STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525273	A. BUILDING ______ B. WING ______	C 01/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN KNOLLS AT BELOIT (THE)	**1905 W HART RD** **BELOIT, WI 53511**

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F 000	INITIAL COMMENTS This was a complaint survey conducted at Green Knolls At Beloit on 1/23/20 . Federal citations issued: 6 The most serious citation is F806 cited at a severity/scope level of J (Immediate jeopardy/Isolated). Census: 67 Sample size: 13	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to prevent abuse or the likelihood of abuse for 1 of 6 residents (R2) reviewed for abuse out of a total sample of 13. R2 was touched by R3 in her vaginal area without	F 600		

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

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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her consent. R3 had begun showing signs of inappropriate behaviors with staff in the preceding four days. No one assessed the risk that R3 might pose to residents and R3's care plan was not updated until 1/20/20, three days after the incident. R2 was trembling and "hysterical" after the incident and feels "uncomfortable" now when she sees R3.

This is evidenced by:
Facility Policy entitled "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property," revised October 2016, states, in part: " ...The Center prohibits the mistreatment, neglect, and abuse of residents and misappropriation of resident property by anyone including staff, family, friends, etc. The Center has designed and implemented processes, which strive to ensure the prevention and reporting of resident abuse, neglect, mistreatment, and/or misappropriation of property. ...Definitions: The Center acknowledges the following definitions: ...Willful - "Willful" means the individual intended the action itself that they knew or should have known could cause physical harm, pain or mental anguish. Even though a resident may have cognitive impairment, they still could commit a willful act. However, there are instances when a resident's willful intent cannot be determined. In those cases, a resident-to-resident altercation should be reviewed ... Abuse willful infliction of injury, unreasonable confinement, intimidation resulting in physical harm or pain or mental anguish, punishment with resulting physical harm or pain or mental anguish. ...The following definitions are not intended as all-inclusive but has examples to assist in the immediate identification and

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reporting of abuse and/or neglect ... Sexual Abuse includes, but is not limited to, humiliation, harassment, coercion or assault ..."

Per CMS (Centers of Medicare and Medicaid), "Sexual abuse" is defined at §483.5 as "non-consensual sexual contact of any type with a resident."

R2 is a 30 year old female, admitted on 6/18/19, with diagnoses that include: Bipolar disorder, major depressive disorder, generalized anxiety disorder, Chronic Post-Traumatic Stress Disorders (PTSD), and end-stage renal disease.

R2's MDS (Minimum Data Set), dated 10/26/19, indicates that R2 has a BIMS (Brief Interview of Mental Status) of 15 out of 15, indicating R2 is cognitively intact. R2 is able to ambulate independently.

R3 is an 87 year old male admitted, on 12/2/2019, with diagnoses that include: Cerebral infarction (stroke), hemiplegia (paralysis on one side), Dementia and alcohol abuse.

R3's MDS, dated 12/9/19, indicates that R3 has a BIMS of an 11 out of 15, indicating moderate cognitive impairment and that R3 requires 2 person physical assist with transfers.

R3's Stop & Watch Early Warning Tool, dated 12/30/19 at 9:00 AM, signed by TD F (Therapy Director) indicates the following: Seems different than usual, sexually inappropriate with all 3 therapy staff. This is not normal behavior with therapy staff and all 3 reported at different times. Form indicates this was reported to ADON C (Assistant Director of Nursing).

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On 12/30/19 at 11:23 AM, R3's Occupational Therapy (OT) Note, states, in part: " ...Today pt (patient) was making inappropriate comments about therapists breasts and what he wanted to do with them. Pt needed max (maximum) redirection to task ..."

On 12/30/19 at 4:57 PM, R3's Speech Language Pathologist (SLP) Note states, in part: " ...Unfortunately pt was making sexual comments to Writer. SLP informed pt that he needs to speak to his caregivers like he would talk to his sister or his mother (attempting to convey the concept of non-sexual topics). Pt continued to make comments that were disrespectful and after a second re-direction and he still continued, SLP had to end session early because of behaviors. SLP discussed this with therapy team including DOR (Director of Rehab) ..."

On 12/30/19, (no time), TD F's written statement regarding R3 states: "Resident making sexually inappropriate comments to all 3 therapy staff members (PT (Physical Therapist)/OT (Occupational Therapist)/ST (Speech Therapist)). This is not reported as normal behavior. ADON (Assistant Director of Nursing) (ADON C's name) notified in AM at morning meeting. Nurse notified and report that no report from CNA (Certified Nursing Assistant) staff at this time. This Writer concerned of medical change to be causing this. Nurse to follow up. Social Worker (SW K) notified of the behaviors and will follow up with resident. Stop & Watch form filled out and provided to ADON."

R3's Nurses Note, dated 12/30/19 at 8:00 PM, indicates no inappropriate comments.

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(No further Nursing Notes indicated for monitoring R3 for inappropriate comments)

R3's Incident Report, dated 1/17/20 at 6:28 PM, filled out by LPN J (Licensed Practical Nurse), states, in part: " ...This nurse was notified that a resident reported that (R3) had touched her in an inappropriate way while she was sitting in the dining room. This nurse was at the nursing station when the incident took place. Resident was removed from dining room immediately. ...When this nurse asked resident what happened in the dining room, his response was I heard that it was snowing outside so I wheeled to the dining room to look out of the window. This nurse asked resident if he did anything that he should not have done while in the dining room. Resident response was "What are you talking about?" this nurse replied with "Did you touch any one while you were in the dining room?" Resident replied "No, I didn't do anything." This nurse then replied with "Another resident is saying that she was touched in an inappropriate way by you." The resident replied "No, I wouldn't touch anyone, I said Hi to a few people and that was it." ... Residents separated immediately. Resident placed one on one. Police were called ..."
(Please note that R3 refused to sign a Witness Investigation Statement, on 1/17/20 at 4:00 PM, which says verbatim what R3's Incident Report says.)

R2's Incident Report, dated 1/17/20 at 6:29 PM, filled out by LPN I, states, in part: "Resident approached nurse in the hall at med cart crying and shaking repeating "That man touched me." Writer asked what happened. Who touched her and was she hurt? Resident said she was unsure who the old man was. She took Writer to the

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MDR (main dining room) to point the resident out she was talking about. ...Resident stated while in the MDR playing games on her phone the resident in question put his hand on her leg, her legs where [SIC] crossed, then put his hand between her legs. States when she said "No!" he wheeled away in his wheelchair. States she came to get Writer immediately. Immediate action taken: ..."Writer immediately took resident out of the MDR and to the nursing station where she called ADON. Writer called 911 to report incident and request an officer come to facility. Skin check done, no physical marks noted. DON (Director of Nursing) notified along with (Physician Name) whom was on call for (Physician Name). Resident did not want Writer to contact any family regarding matter. When resident came to nursing station following resident, Writer escorted him to the other side of the building. Resident was placed on 1-1 (one-on-one) supervision ..."

On 1/17/20, R2's Witness Investigation Statement, signed by R2, states: "I was sitting at my table on my phone, the man put his hand on my lap. My legs were closed but he put his hand further to my crotch. "I, said no" he then wheeled away. I then went and got my nurse (LPN I) right away."

