STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165299	A. BUILDING _____ B. WING _____	03/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTVIEW ACRES	1485 GRAND MARION, IA 52302

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, the facility failed to have resident bathrooms stocked with necessary items to perform basic hygiene needs and failed to provide a clean, homelike environment. The facility reported a census of 79. Findings include: 1. During random observations on 2/19/20 upon entrance to the building revealed the following: a. At 11:50 a.m. the bed in room [ROOM NUMBER] not made. b. At 11:51 a.m. the bed in room [ROOM NUMBER] not made. c. At 12:13 p.m. the bed in room [ROOM NUMBER] not made. d. At 12:25 p.m. the beds in room [ROOM NUMBER], 419 not made. 2. During observations on 2/20/20 at 12:33 revealed the following: a. room [ROOM NUMBER] failed to have hand soap, toilet paper and the bed made. b. room [ROOM NUMBER] failed to have hand soap, toilet paper and the bed made. c. room [ROOM NUMBER] failed to have hand soap, toilet paper and the bed made. d. room [ROOM NUMBER] failed to have hand soap, toilet paper and the bed made. e. room [ROOM NUMBER] failed to have toilet paper and the paper hand towels sat on the back of the toilet. f. room [ROOM NUMBER] with paper hand towels sitting on back of toilet. g. room [ROOM NUMBER] failed to have toilet paper. h. room [ROOM NUMBER] with toilet paper sitting on top of the towel bar. i. room [ROOM NUMBER] failed to have toilet paper, paper towel and hand soap j. room [ROOM NUMBER] failed to have toilet paper, paper towels k. room [ROOM NUMBER] failed to have toilet paper and the resident stated she always has to ask for toilet paper During an interview on 2/20/20 at 1:37 p.m., Staff M, Housekeeper stated she didn't have a key to the paper towel dispensers, is the only Housekeeper on the floor and didn't know why the resident's don't have toilet paper. During an interview on 3/5/20 at 10:20 a.m., Resident #7 stated every time she runs out of toilet paper in her room, she has to ask for a new roll. She stated she is frequently out of paper towels and if she has them, they are sitting in a stack on the back of the toilet. During an interview on 3/4/20 at 5:00 p.m., the Administrator stated a Housekeeper walked off the job today because she was worried about the residents, the Housekeeping supervisor is off work today for an undetermined amount of time and the person responsible for the floor care doing laundry. The Administrator stated they do not have enough staff to clean the facility and do laundry. The Administrator stated she expected the basic needs supplied to the residents like, toilet paper, towels and hand soap.
F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews the facility failed to provide 2 baths weekly for 4 of 9 open sampled residents (Residents #4, #5, #6, #9) The facility reported a census of 79. Findings included: 1. According to the Minimum Data Set ((MDS) dated [DATE], Resident #4 identified with [DIAGNOSES REDACTED]. The resident with a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident intact cognitively. The resident required extensive assistance of 1 person for bed mobility, dressing and extensive assistance of 2 staff for transfers and toilet use. The resident utilizes a wheelchair for mobility about the facility. Review of Resident #4's Care Plan dated 9/26/17 revealed the resident with a self care performance deficit related to activities of daily living. The Care Plan directs staff to complete a shower/bath twice a week and as needed, to toilet the resident routinely, as needed and to transfer with the use of the Sara lift. During an interview with Resident #4 on 3/5/20 at 12:15 p.m., the resident stated she does not get her regular shower because the facility without enough staff to get her up. Review of the February and (NAME)2020 Bath Sheets revealed the resident had 1 shower in February and 1 shower on 3/5/20. 2. According to the Admission Record dated 9/12/17 Resident #5 identified with [DIAGNOSES REDACTED]. Review of the MDS dated [DATE] revealed the resident with a BIMS score of 9 indicating the resident moderately impaired cognitively. The resident required extensive assistance of 1 staff for transfers, dressing, toileting and personal hygiene. The resident utilized a wheelchair for mobility. According to the Care Plan dated 9/12/17 revealed the resident with a self care performance deficit, the plan directed the staff to assist the resident with activities of daily living, to provide bathing/showers 2 times a week and as needed. Review of the January 2020 Bath Sheets revealed the resident received 3 showers; review of the February 2020 Bath Sheets revealed the resident received 2 showers and in (NAME)2020 only a shower on 3/5/20. During an interview on 3/4/20 at 3:00 p.m., Resident #5 stated she would like to have more showers than she is receiving. 