MDO) dated 04/28/22 documented that Resident #71 was to receive Cymbalta 30 mg capsule, delayed release, give one tablet (30 mg) by oral route once daily for Anxiety Disorder. A Pharmacy Consultant Note to Attending Physician/Prescriber dated 10/5/22 documented that Resident #71 has been on their current dose of Cymbalta since 4/8/22 and recommended to order a psychiatric consult and have the psychiatrist evaluate if the resident symptoms of depression and therapeutic goals are being adequately met by their current dose of Cymbalta. An MDO dated 11/10/22 documented a psychiatric consult was ordered to evaluate if the resident symptoms of depression and therapeutic goals are adequately met by their current dose of Cymbalta. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical records dated 11/11/22 to 3/16/23 revealed no documented evidence that Resident # 71 had received a psychiatric evaluation. On 03/15/23 at 12:35 PM, an interview was conducted with the Psychiatric Nurse Practitioner (PNP). The PNP stated that they have not seen Resident # 71 since they started working in the facility in November of last year. The PNP had a referral to see the Resident #71, but there was no consent, so they could not see them. The consent is obtained from the family or the resident if the resident has the capacity. They need new consent for the new year. An order to evaluate the use of the Cymbalta was received on 1/15/23 and 2/22/23. The Director of Nursing has been informed about the PNP's need for consent before they can see Resident #71. On 03/16/23 at 11:39 AM, an interview was conducted with the Attending Physician #3 (AP #3). AP #3 stated that they signed off on the recommendation but were unaware that the psychiatric provider had not seen Resident #71. AP #3 was not sure what had happened. AP # 3 was not aware that the psychiatric provider was waiting for a consent. On 03/16/23 at 11:11 AM, an interview was conducted with the Medical Director (MD). The MD does not know why the psychiatrist has not seen Resident # 71. They use an agency for psychiatry and psychology consults. If the psychiatric provider needs consent, they are responsible for obtaining it themselves. Any specialist must obtain their consent. The MD did not know that the NP did not see the resident because of consent. The PNP should have informed them they were waiting for consent before seeing the resident. On 03/16/23 at 10:01 AM, an interview was conducted with the Director of Nursing (DON). The DON stated they have a new PNP who started last year, in November. The PNP is asking for consent before they see the resident. The PNP informed them in January that they need consent for the resident. Resident # 71's Next of Kin (NOK) had been called about eleven times for a consent, but they had not yet responded. 415.18(c)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40565 Based on observations, record review, and staff interviews conducted during the Recertification survey from 3/9/23 to 3/16/23, the facility did not ensure infection control practices and procedures were maintained to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. Specifically, blood pressure (BP) cuffs were not cleaned/disinfected after use between residents. This was evident for 2 out of 6 licensed nurses observed during the Medication Administration task. The findings are: The facility's policy and procedure titled Cleaning and Disinfecting of Non-critical Medical Devices dated 03/17/2011, last revised 02/2023 documented: disinfect the blood pressure machine/cuff before each resident use by cleaning the blood pressure/cuff and wiping it with germicidal wipes. Always wear gloves when using germicidal wipes. On 03/13/23 at 09:26 AM, while observing Medication Administration on the 6th Floor, Licensed Practical Nurse (LPN) #1 was observed assessing Resident #147's blood pressure (BP) with a wrist BP cuff without sanitizing the cuff prior to use. LPN #1 then placed the cuff on the medication cart without sanitizing it. At 09:33 AM, LPN #1 approached Resident #50 and proceeded to check the resident's BP with the same BP cuff which had not been sanitized after use on the previous resident. On 03/13/23 at 9:40 AM, LPN #1 was interviewed and stated that the cuff is supposed to be sanitized before use on other residents but they forgot to sanitize it. On 03/13/23 at 09:59 AM, LPN #2 was observed during Medication Administration for Resident #24 on the 5th floor. LPN #2 checked the resident's BP with a wrist BP cuff without sanitizing the cuff prior to use on Resident #24 and placed the BP cuff on the medication cart after use without sanitizing it. At 10:10 AM, LPN #2 moved on to Resident # 94 and proceeded to check the resident's BP with the same BP cuff without sanitizing the cuff. On 03/13/23 at 10:15 AM, LPN #2 was interviewed and stated that the cuff should be sanitized between residents use but was not sanitized because they were nervous. On 03/16/23 at 08:46 AM, an interview was conducted with the Registered Nurse Supervisor (RNS) #1 who stated that the purple top sanitizer wipe is used to sanitize the BP cuff prior to use on the resident and in between resident's use. RNS #1 also stated that rounds are made around 5 times daily to monitor that staff are performing proper infection control practices while giving care to the residents and if any staff is observed not following proper protocol, in-service is given to ensure compliance. RNS #1 further stated that they have new nurses in the facility, and they will have to reinforce the education to ensure compliance. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/16/23 at 09:33 AM, an interview was conducted with the Director of Nursing (DON) who stated that the supervisors on the units are supposed to be monitoring the staff to ensure that the staff are practicing proper infection control. The DON also stated that they are surprised that the supervisors are not identifying these problems. The DON further stated that any staff observed not practicing the proper protocol is re-inserviced. 415.19 (b)(4)