On 1/17/20, LPN I's Witness Investigation Statement, signed by LPN I on 1/17/20, states: "Resident came to med cart where I was doing med pass down the hall crying. Resident stated a man touched her while in the dining room. I asked her who, she took me to the MDR to point him out. Writer took resident to nursing station, called ADON for instructions. 911 called to report incident and request officers to come. Resident (R3) came to nursing station where Resident (R2)

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was. Writer took him immediately to other side of building. Resident placed on 1-1 supervision. (Physician Name) on call for (Physician Name) notified. DON updated, RN (Registered Nurse) supervisor starting reportable, awaiting police arrival.

On 1/17/20, R3's Nurses Notes, dated 1/17/20 (no time), states: "Another resident stated that resident touched her in an inappropriate manner while she was in the dining room at 1545 (3:45 PM). Residents were separated immediately and this resident (R3) was immediately placed (with) one on one supervision. Police were called. This nurse questioned resident about incident & resident stated that he did not know what this nurse was talking about & stated that he went to the MDR to see the snow. He became angry as this nurse questioned him & denied touching another resident. Police arrived & questioned both residents. Investigation will continue. Resident has continued on one on one since incident. DON notified. MD (Medical Doctor) notified. Resident's son notified with permission of resident. Incident report completed staff to continue to monitor." (Signed by LPN J)

On 1/17/20 at 4:40 PM, R2's Nurses Note states, in part: "Resident reported another resident touched her inappropriately while in the MDR states resident placed hand on legs then between legs at her vagina. Resident told him "No" then he wheeled away. Writer called ADON to report, 911 called officer to come. (Physician Name) on call notified. Skin check done no concerns. Resident with Writer for comfort. Other resident placed on 1-1 supervision. Resident does not want any family called at this time awaiting police arrival."

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On 1/17/20 at 6:20 PM, R2's Nurses Note states: "(City name) police arrived at facility. Officer questioning resident, Resident refused to have Writer present stated, "I'm ok to do this." (Please note there is no further documentation or Nurses Notes indicating staff are monitoring or following up with R2 after the incident on 1/17/20.)

R3's Individual Care Plan Conference form, dated 1/20/20, indicates R3's son, SW, DON and ADON met indicating that R3 has had a significant change and R3's son has never seen R3 have this type of behavior, although he has been different since his stroke.

R3's Mood and Behavior Symptom Assessment Care Plan, dated 1/20/20, indicates resident touched another resident's vagina, Goal: resident will not repeat this behavior, will exhibit social appropriate behaviors; Goal Date: 4/20/20; Interventions: 1:1 while awake and 15 minute checks while sleeping. (Please note R3's care plan was updated 3 days after the incident and there are no other interventions, goals or assessments indicated for R3 on this Mood/Behavior Care Plan.)

On 1/23/20, Surveyor received a copy of facility's time line of events for R2 and R3's incident on 1/17/20, which is as follows:

1/17/20 (no time) - incident reported by (R2) to (LPN I) that a male resident touched her inappropriately. While she was talking to (LPN I) R2 said resident had started following her to the door. (LPN I) sent the resident to his room. Male resident was immediately put on a 1:1 watch for safety. (R2) was notified that male resident is now

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on 1:1 watch and she is to notify staff if she feels uncomfortable at any time. She was asked if she wanted staff to inform her family. She stated she would call her dad. Immediately the following people were notified of the incident: State, DON, ADON, Social Services Director (SSD), Administrator and Physician notified. Male resident's son was notified of the incident.

1/18/2020 to current date - (no time) Male resident kept on 1:1 with staff. No problems or negative interactions with any residents or staff.

1/20/2020 - (no time) continued investigation. Care plan with SSD, DON and son of male resident. Explained the situation. He has never seen this behavior before. He has noticed differences in his dad's behavior since his stroke. It was decided that an alternative placement would be sought for his dad that will be able to better handle his needs.

1/21/2020 - (no time) DON and SSD met with (R2) to discuss that it was reported that a female resident asked her to point out the resident that this occurred with the previous day after dinner. [sic] She said she did not see him. The male resident was sitting across the room, (R2) has poor distance eye site. (R2) admitted to us (DON and SSD) that it made her very uncomfortable to be asked by the female resident in front of everyone. The DON and I walked (R2) into the dining room. As soon as she looked in the door, she pointed out the male resident. It was the one she had identified when it happened. It was again explained to (R2) that the male resident is 1:1 with a staff member. She said she felt safe. (R2) maintained her usual activities of going to dialysis, eating in the dining room and attending

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facility activities that interest her.

1/22/2020 -(no time) Administrator and SSD met with the male resident (R3). He stated he doesn't remember doing anything wrong, but he is very sorry this is happening. We explained that while his actions may be related to his stroke, we need to ensure the safety of all residents. His son had previously explained we would be looking at alternate placement, but we reiterated this. We also stated he would be 1:1 supervision until he can be moved to another placement. He stated he understood.
(Please note the facility time line provided to Surveyor, on 1/23/20, has no signature and does not indicate who wrote the timeline.)

On 1/23/20 at 11:10AM, Surveyor interviewed LPN I regarding R2 and R3's incident on 1/17/20. LPN I indicated R2 was sitting in the dining room, playing on her phone at a table, in the back of the dining room. LPN I indicated that she was going in and out of the dining room passing medications when R2 came out of the dining room "Hysterical, and couldn't get her breath." LPN I indicated that R2 kept saying the old man touched me. LPN I indicated that R2 was yelling and upset at this time. LPN I indicated that she didn't know what R2 meant for sure so she had her take a seat to catch her breath. LPN I indicated that R2 said to her, I have PTSD, a man touched me, I don't know him and I haven't seen him before. LPN I indicated that R2 pointed to R3. LPN I indicated that R2 couldn't get her breath and that R2 was "Terrified." LPN I indicated that they got her safe by having her sit with LPN I as she called the DON. LPN I indicated that once R2 said he (R3) touched her, she didn't ask any more questions due to wanting to call the police and management

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right away and wanted R2 to feel safe. LPN I indicated that when R3 came out of the dining room he came to the nurses station on the side that R2 resides on and glared at R2. LPN I indicated that she told R3 not to come back to this side and wheeled him to the other side. LPN I indicated that she has never seen R3, not even one time at the nurses' station. LPN I indicated that R3 was looking right at R2 and R3 had no reason to be on that side, as activities were going on in the dining room. LPN I indicated that she is unaware of any other incidents occurring with R3. LPN I indicated that LPN J was told of the incident, who was R3's nurse at the time. LPN I indicated that LPN J pulled a person for one-on-one with R3. LPN I indicated she is unable to say if it did or did not happen. LPN I indicated she had to call the police twice, once they arrived she went with R2 and the male police officer to the lounge to ensure R2 was okay. LPN I indicated that R2 has anxiety and, during the incident, R2 could barely speak which is very unlike her. LPN I believes something happened. LPN I has never taken care of R3, has only seen him in a wheelchair. LPN I indicated that R2 walks with a walker and is unsteady and that R2 has vision and hearing impairments.