3. According to the Minimum Data Set ((MDS) dated [DATE] Resident #6 identified with [DIAGNOSES REDACTED]. The resident with a BIMS score of 11 indicating a moderately impaired cognitive ability. The resident required extensive assistance of 1 staff for bed mobility, dressing, personal hygiene and extensive assistance of 2 staff for transfers and toilet use. The resident identified as always incontinent of bowel and bladder. Review of the Care Plan revised on 7/19/16 indicated the resident totally dependent on 1 staff for showers and directed staff to provide shower assistance twice weekly and as needed. Review of the February 2020 Bath Sheets revealed the resident received 5 showers, and as of [DATE] the resident received 1 shower in (NAME)on 3/6/20. 4. According to the Minimum (MDS) data set [DATE] Resident #9 identified with [DIAGNOSES REDACTED]. The resident required extensive assistance of 2 staff for transfers and toilet use. Review of the Care Plan dated 11/24/14 indicated Resident #9 with a self care deficit and directed staff to provide bathing assistance twice weekly and as needed. Review of the Monthly Shower Sheets revealed the resident received 7 showers in January 2020, 6 showers in February 2020 and 1 shower in (NAME)upon review on [DATE]. During an interview on [DATE] at 9:15 a.m., Staff-B, Shower Aide stated she is the full time bath aide but is frequently pulled to the floor due to lack of staff. She stated when she does do baths she is often pulled to assist with 2 person lifts as they have only 1 aide per hall. Staff B stated in February 2020 she was pulled off of showers and assigned to the floor.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff and resident interviews, the facility failed to provide timely and appropriate incontinence cares for 2 of 9 open sampled residents (Resident #4 and 6). The facility reported a census of 79. Findings included: 1. According to the Minimum Data Set ((MDS) dated [DATE], Resident #4 identified with [DIAGNOSES REDACTED]. The resident with a Brief Interview for Mental Status score of 15 indicating the resident with intact cognitive ability. The resident required extensive assistance of 1 person for bed mobility, dressing and extensive assistance of 2 staff for transfers and toilet use. The resident utilizes a wheelchair for mobility about the facility. The MDS indicated

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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F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) the resident without any skin issues which included moisture associated skin damage. The resident has frequent urinary incontinence and always continent with bowels. Review of Resident #4's Care Plan dated 9/26/17 revealed the resident with a self care performance deficit related to activities of daily living. The Care Plan directs staff to complete a shower/bath twice a week and as needed, to toilet the resident routinely and as needed and to transfer with the use of the Sara lift. The Care Plan indicated the resident wore briefs for incontinence and staff are to maintain perineal cleaning per protocol. The Care Plan also identified the resident with a risk for development of pressure sores and other skin breakdowns due to incontinence. The resident has a history of moisture related open areas to the right inner thigh. The plan directed the staff to keep skin dry and clean, to document/monitor skin breakdowns, use caution during transfers and bed mobility and to document weekly treatments to include measurements and condition of each area of skin breakdown. During an interview with the Resident #4 on 3/5/20 at 10:05 a.m., the resident stated she hasn't been up for some time because it takes 2 staff to get her up with the lift and they don't have enough people. She indicated she can only stay up for about 3 hours each time due to coccyx pain. The resident stated up to this point today the staff failed to perform any peri cares for her. During an interview on 3/5/20 at 10:35 a.m., Staff J, Certified Nurse Aide and Staff K, CNA both report are assigned to the 100 Hall today. The aides stated so far today they did not provide any perineal cares for Resident #4. Staff K stated the resident will put on her call