STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235582	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVERGREEN HEALTH AND REHABILITATION CENTER	19933 WEST THIRTEEN MILE ROAD SOUTHFIELD, MI 48076

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

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number(s): MI 057. Based on interview and record review, the facility failed to assess, treat, and respond in a timely and appropriate manner to a resident with a critically low oxygen saturation level ranging from the low 50's to low 60's over the course of approximately six hours for one (R#611) of four residents reviewed for changes in condition, resulting in an emergent hospital transfer for acute [MEDICAL CONDITION] requiring mechanical ventilation via bi-level positive airway pressure ([MEDICAL CONDITION] - a treatment that uses mild air pressure to keep your airways open without intubation). Findings include: A complaint was submitted to the State Agency on 8/17/20 that alleged the following: (R#611) resides at (facility name redacted). (R#611) is in the COVID-19 (Coronavirus Disease - 2019) wing of the nursing home due to being exposed to COVID. Today, (R#611) had low oxygen saturation in the 50s. (R#611) was on a nasal cannula at 3 Liters per minute. There was no staff caring for (R#611) during this time. EMS (Emergency Medical Services) was contacted and immediately noticed (R#611) was not receiving enough oxygen. EMS put (R#611) on 15 Liters per minute of oxygen. (R#611's) oxygen level improved prior to her being transferred to (hospital name redacted). It is unknown how long (R#611) was in the room alone with her low oxygen level. There is a concern with the lack of care (R#611) did not receive. A review of R#611's clinical record was conducted and revealed the following: R#611 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. R#611 was discharged from the facility to the hospital on [DATE]. A Minimum Data Set (MDS) assessment dated [DATE] documented R#611 had intact cognition and required oxygen therapy while in the facility. A review of R#611's progress notes revealed a Physician Team - Progress Note dated 8/15/20 at 7:07 AM written by Nurse Practitioner (NP) R that documented, (R#611) is seen urgently this morning in f/u (follow up) respiratory distress. She is lying in bed, states it is very hard for her to breathe. She cannot answer other questions d/t (due to) DIB (difficulty in breathing) .: Vitals: T (temperature): 96.9, BP (blood pressure): 140/77, HR (heart rate): 87bpm (beats per minute), RR (respiratory rate): 22brpm (breaths per minute), SpO2 (blood oxygen saturation level, normal is 95-100): 50% 5L (liters) NC (nasal cannula) GEN: Frail, elderly lady lying in bed with labored breathing .RESP (respiratory): breathing even, labored, chest equal/symmetrical, lungs congested, extending neck outward to get more air .Psych: anxious about difficulty breathing .Imp/Plan 1. Respiratory distress/[MEDICAL CONDITION] (decreased oxygen level): Patient struggling to breath- O2 (oxygen) still at 50% on 5LNC. She continues to extend her neck out to get more air. Will send to (hospital name redacted) for evaluation. Nursing to call 911 as this is an emergent transfer. Patient has + COVID-19, [MEDICAL CONDITION], and [MEDICAL CONDITION] . On 8/19/20 at 11:26 AM, NP R was interviewed. When queried about what occurred with R#611 the morning of 8/15/20 and how they were notified to see the resident, NP R reported Physician U contacted them saying they were paged to R#611's room. NP R reported they were in the building so they walked over to R#611's room to see the resident. NP R further reported the nurses said they paged the physician because R#611's oxygen saturation was at 50 percent on five liters of oxygen. NP R reported when they assessed R#611, they were not doing well and I told them (the nurses) to call 911. NP R reported they would have expected the nurses had already called 911 based on their assessment of the resident. When queried about who stayed with the resident after 911 was called, NP R reported (Nurse S) and (Nurse T) stayed with the resident. On 8/19/20 at 1:40 PM, Nurse S was interviewed via the telephone. Nurse S reported they worked the night shift from 7:00 PM beginning 8/14/20 until 7:00 AM on 8/15/20 assigned to the Redwood Unit (a unit designated for residents who tested positive for COVID-19). Nurse S reported residents' vitals were monitored at least one time each shift and were documented in the electronic medical record. When queried about what occurred with R#611 during the night shift on 8/14/20, Nurse S reported there were two nurses assigned to the Redwood Unit, Nurse S and Nurse T. Nurse S reported they entered the room of R#611 with Nurse T to administer wound care and to change the resident's brief. At that time, R#611 reported they felt like they did not have their oxygen on. Nurse S reported R#611's oxygen was running at 3 liters per minute, their vital signs were checked at that time and R#611's oxygen saturation was just below 64 