On 1/23/20 at 11:36 AM, Surveyor interviewed LPN J regarding the incident. LPN J indicated that around approximately 4 PM, LPN J had been down the hall passing medications. LPN J indicated that a nurse had told her the incident already occurred and that they already removed him (R3) and had him on 1:1. LPN J indicated that LPN I told her that R2 said R3 touched her knee and moved his hand up and R2 said "top" twice and he left, and then the police had been called. Calls were placed to the physicians, DON

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and RN L put him on 1:1 at all times. LPN J indicated that R3 is not aware of the incident and that he gets confused at times and R3's stories don't match. LPN J indicated she asked R3 what happened in the dining room and that R3 told her he was going to the dining room to see if it's snowing and someone wheeled him back. LPN J indicated that R3 told the police he was in the dining room for dinner and was drinking coffee when it wasn't dinner time. LPN J indicated that R3 is not inappropriate with staff and that all he usually asks is if staff is married and gives staff looks, but has not touched any staff, to her knowledge. LPN J indicated R3 is not verbally inappropriate to staff to her knowledge, R3 just asks staff if they are married. LPN J indicated that she knows that R2 feels uncomfortable now. LPN J indicated she is unsure what staff is doing for R2, as she has not been her nurse. LPN J indicated that R3 is on 1:1's.

On 1/23/20 at 12:00 PM, Surveyor interviewed TD F regarding R3. TD F indicated she has not seen inappropriate behaviors, but her staff have verbalized it and reported it to TD F that R3 had been verbally inappropriate to her staff. TD F indicated to talk to OT G and PT H for more information.

On 1/23/20 at 12:01 PM, Surveyor interviewed LPN M regarding R3. LPN M indicated R3 is not inappropriate with her, as he knows she's his nurse. LPN M indicated R3 has been inappropriate with a CNA and it's been reported to the supervisor. LPN M indicated that Surveyor should talk with CNA E. LPN M indicated she is unsure when it was reported to the supervisor, but it was reported. LPN M indicated staff are to be arm's length from R3 and to let their nurse

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know if R3 is inappropriate with them. LPN M indicated she is only aware of the one incident with R2 that occurred, and has no knowledge of any other incidents with residents. On 1/23/20 at 1:00 PM, Surveyor interviewed LPN M regarding her previous statement. LPN M, at this time, indicated she did not know anything about the situation with CNA E until last week. LPN M indicated she heard through the grapevine CNA E had reported it to her (LPN M), and that management already knew, so she (LPN M) didn't report it. LPN M indicated CNA E never reported R3's behaviors to her. LPN M indicated to Surveyor she just spoke to DON B regarding this.

On 1/23/20 at 12:10 PM, Surveyor interviewed RN L regarding the incident between R3 and R2. RN L indicated that LPN I came to her saying that R2 was crying and R3 was placed on 1:1. RN L indicated she got statements from interviewable residents. RN L indicated R2 was upset and normally is not upset. RN L indicated she updated both MDs, DON, NHA and families were notified. RN L indicated R3 is 1:1 which makes R2 feel safe and R2 is seeing the in-house psychiatrist. RN L indicated she is not aware of any staff inappropriateness or other resident incidents.

On 1/23/20 at 12:15 PM, Surveyor interviewed OT G and PT H regarding R3. OT G indicated R3 was verbally inappropriate with her by asking if he can touch or play with her breasts. OT G indicated she would redirect him and then he would re-ask if he could play with OT G's breasts. PT H indicated that she witnessed R3 saying this to OT G. OT G indicated she completed therapy with R3 and would try to redirect him and reported R3's verbal inappropriateness and that R3 did not

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try to physically touch her. OT G and PT H indicated they have both heard of other incidents, but have not witnessed R3 being inappropriate with others besides OT G. OT G indicated she didn't think he would physically touch anyone, as it wasn't normal for R3 and that it was a one time thing that occurred with therapy approximately a month ago and did not have any real warning signs, it just happened.

On 1/23/20 at 12:25 PM, Surveyor interviewed CNA E regarding R3. CNA E indicated R3 is usually pretty good, but kind of grumpy and uncooperative. CNA E indicated "Approximately three weeks ago on a Thursday" she was assisting R3 with his cares. CNA E indicated R3 was in the bathroom getting washed up and he had put his head on CNA E's breasts. CNA E indicated she told R3 he can't be doing that and then he tried to touch CNA E's breasts multiple times. CNA E indicated while she was washing R3's back, R3 grabbed CNA E's private area (vaginal area). CNA E indicated she told R3 it was inappropriate and not allowed and R3 replied, "Oh, you know you like that." CNA E indicated she told R3 he can't be doing that. CNA E indicated R3 apologized to her and hasn't tried anything since then. CNA E indicated she is unaware of any other incidents with staff, but did hear about the situation with R2. CNA E indicated she reported his inappropriateness with her to the nurse on duty, LPN M. CNA E indicated R3 has been 1:1 since the incident with R2 and that 2 staff are required with cares since the incident with R2. CNA E indicated the DON, SW and ADON met with her regarding what happened. CNA E indicated R3 had no behaviors leading up to the incident and she had gotten R3 up today (1/23/20) without any incident.

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(Please note that this would make an additional incident of inappropriateness for R3 involving staff since 12/30/19, prior to the 1/17/20 incident.)

On 1/23/20 at 12:50 PM, DON B indicated to Surveyor that she found out about CNA E yesterday.

On 1/23/20 at 12:55 PM, Surveyor interviewed CNA E regarding R3. CNA E indicated she told LPN M the day it happened and the DON was told last week and had talked to her, she thinks on Monday (1/20/20).CNA E again indicated she can't remember the exact date, but it was about three weeks ago, on a Thursday, that the incident with R3 and herself occurred.

On 1/23/20 at 1:30 PM, Surveyor interviewed TD F regarding the therapy incident with R3. TD F indicated she reported it in morning meeting and only had one incident at that time, but by the end of that day, I had all three reports. TD F indicated she gave a Stop & Watch Tool to the ADON on 12/30/19. TD F indicated she also approached the SW and the nurse on the hall at that time (unable to say who it was) to report R3 being sexually inappropriate verbally. TD F indicated that the nurse was to follow up and that nursing was taking care of it. TD F indicated they monitored for it a couple days in therapy and nothing else was reported. TD F indicated she reprinted therapy notes and the Stop & Watch Tool on the day the incident with R2 occurred.

On 1/23/20 at 1:40 PM, Surveyor interviewed ADON C regarding the therapy incident, between R2 and R3. ADON C indicated she is aware that therapy brought up R3 being verbally sexual to one of the therapists and filled out a Stop &

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Watch form. ADON C thought R3 was sick and asked nurse if medical issues or any verbally inappropriate behaviors and nothing was indicated. ADON C indicated there was nothing else to her knowledge reported for inappropriate behaviors with R3. ADON C indicated she was aware of the incident with CNA E, after the incident between R3 and R2 occurred. ADON C indicated CNA E and LPN M both knew about the incident regarding CNA E being inappropriately touched, approximately a month ago. ADON C indicated CNA E told her she told the nurse, but didn't make a big deal out of it. ADON C indicated she told CNA E that they need to know about it. ADON C indicated CNA E should have told administration right away. ADON C thinks that CNA E probably did tell LPN M, but LPN M didn't report it to management. ADON C indicated no knowledge of any further inappropriate incidents since the incident between R3 and R2. ADON C indicated R2 see's a psychiatrist and had been, even prior to the incident with R3. ADON C indicated CNA E and LPN M have not had 1:1 coaching/education yet, but education has been started with staff related to reporting inappropriate touches. ADON C indicated R2 has diagnoses of Bipolar, anxiety and PTSD. ADON C indicated she noticed R2 had a diagnosis of PTSD upon admission, but didn't think anything of it.