light when she needs to have her brief changed. During an interview on 3/5/20 at 11:00 a.m., Staff A, Skin Nurse stated Resident #4 did not have any open areas to the thigh or back area prior to this day that she knew of. During an observation on 3/5/20 at 12:15 p.m., staff assisted the resident to sit up at the side of bed, applied the sling and lifted the resident up to transfer into the shower chair. The bed noted to be wet with urine, the brief the resident wore soiled with excessive amounts of urine and bowel movement. Noted in the brief is a reddened, bloody appearing drainage on the right side of brief. The resident complained of pain with the transfer. During an observation on 3/5/20 at 12:45 p.m., the staff completed the shower, Staff A, Skin Nurse assessed the areas and measured the open areas noted to the resident's upper right thigh: the areas measured: #1-measured 0.5 by 2.0 centimeters, #2- measured 0.7 by 4.0 centimeters and #3- measured 0.3 by 3.0 centimeters. During an interview on 3/5/20 at 3:00 p.m., Staff A, Skin Nurse stated she believes the open areas noted today on the resident's right thigh is a result of excessive moisture and friction. She feels the aides just pull the brief out from under her instead of rolling her. 2. According to the Minimum Data Set ((MDS) dated [DATE] Resident #6 identified with [DIAGNOSES REDACTED]. The resident with a BIMS score of 11 indicating moderately impaired cognitive ability. The resident required extensive assistance of 1 staff for bed mobility, dressing, personal hygiene and extensive assistance of 2 staff for transfers and toilet use. The resident identified as always incontinent of bowel and bladder. Review of the Care Plan revised on 10/11/17 indicated the resident needed encouragement to communicate their need for urination, provide toileting per the facility schedule, the resident may wear a brief and to maintain perineal cleaning per protocol. Observation on 3/4/20 at 2:00 p.m., revealed the resident's room door closed. Surveyor knocked and entered the room to find the resident laying in bed, night clothes still on, food tray from lunch at the foot of her bed, untouched. The resident's bed sheets soaked with urine. The over the bed table approximately 3 feet from the resident, out of her reach, with the call light also on the bed table out of the resident's reach. The resident's room smelled strongly of urine. During an interview on 3/4/20 at 2:15 p.m., Staff K, CNA stated responsible for the care of Resident #6 today on the day shift. When asked if she provided cares to the resident today she said she had not provided any cares because working by herself. The aide stated she had not assisted the resident to get up yet today, nor toileted the resident, or provided food and fluids to the resident. Staff K stated the Dietary Staff sat the food at the foot of the resident's bed and left the room. Staff K acknowledged the resident could not reach her call light with the over the bed table too far way from her. During an observation on 3/4/20 at 2:15 p.m., Staff K, CNA, Staff L, CNA and Staff D, Assistant Director of Nursing (ADON) entered the resident's room to complete cares. The aides sat the resident up at the side of the bed to prepare to transfer, the resident complained of being dizzy when sat up. Upon sitting up, it is noted the resident's bed sheets wet the entire length of the bed from the resident's shoulders to below the soaker pad on the bed. The staff provided cares and escorted the resident via wheelchair to the dining room to get something to drink per the resident's request. During the provision of cares and the transfer the resident constantly said in a loud tone, no one ever comes in here to help me. Upon skin assessment at this time by Staff D, ADON, the resident is noted to have a reddened area on her right upper buttock. The area described as a dry, scaly patch which measured 2 by 1 centimeters. During an interview on 3/4/20 at 3:00 p.m., Staff D, ADON stated she could not believe the condition the aide left this resident in and upset the aide provided no cares for this resident today. Staff D stated the aide had 2 float aides on the floor with her and could of asked for help to get the resident up. The resident requires extensive assistance to get up and cannot get up by herself. Review of an undated Incontinence Care policy indicated the policy is an established guidelines that are to be followed to aide the caregiver in caring for the incontinent resident. Each resident who experiences an episode of incontinence will be appropriately cleaned.