percent. At that time, Nurse S reported they increased R#611's oxygen to 4 liters per minute to see how they responded. Nurse S explained they completed R#611's care with Nurse T, reassessed the resident and their oxygen saturation was still low, had crackles in their breathing, but she was talking so Nurse S increased the oxygen to 5 liters per minute, lifted up the resident's feet, and allowed them to rest. Nurse S was further interviewed. When queried about any increased monitoring of R#611's oxygen saturation after they received low readings and increased the oxygen, Nurse S reported the resident was checked on about four times. Nurse S further reported that R#611 was due to be changed again at approximately 6:00AM and R#611's oxygen saturation continued to drop. Nurse S stated, That's when I told the other nurse she (R#611) is not getting better and we should think about sending her out. When queried about what was done at that time, Nurse S reported they paged Physician U and started pulling paperwork to send the resident out. Nurse S stated, (Physician U) always calls us back, but she didn't call us this time and called the nurse practitioner who was in the building. She (the NP) asked what was going on and went to see the patient. Nurse S reported after NP R assessed R#611 they said the resident had to go to the hospital and to call 911. Nurse S reported they called 911 at that time and it was approximately 6:20 or 6:30 AM. When queried about who stayed with the resident after 911 was called, Nurse S reported NP R was in the room and Nurse S and Nurse T were trying to get the paperwork ready for EMS. They were unsure when NP R left the resident's room. When queried about the interaction with the EMS members when they arrived to the facility, Nurse S reported EMS was concerned there was nobody with the resident in the room. Nurse S stated, I explained that the resident was not deteriorating and was stable and talking. Nurse S explained Nurse T then followed the EMS team to R#611's room, then Nurse T came back to ask Nurse S about an oxygen mask. When Nurse S spoke with EMS, EMS asked Nurse S if the facility had a non-rebreather mask. Nurse S stated, According to the respiratory policy, up to 5 liters (of oxygen) is best by nasal cannula and if more was needed then switch to a mask. Nurse S then explained EMS took R#611 to the hospital and Nurse T documented in R#611's clinical record. On 8/19/20 at 2:56 PM, NP R was interviewed a second time. When queried about when a non-rebreather mask should be considered for oxygen delivery, NP R stated, If they start desating (decreased oxygen saturation), you should consider using one. NP R reported they probably should have switched to a non-rebreather mask for R#611 based on the assessment. When queried about whether or not they were aware R#611 had oxygen saturation levels in the low 60's earlier in the night, NP R reported they were not made aware and the physician should have been called right away and the resident should have been sent out to the hospital. On 8/20/20 at 7:30 AM, Nurse T was interviewed via the telephone. Nurse T reported they worked the night shift on 8/14/20 from 7:00 PM until 7:00 AM on 8/15/20 on the Redwood Unit. Nurse T reported there were two nurses assigned to the unit, Nurse S, who passed the medications during the shift, and Nurse T who took care of the resident care. When queried about what occurred with R#611 that night, Nurse T reported they checked the resident's vitals at the start of the shift and their oxygen saturation was between 90 and 91 percent, the resident did not experience any

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

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) shortness of breath, had the oxygen infusing via nasal cannula that was properly positioned on the resident, and the resident did not have any complaints. Nurse T further explained that a few hours later, they, along with Nurse S put R#611 into bed from the wheelchair, performed a dressing change, and changed the resident's brief. Nurse T reported Nurse S then gave R#611 medications and they let the resident rest in bed. Nurse T reported there was nothing abnormal with the resident at that time. Nurse T further explained when they went into R#611's room around 6:00 AM to change the resident during rounds, the resident's nasal cannula was not in their nostrils so they assisted the resident to put it back in properly and left the room. Nurse T reported, Nurse S then entered R#611's room to pass medications and came out and said, We need to send her to the hospital. When queried about why R#611 required a hospital transfer, Nurse T stated the resident had shortness of breath and low oxygen saturation. Nurse T was queried about R#611's presentation between the beginning of the shift at 7:00 PM, during the dressing change a few hours after that, and 6:00 AM. Nurse T reported R#611 was stable throughout the shift until 6:00AM at the last medication pass. When queried about what happened next, Nurse T reported they let NP