On 1/23/20 at 2:10 PM, Surveyor interviewed SW K regarding the incident. SW K indicated that on Friday (17th) she got a call that R3 had an incident with R2; that R3 had put his hand on her and moved it towards her vagina at approximately 4 or 5 PM and that R3 was put on 1:1. SW K indicated R2 went to LPN I and reported it. SW K indicated R2 is able to walk with a walker and R3 uses a wheelchair. SW K indicated R2 was able

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to identify R3 right away. SW K indicated this was not the first inappropriate behavior incident. SW K indicated, a few weeks ago, TD F mentioned that on one day, R3 made inappropriate comments to staff, it was out of nowhere. Surveyor asked SW K about the Stop and Watch Tool written on 12/30/19, from therapy. SW K indicated they did not receive anything until yesterday (1/22/20) or the day before (1/21/20). SW K indicated that no further incidents were reported other than 3 therapy staff in one day. SW K agreed R3's care plan was not updated until 1/20/20. SW K is unable to tell Surveyor about R2's PTSD. SW K indicated she did not know about R2's PTSD other than she was told R2 was assaulted prior to coming to the facility and it did not happen here. SW K indicated she did not do R2's Mood/Behavior Care Plan. SW K indicated R2 saw the psychologist this week on Monday (1/20/20). SW K indicated staff have not changed or updated R2's care plan yet.

On 1/23/20 at 2:20 PM, Surveyor interviewed DON B regarding the incident. DON B indicated she just saw the Stop and Watch Tool, from 12/30/19, the other day. DON B indicated the other day may have been yesterday (1/22/20). DON B indicated it had been put on the ADON C's desk. DON B indicated that she explained to TD F that a Stop and Watch Tool is to be brought to the staff's attention and not left on a desk. DON B indicated that R3's care plan should have been updated, after the therapy incident, to have cares in pairs. DON B indicated staff should have known about the therapy incident in order to keep an eye on R3. DON B then indicated that all R3 does is go to the dining room and then back to his room. (Please note that it's indicated that the incident with R3 having verbal inappropriateness

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with therapy staff was reported in the morning meeting and a Stop and Watch Tool was filled out on 12/30/19.)

On 1/23/20 at 3:00 PM, NHA A indicated to Surveyor that the facility did not know about the other events until this week (1/20 - 1/23/20). (Please note that therapy staff and CNA's are indicating that management was told prior to this week (1/20/20 - 1/23/20).)

On 1/23/20 at 3:15 PM, Surveyor interviewed R2 regarding the incident. R2 indicated his name is (R3's name). R2 indicated that R3 was talking to her, then he put his hand in her lap and proceeded to touch R2's vagina. R2 indicated she pushed his hand away and came out to (LPN I) right away. R2 indicated she has PTSD and stated, "When I was 19, I was raped," when Surveyor inquired about R2's PTSD diagnosis. R2 indicated she felt more shocked, was shaky and started to cry because it sent her back to the incident when she was 19. R2 indicated the touching was most uncomfortable for her. R2 indicated she feels "uncomfortable" when she sees R3. R2 indicated she "mostly" feels safe only when she knows someone is with R3. R2 indicated she doesn't see well and that she usually doesn't see him. R2 stated to Surveyor, "Someone told me a CNA was touched also, so it's not his first time."

R2's Mood/Behavior Care Plan and CNA Care Plan, on 1/23/20, have no indication of being updated since the incident with R3 on 1/17/20.

R3's CNA Care Plan, on 1/23/20, indicates one-on-one supervision and 15 minute checks while sleeping. No further interventions indicated

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F 600	Continued From page 18 to CNA's. On 1/23/20 at 5:10 PM, Surveyor requested Social Worker documentation for R2 regarding follow up from the incident with R3. SW K, at this time, indicated she has not documented in R2's chart, as all her follow up notes are currently on sticky notes. On 1/23/20 at 5:30 PM, Surveyor received notes from SW K for R2. SW K's notes state, in part: "1-20-2020 (no time) met privately with (R2) RE: (regarding) discussed how she was doing. If she needed any extra support. Discussed her seeing (Psychiatry Doctors Name) today. She agreed and signed release. Restated that the male resident is under 1:1 supervision." "1-21-2020 (no time) (DON B's name) and I met with (R2) discussed with incident in dining room where another female resident asked her to identify the male resident across the room. (R2) was unable to identify him at that time. (DON B) and I walked (R2) to the dining room. She immediately identified the male resident. (R2) stated it made her very uncomfortable to be asked to identify R3, by the female resident, in front of every one. I told her I would speak to the female resident. Again reassured (R2) that the male resident was on a 1:1. (R2) stated she felt safe." "1-22-2020 (no time) checked in with (R2) to see how she was doing. No concerns. She is attending meals and activities per her usual routine." "1-23-2020 (no time) Checked with (R2). She was tired from dialysis. I walked her to the dining room, no concerns." (Please note that none of these entries have times or indicated as late entries, which were written on 1/23/20, after Surveyor requested	F 600		

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F 600	Continued From page 19 SW's documentation for R2.)	F 600		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility did not follow proper infection control practices and hand hygiene during for 1 of 2 residents reviewed for pressure injuries (R1). The facility failed to follow proper infection control and hand hygiene practices during a wound care observation for R1. This is evidenced by: The facility procedure guide, "Infection Prevention and Control Manual," related to hand hygiene procedures, effective July 2015 and revised January 2017, states, in part: "Hand Hygiene is the most important procedure for preventing Healthcare Associated Infections." The policy indicates that a plain soap and water will be used when hands are visibly soiled, before eating, after	F 686		

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using the restroom, and if there is possible or proven exposure to specific spores, and "a plain soap and water or an alcohol hand rub may be used: If hands are not visibly soiled, before having direct contact with residents, before inserting indwelling catheters, peripheral vascular catheters, other invasive devices that do not require a surgical procedure, after contact with a resident's intact skin, after contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressings if the hands are not visible soiled, during resident care if moving from a contaminated-body site to a clean-body site, after contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident and after removing gloves."

R1 is a 93 year old resident who was admitted to the facility, on 6/11/1981, and developed several unavoidable (PI's) pressure injuries beginning in September 2019. R1 also had diagnoses including Diabetes Mellitus, spastic hemiplegia, and history of traumatic brain injury after a motor vehicle accident.

R1's care plan for "Skin integrity assessment: Prevention and treatment care plan," dated 7/18, indicates R1 is "At Risk" requires frequent turning, maximal remobilization, protect heels, manage moisture, nutrition, friction and shear, and pressure-reduction support surface if bed or chair bound. The goal states: "Will remain free of open areas. 10/29/19 a new (emphasis intended) air mattress was added to the care plan.

Of note R1 had an air mattress on her bed in August of 2019 prior to PI development. Although this was not specific on the plan of care

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it was documented in nursing progress notes.

R1 has a care plan for "Actual" infection, dated 1/10/2020, for "wound," indicating "MRSA (Methicillin-resistant Staphylococcus aureus) coccyx."