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff and resident interviews, the facility staff failed to provide proper supervision for two of nine residents reviewed to prevent a burn on one resident (Resident #1) and prevent a fall for another resident (Resident #3). The facility reported a census of 79 residents. Findings include: 1. According to the Minimum Data Set (MDS) dated [DATE], Resident #1 identified with [DIAGNOSES REDACTED]. The resident required extensive assistance of two staff with bed mobility, transfers, dressing and totally dependent on staff for toilet use and the resident did not walk. The resident noted with severe cognitive ability and the staff utilized a wheelchair to move the resident about the facility. Review of the Care Plan revised on 10/27/17 revealed Resident #1 with a high risk for falls due to gait/balance problems, unaware of safety and history of falls. The Care Plan indicated Resident #1 rolled out of bed on 1/14/20. The plan directed staff to position the resident's bed in low position, anticipate the resident's needs, assist with two staff for transfers and place a fall mat next to bed. Review of an Incident Report dated 2/20/20 revealed a staff member found Resident #1 the morning of 2/13/20 with her right leg resting on a heater vent in her room. The right leg reddened from the knee to the foot and warm to the touch. The right great toe and second toe on the right foot noted to have blisters on each toe. The blisters and surrounding red areas measured 1.0 centimeter by 1.2 centimeters to the right great toe and a 1.0 centimeter by 0.5-centimeter blister noted on the second toe on the right foot. The report indicated the resident's bed pushed against the wall by the radiator. The Incident Report indicated the family and physician notified on 2/20/20 about the 2/13/20 incident. Review of Incidents Reports dated 10/6/19, 11/1/19 and 2/11/20 revealed staff found Resident #1 on the floor in her room, with unwitnessed falls from her bed at these times. Review of the Progress Notes dated 2/13/20 failed to reveal documentation regarding the incident and blisters noted on the resident. Review of the Progress Note dated 2/20/20 at 9:52 a.m., documented Staff A, Skin Nurse placed a phone call to Resident #1's primary care physician to report the incident on 2/13/20. Staff A reported the staff found the resident laying on the heat radiator in the room and the resident had new blisters on her toes as a result of this. The notes revealed Staff A then notified the family of the incident and blisters the resident sustained [REDACTED]. The blister measured 1.0 centimeter by 1.2 centimeters. In addition, an intact blister on the second toe on the right foot measuring 1.0 centimeter by 0.5 centimeter with redness to skin around the area. Review of a third Non-Pressure Skin Condition Report dated 2/13/20 indicated at 9:00 a.m., the resident had redness on the right lower leg from the knee to the foot, the skin warm to touch; Staff A described the area as a heat rash. Observation on 2/19/20 at 2:00 p.m. revealed Resident #1 with 2 reddened areas on her right foot, the first reddened area noted to the right great toe and the second reddened area on the second toe. Staff A, Skin Nurse removed the resident's socks to reveal the reddened areas and stated the staff found the resident on the radiator next to her bed the early morning of 2/13/20. The staff found the resident's right leg resting on the radiator, the redness to her right lower leg resolved but the blisters remained. Staff A stated she became aware of the incident on 2/13/20 but was informed by the former Director of Nursing (DON) the incident was taken care of. Staff A stated she completed skin sheets on 2/13/20. During an interview on 2/20/20 at 10:30 a.m., Staff B, Bath Aide stated assigned to do baths the morning of 2/13/20. Staff B reported at approximately 6:20 a.m. she and another aide walked into Resident #1's room to get her for a shower when she noted the resident had rolled over in bed. The resident's right leg resting on the radiator hanging on wall next to her bed. Staff B indicated the resident's bed was up against the radiator at that time. Staff B

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) rolled the resident back onto her bed and noted her knees had indentations from resting on the radiator and her right leg from the knee down reddened. The resident's toes to right foot noted to have blisters on them. Staff C, Certified Nurse Aide (CNA)/Bath Aide left the room and asked Staff D, Acting DON to assess the situation. Staff B stated the resident appeared hot, sweaty and with matted hair. Staff B completed the resident's shower, while in the shower the former DON and Nurse Consultant assessed the areas. Staff B stated the Administrative staff did not approach her regarding the incident until 2/20/20. During an interview on 2/20/20 at 7:58 a.m., Staff C, CNA stated she just wrote a statement regarding the blisters on Resident' #1's toes today. Staff C