On 1/23/2020 at 9:45 AM, Surveyor observed LPN N (Licensed Practical Nurse) complete the dressing change treatment to R1's PI, on coccyx. Surveyor observed that the old dressing on R1's coccyx was soaked through with serosanguinous fluid. Both ischial tuberosity's have dressings and there is visible drainage shadows apparent on each of those. LPN N used a small pair of scissors to cut R1's old dressing off of coccyx. LPN N then placed the scissors on top of the drainage on the old soiled dressing. LPN N did not remove her gloves or perform hand hygiene. Wearing the same gloves, LPN N completed R1's treatment; LPN N poured Dakin's solution on gauze, then wiped the wound, then applied skin prep to the periwound area. Surveyor observed Dakin's solution bottle was brought into R1's room for treatment. LPN N did not clean her scissors prior to R1's treatment. After R1's treatment, LPN N removed the scissors and supplies from R1's room, without cleaning her scissors prior to leaving a contact precaution room, LPN N was observed holding her scissors bare handed. LPN N cleaned the scissors bare handed and placed them into the treatment cart. R1 is on contact precautions for MRSA infection in her wound.

On 1/23/2020 at 10:35 AM, Surveyor observed R1's dressing change for Left and Right gluteal areas with LPN N and RN L (Registered Nurse). Surveyor observed left gluteal fold Stage IV with

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F 686	Continued From page 22 100% slough, with scattered black, necrotic areas. Left gluteal PI had serosanguinous purulent drainage per RN L. LPN N had to leave room to get scissors. LPN N returned with scissors and used them to cut dressing in half. LPN N did not clean scissors prior to use. LPN N and RN L then completed R1's dressing change to the right gluteal area. Surveyor and RN L observed wound with purulent serosanguinous drainage on old dressing, 80% slough and 20% granulation tissue with red periwound and a slight foul odor. RN L indicated, after R1's treatments, that the Dakin's bottle should not have been brought into R1's room, as it is used on multiple residents and she had thrown the Dakin's bottle way. Surveyor discussed observations with LPN N and RN L. RN L indicated that, since R1 is on MRSA precautions, nothing should be brought out of the room, but if something is not left in the room, it should be sanitized after being removed. LPN N acknowledged hand hygiene should be performed anytime gloves are changed. LPN N also indicated gloves should be changed after cleaning a wound, after a treatment, and if touching anything else. LPN N stated scissors should be cleaned after a treatment. Surveyor asked if scissors should be cleaned before a treatment, and LPN N said, "I would say you should."	F 686		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment	F 742		

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difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility did not ensure that a resident who displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder (PTSD), receives appropriate treatment and services to correct the assessed problem or attain the highest practical mental and psychosocial well-being for 1 of 6 residents reviewed for care plans out of 13 sampled residents (R2).

R2 has a diagnosis of PTSD and her care plan is not person centered, as it does not specify triggers, symptoms to monitor for or interventions to use to ensure R2 is reaching her highest practical mental and psychosocial well-being.

This is evidenced by:
Per CMS (Centers for Medicare and Medicaid Services), "...Although PTSD is commonly viewed as a disorder experienced only by military veterans, it is not exclusively a consequence of combat or war zone exposure. Individuals who have been physically or sexually assaulted or who experienced a terrorist attack or natural disaster, among other things may also be affected by PTSD."

R2 was admitted, on 6/18/19, with diagnoses that include: Bipolar disorder, major depressive disorder (MDD), generalized anxiety disorder

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(GAD), chronic PTSD and end-stage renal disease.

R2's Mood and Behavior Symptom Assessment/Care Plan, dated 6/19, indicates, in part, the following: ...At risk for inadequate rest as evidenced by Insomnia/change in sleep pattern (specify): Trouble falling asleep and trouble staying a sleep are both marked on R2's CP (care plan). Possible causes (specify): indicates pain/discomfort in the back and depression, and Medical conditions: anxiety, PTSD, MDD, and Bipolar. R2's Goals: ... "will maintain adequate rest as evidenced by: Feeling rested, less anxious" and decrease in depression. Goal Date: 9-19. Interventions include: Medications (Mirtazapine, Duloxetine, Buspar, Abilify) as needed, Baclofen for back pain. Promote sleep using interventions such as proper diet education. Distraction: TV/radio. Leave door open and a night light, prefers room temperature warm. Music calms resident. Special blanket or pillow/cuddle object: pillows she cuddles for security. (Psychiatrist Name) is indicated under Psychological/psychiatric consult recommendations.

(Please note that R2's care plan is indicated for sleep and pain. There are no indications of what PTSD symptoms look like for R2, what symptoms to monitor R2 for or what interventions are to be used for R2's PTSD if she were to experience a PTSD event. This is especially important since R2 had an incident with another resident sexually inappropriately touching R2 on 1/17/20.)

R2's Social Services Short Stay Care Plan, dated 6/19, focuses on discharging R2 and does not indicate anything regarding R2's PTSD or other

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mental health diagnoses. Social Services Care Plan indicates to monitor for signs and symptoms of depression, monitor for changes in mood and monitor for changes in behavior, all of which references Mood and Behavior Symptom Assessment: Psychosocial Well-being - Mood State Care Plan.

R2's CNA (Certified Nursing Assistant) Care Plan, on 1/23/20, does not indicate that R2 has PTSD or any other mental health disorders such as Bipolar, GAD, MDD, and it does not indicate what type of symptoms or behaviors to monitor for or what to report to the nurse. In addition, there are no interventions indicated for mental health or PTSD for R2 on the CNA Care Plan.

On 1/23/20 at 2:10 PM, Surveyor interviewed SW K (Social Worker) regarding R2's care plan. SW K indicated she doesn't know R2's history, but believe she was assaulted prior to coming to the facility. SW K indicated she did not develop R2's Mood/Behavior Care Plan, as she's only been here since September. Surveyor asked SW K to help her understand what R2's triggers are or what PTSD looks like for R2. SW K indicated, based on R2's CP, she's unsure what R2's triggers are or what symptoms R2 would have to indicate she's having any type of trigger for her PTSD. SW K indicated she has not yet changed or updated R2's care plan and that it should be updated to include PTSD triggers and symptoms to monitor for, including current incident on 1/17/20.

On 1/23/20 at 1:40 PM, Surveyor interviewed ADON C (Assistant Director of Nursing) regarding R2's PTSD. ADON C indicated that she noticed R2 had PTSD upon admission, but didn't think

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F 742	Continued From page 26	F 742		

anything of it.

On 1/23/20 at 2:20 PM, Surveyor interviewed DON B (Director of Nursing) regarding R2's care plan. DON B indicated that R2's care plan was last updated on 12/21/19 and that it has not been currently updated. DON B indicated R2's CP should have been updated for potential behaviors due to PTSD, monitoring for distress, interventions such as checking on her daily, asking if she feels safe etc... DON B indicated she is unable to say what PTSD looks like for R2 based on her CP, but that DON B knows she has a history of PTSD from abuse in the past, and it should be on her CP. DON B indicated, based on R2's CP, you're unable to tell what R2's triggers are for her PTSD. DON B indicated you wouldn't know unless it was care planned and it should be on the CNA CP's as well.

On 1/23/20 at 3:15 PM, Surveyor interviewed R2. R2 indicated to Surveyor that she has PTSD and it's from being sexually assaulted when she was 19 years old.

R2's care plan does not address individualized care approaches to meet R2's emotional and psychosocial needs for her mental health disorders. Staff are unable to assure they're consistently implementing care approaches in the care plan as there are no interventions specific to R2's mental health disorders such as PTSD, Bipolar etc.. There is no indication that staff can/are monitoring or providing ongoing assessment to whether care approaches are meeting the emotional and psychosocial needs of R2, as there are no personalized interventions in R2's care plan. R2's care plan has not been reviewed and revised to ensure effectiveness and

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F 742	Continued From page 27 it does not accurately document all of the interventions needed to support R2, especially when R2 experienced an incident of sexual abuse on 1/17/20.	F 742		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility did not always serve food that was palatable and served at the right temperature. This has the potential to affect all 67 residents residing in the facility. The lunch meal was served over an hour late, with some residents not getting served until an hour and forty minutes after posted meal time. Residents, Resident Representatives, and staff voiced concerns with this. Staff, residents, and family members voiced concerns with facility not having enough staff working in the kitchen. Cook O was observed not following a recipe while preparing residents' lunch meal. Cook O and DM D (Dietary Manager) state they alter recipes without education on preserving the nutritional value for elderly population and without consulting a Registered Dietician.	F 804		

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Cook O stated he rarely has all of the ingredients to follow a recipe. Surveyor observed residents ask for Ranch and French salad dressing and staff tell them there was none. DM D stated to Surveyor there were no onions available at the facility for the lunch meal, so they did without.

Surveyor did a test tray. It did not taste hot, was bland.

This is evidenced by:

Example 1
Resident Council Minutes, dated 11/21/19, include, in part: One resident asked what time is lunch. (Facility Staff) stated noon. Resident stated that it is always late and we are lucky if it is 12:20 PM before they start. Another resident stated it varies a lot.

Resident Council Minutes, dated 12/12/19, include, in part: ... One resident said they are constantly running out of items like creamer, hot cocoa, juice, etc. One resident asked why they are serving grape Kool-Aid for breakfast.

Resident Council Minutes, dated 1/2/20, include, in part: One resident stated that they have things listed on the menu and they don't have them, such as creamy coleslaw and California vegetables. 5 other residents agreed. One resident stated the menus are printed in the morning and should be accurate. One resident stated when they have barbeque chicken, she wanted dark meat and all they had was breasts. One resident stated that they are always running out of yogurt, salad, skim milk, and they don't have any fresh vegetables. One resident stated

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another resident was given real sugar, when she should have had diabetic sugar substitute, since she is diabetic. One resident stated the meals are always at least 15 minutes late or more. 4 other residents agreed. One resident stated that the menu states they are having pie and they get canned fruit. One resident stated they are always serving sandwiches and we don't need all those sandwiches. One family member stated that they used to have 2 meal choices, now it is 1 choice and the only other choice is a sandwich and soup ...

Resident Council Minutes, dated 1/16/20, include, in part: ...One resident stated that the cream of potato soup was actually sweet potato soup and it was gritty and tasted bad. One other resident agreed. One resident stated that it rarely happens, on any given day, that the kitchen has everything that is on the menu. One resident stated that the meals are still late- usually 30 minutes late most of the time. One resident stated that the pizza supreme last week was cheese pizza- not supreme, because there were no toppings other than cheese. One other resident agreed. One resident stated the food is cold on her hallway and it isn't always what she ordered. One resident asked if they could put more onions, celery, and mayonnaise in the chicken salad because it is bland. One resident stated the green bean and ham soup was nasty last week. One resident stated most of the time they do not have yogurt.

On 1/23/20 at 9:35 AM, during an interview, DM D indicated they are working short staffed in the kitchen. She indicated she had lost three staff members on the same day and has only been able to hire one staff member to replace them.

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DM D also indicated the newer staff members have not been properly trained because she has not had time to train them. DM D stated her company has sent a couple people to help them, but they are temporarily working in facility.

Example 2
R10 was admitted to the facility on 11/9/19. R10's most recent Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 11/16/19, indicates R10 is cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15.

On 1/23/20 at 12:47 PM, Surveyor was observing in the facility's main dining room. R10 propelled herself out of the dining room stating, "This is every day and night. It is a mess up in here. They aren't feeding us. I'm leaving, going to Applebee's if I can get my friend to pick me up." R10 left the dining room without eating.

Example 3
R11 was admitted to the facility on 10/28/18. Her most recent MDS, with ARD of 12/2/19, indicates R11 is cognitively intact with a BIMS score of 15 out of 15.

On 1/23/20 at 12:50 PM, during an interview, R11 indicated she hopes the kitchen can get it together and the facility is always out of something every day. R11 also indicated she gets her meals late often and they need more staff in kitchen.

Example 4
On 1/23/20 at 12:59 PM, R9 asked DA T (Dietary Aide) for ranch dressing. DA T indicated to R9 the facility only has Creamy Italian dressing. R9

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indicated to Surveyor the facility often does not have ingredients and she has told the facility her concerns at Resident Council meetings. DA T shook his head in agreement with R9.

Example 5
On 1/23/20 at 1:05 PM, R8 asked for French dressing. AA S (Activity Assistant) went to kitchen door and requested French dressing for R8. DM D replied in a loud voice that could be heard at nurse station, "There is no French dressing."

Example 6
R13 was admitted to the facility on 5/10/19. His most recent MDS, with ARD of 11/5/19, indicates R13 is cognitively intact with a BIMS score of 13 out of 15.

On 1/23/20 at 1:10 PM, during an interview, R13 indicated meals are always late, never on time. Food is served cold when supposed to be hot, there is often no choices given to residents at breakfast time, and the facility often does not have the options listed on the menus. R13 asked Surveyor to wait to see what time the last meal is served. On 1/23/20 at 1:40 PM, Surveyor observed the last meal served in the dining room to R13. R13 stated, "I told you. An hour and 40 minutes late. I got a dry turkey sandwich too. No gravy." R13 called out for gravy. DA T indicated there is no gravy. R13 and Surveyor reviewed the paper copy of the menu, dated 1/23/20, which stated, in part: Beef Noodle Soup, Crackers, Tuna Melt, House Garden Salad, Texas Sheet Cake, Soup of the Day, Hot Turkey Sandwich with Gravy ...

On 1/23/20 at 1:20 PM, during an interview, RR

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W indicated meals have not been served on time in the last month and they are usually served after 12:30 PM and sometimes after 1:00 PM. RR W also indicated the facility doesn't always have the food that is posted on the menus either.

Example 7
R12 was admitted to the facility on 1/18/20.

On 1/23/20 at 1:27 PM, during an interview, R12 indicated he owned two restaurants and was in the business for over 25 years and the facility's food service is "pathetic."R12 indicated he has only resided in the facility for 5 days and every single meal he has had at the facility was given to him late, this time it was an hour and a half late. R12 also stated he is disappointed in the food being served, as it is not what is stated on the paper menu he was given.

On 1/23/20 at 12:54 PM, during an interview, RR R (Resident Representative) indicated meals have been extremely late for a month or so now, the kitchen runs out of food, does not always serve what the menu reads. RR R also indicated that many staff have quit in the kitchen and there is not enough help.