stated she assisted Staff B transfer the resident for her shower the morning of 2/13/20. Staff C stated she found Resident #1 with her bed against the wall, almost laying on her stomach with her right leg resting on the radiator next to her bed. Staff C stated the resident had both legs on the radiator; both knees had indentations from the radiator on them. The resident had her whole lower leg resting on the radiator, and the resident's right lower leg reddened. Staff C stated Staff B pointed out the blisters to the resident's right toes. The Acting DON came into the room and stated they will watch the area. Staff B and Staff C informed the current DON at the time and the Corporate Nurse that the staff found the resident on the radiator. Staff C stated both the former DON and the Nurse Consultant thought the resident had [MEDICAL CONDITION]. During an interview with Staff D, Acting DON on 2/19/20, Staff D stated she did not make out an incident report regarding the incident on 2/13/20 and stated she did not know anything about the incident. During a second interview with Staff D on 2/20/20, Staff D stated Resident #1 unable to move herself in the bed as she has contractures. Staff D reported unaware how the resident came to rest on the radiator. Staff D stated the Administrator just started the incident investigation on 2/19/20. During an interview on 2/20/20 at 2:10 p.m., Staff E, CNA stated she worked the night shift on 2/12-2/13/20 and last saw the resident at 5:00 a.m. on rounds. Staff E stated at this time there resident was asleep in her bed, facing the window. The resident's bed against the radiator on the wall. During an interview on 2/20/20 at 2:00 p.m., Staff A, Skin Nurse stated she notified the physician and the family on this day to alert them of the incident with the burns. Staff A stated she thought the former DON handled this. During an interview on 2/19/20 at 4:00 p.m., Staff F, Administrator stated the incident reported to her but the staff only speculated the resident had her leg on the radiator. She indicated the staff told her Staff A, Skin Nurse monitoring the situation. They took immediate action by moving the bed away from the radiator but they still have not gone thru, checked all resident rooms to assure the beds away from the wall radiators, and indicated she did not provide re-education to staff regarding the incident at this time Review of a Risk Management policy dated 2/26/20 directed staff to understand the root cause behind the incident, to complete a Comprehensive Incident Report, to notify the family and physician of the incident, to document the incident in the progress notes, complete a head to toe assessment and to ensure interventions in place. The Policy directed staff to document in the Notes section and update the resident's Care Plan with interventions put into place. 2. According to the Minimum Data Set ((MDS) dated [DATE] indicated Resident #3 identified with [DIAGNOSES REDACTED]. The resident required extensive assistance of two staff for bed mobility, dressing and had total dependence on staff for transfers. The resident with severe cognitive ability required a Hoyer lift for transfers and utilized a wheelchair to move about the facility with staff assistance. The MDS indicated the resident experienced a fall since admission. Review of Resident #3's Care Plan dated 12/20/19 informed staff the resident identified with a risk for falls related to dementia, history of falls and impaired mobility. The Care Plan indicated the resident experienced a fall while in her wheelchair on 2/9/20 in the 100 Hall lounge and another fall on 2/18/20 from leaning forward out of her wheelchair in the lounge area. The intervention put into place after the 2/9/20 fall in the 100 Hall lounge included to not leave the resident unattended in the lounge with her spouse. Observation on 2/19/20 revealed the resident in her room in wheelchair, the resident noted to have bruises to the right side of her face, a black eye and a bruised lump on the left side of her forehead. Staff reported at this time, the resident fell forward out her wheelchair yesterday while alone in the 100 Lounge with her husband. The staff said she could now only visit with her husband in the main dining room. Observation on 2/20/20 at 7:30 a.m., Staff A, Skin Nurse assessed the resident's facial bruising. The bruises to her right eye/facial area measured 6.5 centimeters by 5.0 centimeters, the resident with a black eye and bruised lump to the left side of forehead. Review of an incident report dated 2/18/20 at 6:52 p.m. stated the staff found Resident #3 on the floor in the 100 Hall lounge, she sat in the wheelchair accompanied by her husband. The nurse who completed the incident report indicated the resident became tired and fell forward out of her wheelchair, hitting her head on the floor. The staff transferred the resident to a local emergency room for evaluation. The Incident Report stated the resident's husband is also a resident in the facility and took the resident to