Example 8
On 1/23/20 at 10:14 AM, Surveyor observed Cook O preparing lunch. Cook O indicated he was making beef noodle soup and he does not follow a recipe because 9 out of 10 times the facility does not have all of the ingredients needed, so he wings it. Cook O did pull out a recipe for Surveyor to review and indicated today he does not have any onions to work with, so he is omitting them. Cook O indicated he had not received any education on preserving the

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nutritional value for the elderly population and he does not consult with a Registered Dietician before changing the recipe.

Beef Noodle Soup recipe, includes, in part: servings 50 ... 0.5 cup vegetable oil, 2 pounds of beef, 2 teaspoons salt, 0.5 teaspoons black pepper, 8 ounces chopped onions, 12 ounces celery, 3 gallons beef stock, 12 ounces of noodles ...

Example 9
On 1/23/20 at 1:18 PM, Surveyor was served a room tray test tray. There was thin sliced lunch meat turkey between two slices of white bread. The temperature of this was 106 degrees Fahrenheit. The sandwich was cool to the touch, not even lukewarm. There was no gravy on it as the menu and recipe read. Also on tray was a bowl of beef noodle soup with temperature of 137.2. This soup had no evidence of onions in it and was thick, like gravy. It did have hamburger, noodles, and celery that was crunchy, not cooked soft. Also on tray was a house salad with Italian dressing.

Hot Turkey Recipe, includes, in part: serves 68 ... 13 pounds of turkey breast, 2 quarts of turkey gravy, 68 slices of bread, roux, base chicken, 1.5 gallons water ... portion: turkey 3 oz (ounce), 1 slice of bread, gravy 2 oz spoodle ...

On 1/23/20 at 1: 49 PM, DM D indicated she is still trying to figure out the ordering of food process and she often has to get things locally that she missed when ordering her shipment. She indicated today the facility had no onions in house, so the onions were omitted from the recipe. DM D indicated she does not consult the

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Registered Dietician when altering a recipe. She also indicated she has not been educated on preserving the nutritional value in meals for the elderly population. DM D indicated the food service observed today was "atrocious and not normal."

On 1/23/20 at 2:18 PM, during an interview, NHA A (Nursing Home Administrator) indicated he is aware of troubles in the kitchen and the Registered Dietician meets with DM D and gives her lists of things to follow to improve the kitchen, but DM D does not do it.

F 806 SS=J — F 806

Resident Allergies, 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 allergies, intolerances, and preferences;

§483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;
This REQUIREMENT is not met as evidenced by:
Based on observation, interviews, and record review, the facility did not ensure that 1 of 13 residents (R7) reviewed received food that accommodated the resident's allergies.

R7, who is allergic to fish, received fish for lunch. The Cook, who cooked and plated the food admitted that he did not use the dietary cards due to being in a rush. The CNA (Certified Nursing Assistant) who served the food indicated that she

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did not take the cover off of the food to view it before leaving it with R7 and was unaware of the allergy. The AD (Activity Director) was unaware of R7's food allergy until R7 made her aware of it.

The facility's failure to provide food that accommodated the resident's fish allergy created a finding of Immediate Jeopardy (IJ) that began on 1/23/20. The NHA A (Nursing Home Administrator) and DON B (Director of Nursing) were notified of the IJ on 1/23/20 at 5:00 PM. The IJ was removed on 1/23/20. The deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its plan of correction.

This is evidenced by:
R7 was admitted to the facility, on 10/4/19, with diagnoses that include: acute and chronic respiratory failure, acute and chronic congestive heart failure, lung cancer, epilepsy, chronic obstructive pulmonary disease, and food allergies to fish derived products, onions, mushrooms extract complex, and aspirin.

R7's most recent Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 1/9/20, indicates R7 is cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 out of 15. Section G indicates R7 requires setup help only to meet his needs in eating.

R7's Physician Orders, 1/1/2020-1/31/2020, include, in part: ... allergies- fish derived products, onions, mushroom extract complex, mushroom, aspirin ...

R7's Admission Nutrition Assessment, dated

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10/15/19, includes, in part: Food Allergies: onions, mushrooms, fish ...

R7's Nutrition Risk Care Plan, reviewed 1/9/20, with a goal date of 4/20, does not include an entry related to R7's allergies.

(It is important to note R7's Comprehensive Care Plan does not indicate R7 is allergic to fish, onions, mushrooms, or aspirin.)

R7's Meal Cards for 1/23/20, include, in part:
breakfast- allergy: fish, mushroom, onion ...
lunch- allergy: fish, mushroom, onion ... DO NOT SERVE: Tuna Melt
supper- allergy: fish, mushroom, onion ...

On 1/23/20, between 1:10 PM - 1:50 PM, Survey Team observed the dining process in main dining room and down the hallways. In Main Dining Room, Surveyor observed DM D (Dietary Manager) give instructions to DA T (Dietary Aide) to pass out salads to all residents who wanted one. DA T stated, "I don't know diets or who can have what. I don't really want to do this. I am not trained on who gets what here." DM D replied to DA T, "Just ask them." Outside of the kitchen door, in hallway, Surveyor observed AA S (Activity Assistant) bring a tray back to the kitchen indicating the resident wants tuna melt, not what was on the plate. DM D called out in a loud stern voice, "This is why we take orders." AA S stated to Surveyor, "This is embarrassing. I have been here 9 years." AA S also indicated the hallway that the meals are being passed on did not have any desserts on the trays. DM D brought out a tray of desserts and told AA S to give them to all who want one. Surveyor observed DM D going table-to-table asking residents what they wanted

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to eat. DM D was telling Cook O orders and Cook O was plating orders. During an interview, Cook O indicated he was unsure who the plates were for, he was just fulfilling orders that staff, including DM D, were telling him.
(It is important to note resident Meal Cards were not passed out with meal or used by Cook O in the main dining room and were not accessible for DA T. They remained in a stack on hot cart for the duration of this meal.)

On 1/23/20 at 1:13 PM, Surveyor observed CNA U set R7's meal on a bedside table and leave R7's room. R7 took cover off his meal and called out, "Hey. I am allergic to fish, mushrooms, and onions. I can't eat this. I am allergic to fish and onions and mushrooms. You have to take this back. I can't eat this." AD V entered the room. R7 explained to her he was not able to eat the meal provided to him due to his allergies. AD V looked at R7's Meal Card and took plate from his room. AD V returned with a different meal for R7.

On 1/23/20 at 1:25 PM, during an interview, R7 indicated he sent the first plate back because it contained fish and he is allergic to fish. R7 stated he did not eat it, because he knows what would happen to him. R7 stated, "I swell up when I eat fish. Then I have to go to hospital for a bunch of injections."

On 1/23/20 at 1:49 PM, during an interview, DM D indicated that Cook O is supposed to look at cards before plating food, but he was rushed and they did not use Meal Cards this noon meal. DM D indicated that she did not use resident Meal Cards at noon meal, because she just knows what they can have and can't have. DM D indicated that DA T would not know the residents'

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allergies, diets, and preferences by memory and he should have had access to resident Meal Cards, while he was passing out salads to residents. DM D indicated that Volunteer Q, who passed beverages in the main dining room, does not know residents' preferences, diets, and allergies by memory and should have access to the resident Meal Cards when passing drinks out. DM D indicated this practice of not using Meal Cards is "dangerous."