the lounge area by himself even though instructed not to do so. The resident's spouse tries to care for the resident but is not able to do so. The Incident Report stated the resident is not to be left alone with her husband and they must visit in the main dining room, the spouse cannot take the resident out of the dining room himself. Review of a crossed out Progress Note dated 2/9/20 completed by Staff G, Licensed Practical Nurse (LPN) at 11:12 a.m., documented Staff G informed by a visitor that Resident #3 fell in the 100 Lounge and on the floor. Staff G contacted the family regarding the fall and the family member requested Resident #3 not be left in the lounge with the resident's spouse. Review of a Progress Noted dated 2/18/20 at 11:39 a.m., Staff H, Registered Nurse (RN)/MDS Coordinator contacted the resident's family of the transfer to the local emergency room , the notes revealed the resident experienced a fall in the 100 Hall lounge. During an interview on 2/20/20 at 2:30 p.m., Staff H, RN reported responsible for updates on Resident #3's Care Plans and updated the Care Plan after a fall on 2/9/20. The fall intervention added on 2/9/20 included resident should not be alone with her husband in the 100 Hall lounge due to questions the husband is attempting to provide assistance to the resident and is unable to do so safely. During an interview on 2/20/20 at 10:30 a.m., Staff B, CNA stated the resident experienced a prior fall from her wheelchair while in the 100 Lounge with husband present. Staff B stated at the time of the fall the resident required supervision when in the 100 Hall Lounge with her husband. During an interview on 2/20/20 at 11:00 a.m., Staff I, CNA stated the resident allowed 1 hour of time with his wife, Resident #3. Staff I stated the spouse pushed Resident #3 to the 100 Hall on 2/18/20. Staff I stated unaware the spouse took his wife back there as she went to break. Staff I reported unaware the resident needed supervision when in the 100 Hall lounge with her husband. Staff I stated the nurses never told her of this change. During an interview on 3/3/20 at 11:00 a.m., Staff G, LPN stated after the fall on 2/9/20 an intervention went into place that the resident remain supervised when with her husband in the 100 Hall lounge area. Staff G reported she wrote the entry in the Progress Notes on 2/9/20, but the former DON got into the computer and crossed out the entry. Staff G reviewed the charting she completed on 2/9/20 and stated it was accurate.
F 0808 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews and observations the facility failed to serve the appropriate diet for 1 of 9 open sampled residents (Resident #10). The facility reported a census of 79. Findings include: Review of the Admission Record dated [DATE] revealed Resident #10 identified with [DIAGNOSES REDACTED]. Review of an Assessment Scoring Report the Brief Interview for Mental Status (BIMS) obtained on 2/19/20 revealed Resident #10 with a score of 15 indicating the resident as cognitively intact. Review of a local Hospital Discharge Summary revealed Resident #10 with an admitted to the hospital of 2/26/20 and discharged back to the facility on [DATE]. The principal [DIAGNOSES REDACTED]. The discharge orders included a Dysphagia Level 1 pureed diet. Review of the Diet Card which accompanied Resident #10's breakfast tray on 3/5/20 at 8:20 a.m., identified the resident with a regular consistency diet but Staff N, Dietary Aide stated the resident received a pureed diet since returning from the hospital, about 3-4 days now. During an interview on [DATE] at 10:20 a.m Resident #10 reported having the best breakfast this am, stating they finally gave me some real food. The resident stated he had several pieces of bacon, several pieces of french toast sticks and large bowl of oatmeal. During an interview on [DATE] at 10:23 a.m., Staff O, Cook stated she did serve the resident a regular consistency breakfast this morning. Observation of the resident's breakfast tray on [DATE] at 10:22 a.m. revealed an empty plate and bowl. The diet card on the tray revealed the resident should have received a pureed diet. During an interview on [DATE] at 10:24 a.m., Staff G, Licensed Practical Nurse (LPN) stated she walked in to give Resident #10 his medications this morning and noted the resident eating a regular consistency breakfast. Staff G stated the resident already consumed his bacon and eating the french toast sticks. Staff G stated the hospital felt the resident aspirating while eating causing his pneumonia and this is the reason they placed him on pureed diet until further testing could be completed. During an

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F 0808 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) interview on [DATE] at 9:41 a.m., Staff P, Food Service Supervisor stated did not utilize the diet cards until 3/5/20 when surveyor asked about them, he stated the Cooks can remember what diet the residents should get. Review of a physician's orders [REDACTED].