On 1/23/20 at 4:20 PM, during an interview, CNA U indicated that she was unaware R7 was allergic to fish or that it was on the menu for that day. CNA U also indicated she did not remove the cover off of R7's meal before exiting the room.

On 1/23/20 at 4:25 PM, during an interview, AD V indicated R7 was calling from his room and she went in. AD V indicated R7 told her he was allergic to fish, she looked at his Meal Card that was with meal, and looked at the plate and saw fish. Then AD V took the plate to kitchen and brought him a new one without fish.

On 1/23/20 at 6:18 PM, during an interview, R7 indicated he was thankful he looked before biting into the sandwich he was given, because it would have been an emergency situation. R7 stated he swells way up when he eats fish and then has to go to the hospital for injections.

On 1/28/20 at 3:00 PM, during a phone interview, DON B indicated there were 10 residents residing in the home with food allergies and out of those 10, 2 of them were cognitively impaired.

The facility's failure to provide food that accommodated R7's fish allergy created a finding

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of Immediate Jeopardy. The Food Allergy Research and Education (FARE) notes, in part: "Finned fish can cause severe and potentially life threatening allergic reactions (such as anaphylaxis). Allergic reactions can be unpredictable, and even very small amounts of fish can cause one."
https://www.foodallergy.org/common-allergens/fish-allergy

The facility removed the jeopardy, on 1/23/20, when it had initiated and/or completed the following:

1. The Dietary Manager will audit the electronic dietary Kardex (CNA care plan) and put watermark allergy across the ticket for each resident who has a known dietary allergies.
2. Allergies will be called out to plater before plate is dished, effective with supper meal and ongoing.
3. Dietician and Dietary Manager will educate staff on the importance of reading the information on the tickets and assembling the meal accurately to the ticket.
4. Dietician and Dietary Manager will educate new staff on the importance of reading the information on the tickets and assembling the meal accurately to the ticket.
5. All trays will be checked by a person other than the person assembling the tray prior to the trays leaving the kitchen.
6. The Dietary Manager will audit 10 percent of trays for 1 breakfast, 1 lunch, and 1 supper meal per week for three months and report results to Quality Assurance Performance Improvement committee. If 100 percent accurate, then will discontinue audit.
7. Nursing will include asking about known food allergies in admission assessments.

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F 806	Continued From page 40 8. The dietician will audit the medical record for food allergies and match to electronic dietary Kardex monthly for three months. 9. For residents eating in the dining room, meal tickets will be placed at the table, order written on ticket, ticket used for plating, and left at table when meal is served.	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not maintain a safe and sanitary environment in which food is prepared, stored, and distributed. This has the potential to affect all 67 residents who reside in the facility. Surveyor observed staff preparing food in main	F 812		

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kitchen without hair restraints.

Surveyor observed hairlike dust on walls, soffit, vents, and piping coming down in the stove hood unit and a radio/cd player with a layer of dust covering it in the food preparation area.

Surveyor observed scoops being stored inside food container with handles lying in direct contact with food.

Surveyor observed food items without open dates and staff were unsure when item was opened.

Surveyor made four handwashing observations that were not up to current standards of practice inside main kitchen, during food preparation.

This is evidenced by:
Example 1
On 1/23/20 at 9:35 AM, Surveyor observed three staff members with facial hair and no hair restraints. Cook O, Chef P, and Dietary Aide (DA T) were inside the main kitchen and all were working in the food preparation area while food was exposed.

On 1/23/20 at 10:14 AM, Surveyor observed the same three male staff with beards and without beard restraints in the main kitchen, in food prep area while food was exposed. Cook O was cutting ground beef and celery and putting together a soup. Chef P and DA T were cleaning up from breakfast meal, putting food items away.

On 1/23/20 at 10:22 AM, Surveyor observed Volunteer Q enter the kitchen. DM D called to her to put on a hairnet. Volunteer Q did put on a hairnet leaving her bangs exposed. Volunteer Q

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was in the food preparation area while food was exposed with her hairnet not covering all of her hair.

On 1/23/20 at 12:43 PM, Surveyor observed HS X (Housekeeper Supervisor) inside facility's main kitchen with a hairnet on that did not cover her bangs. HS X was assisting with food preparation of residents' lunch meal.

On 1/23/20 at 1:49 PM, during an interview, DM D indicated the facility does have beard restraints available, but staff were not using them and they should have been. Also, DM D stated it is her expectation that staff or volunteers wearing hairnets should cover their full head of hair with net and not leave bangs on the outside of hairnet.

Example 2
On 1/23/20 at 9:35 AM, Surveyor and DM D observed hairlike dust on vents, soffit, walls, and piping directly above cooking area inside stove hood. Surveyor and DM D also observed a CD player/radio next to stove that had a thick layer of dust covering it. DM D indicated this CD player should be wiped off and the stove hood cleaning schedule is something she has not figured out yet, but it is probably due to be cleaned.

Example 3
On 1/23/20 at 9:35 AM, Surveyor and DM D observed a scoop lying inside of the ice machine with the handle lying directly on the ice. Surveyor also observed bins with oatmeal and sugar in them that had bowls lying directly on the oatmeal and sugar. During an interview, DM D indicated staff use the bowls as scoops and scoops should not be left inside of container, in direct contact with food or ice. DM D indicated she planned to

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F 812	Continued From page 43 educate staff on this. On 1/23/20 at 1:49 PM, DM D indicated the facility does not have scoops available, so her staff use bowls and she does not know which side of the bowl is the handle when used as a scoop. DM D indicated she is ordering scoops for the facility kitchen and staff are not to leave scoops/bowls lying directly on food inside storage containers. Example 4 On 1/23/20 at 9:35 AM, Surveyor observed an open gallon of 2 percent milk without an open date. Chef P indicated he was not sure when the milk was opened. DA T indicated he was not sure when milk was opened or how long the facility will use it for once it is opened. DM D indicated she was unsure when the milk was opened and she tells her staff frequently to date items when opened. Surveyor also observed an open prune juice container without a date on it. Chef P and DM D also indicated they were not sure when this product was opened. Example 5 On 1/23/20 at 10:14 AM, Surveyor observed Cook O put on a pair of gloves and wipe counter down with sanitizing solution from a red bucket. Cook O removed his gloves, put on a new pair of gloves, and then Cook O started cutting cold meatloaf/ground beef cubes apart. Surveyor observed Cook O remove his gloves and re-glove three more times without washing hands in between. Surveyor did observed Cook O wash his hands while food prepping. He rubbed his soapy hands together under running water, turned off faucet with bare hand contact with faucet, and dried his hands with paper towel.	F 812		

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This whole process from start to finish was five seconds long. During an interview, Cook O indicated he did not have much training on handwashing.
(It is important to note Cook O removed gloves and put on new gloves four times without washing hands in between. Also, when he did wash hands, he used bare hand contact to shut off running water and did not wash long enough in accordance with current standards of practice.)

On 1/23/20 at 1:49 PM, during an interview, DM D indicated the staff was rushed and are working short, but it is her expectation that staff would wash hands when they remove gloves for the duration it takes them to sing the ABC song three times.

On 1/23/20 at 2:18 PM, during an interview, NHA A (Nursing Home Administrator) indicated it was his expectation that staff wash hands after removing gloves and before preparing resident food.