R know and they went in to see the resident and told the nurses to call 911. Nurse T was queried about who stayed with the resident after 911 was called. Nurse T reported NP R left the room and when EMS arrived there was nobody in the room with the resident. Nurse T stated, I handed them (EMS) the paperwork and walked with them to the resident's room. When queried about the interaction with the EMS staff, Nurse T reported EMS questioned her about whether or not the facility had a non-rebreather. Nurse T stated, I told them there was one in the crash cart and they started questioning the other nurse and asking why they were not using a non-rebreather. Nurse T reported they later asked the respiratory therapist what should have been done and they reported a non-rebreather could have been used. Nurse T could not remember R#611's oxygen saturation level at the time of the 911 call, but reported it was very low and could not remember what setting the oxygen concentrator was set to and stated, (Nurse S) told me he turned it up. Nurse T was further interviewed about where vital signs and assessments of R#611 were documented. Nurse T reported they took vitals on the shift and the first set taken at the beginning of the shift would be in the vital signs section in the electronic medical record. Nurse T further explained that subsequent checks of R#611's oxygen saturation were performed, but was not sure where they were documented. It was reported by Nurse T that they were required to check residents' vitals on the COVID-19 unit once per shift, unless there was something abnormal, then they would check them periodically. When queried about who would have documented the events that occurred with R#611 on 8/14/20 and 8/15/20, Nurse T stated, I did not. I was assuming (Nurse S) did it. All I did was hand EMS the paperwork and call the son. On 8/20/20 at 8:51 AM, the facility's Director of Nursing (DON) was interviewed. When queried about vital signs monitoring for residents who resided on the COVID-19 positive unit, the DON reported the staff assigned to that unit worked 12 hour shifts and were required to take a full set of vitals once every 12 hour shift and more frequently if the resident was in any distress. The DON reported the vital signs were documented in the Weights and Vitals section of the electronic medical record. The DON was queried about what oxygen saturation level would trigger the nurse to contact the physician or send a resident to the emergency room . The DON reported it depended on the resident's baseline, but anything lower than 88 percent would require an intervention. When queried about when a non-rebreather mask would be used to deliver oxygen, the DON stated, If their oxygen was very, very low in the 50's you would put it on depending on what was going on with the resident. The DON reported the nurses would use their best clinical judgement to determine the best delivery method for oxygen. The DON was further interviewed and queried about their knowledge of what occurred with R#611 during the night shift on 8/14/20. The DON reported they were aware R#611 was in acute respiratory distress and was sent to the hospital. The DON was not aware there was no nursing documentation prior to the progress note written by NP R and reported the vital signs and assessments of the resident should be documented by the nurse. When queried about what should have been done when Nurse S assessed R#611's oxygen saturation at less than 64 percent, the DON reported they should have increased the oxygen, reassessed the resident, and documented in the clinical record. When queried about when the nurses should have called 911 for R#611, the DON reported they were required to get a physicians order to send a resident out to the hospital, but in an emergent situation they should do what was best for the resident to keep them safe. When queried about whether or not a staff member should remain with the resident in respiratory distress after 911 was called and before EMS arrived, the DON reported someone should remain with the resident. On 8/20/20, a (City name redacted) Fire Department Patient Care Record (EMS run sheet) for R#611 dated 8/15/20 was reviewed and documented the following: .PTA (prior to arrival) Oxygen Flow Rate 3 lpm; unsuccessful .7:08 (AM) Oxygen Flow Rate 15 lpm; Patient Response: Unchanged; Successful .dispatched to a (sex redacted) pt (patient) with low oxygen saturation. Arrived to find the .pt lying in bed. RN (Registered Nurse) on scene states that the NP came out of the room and stated that her spO2 is low. The RN reported an SpO2 in the 50s. Upon assessment, the pt is alert but speaks in 1 or 2 work <sic> sentences with labored breathing. There was no care provider in the room with the patient. The pt was found to be on a NC at 3 LPM. Paramedics were unable to obtain a pulse ox reading. The pt was placed on oxygen via NRB (non-rebreather) at 15 lpm. The pt was transferred to the stretcher .Following the increase oxygen delivery, the pts SpO2 had increased, but the pt was still labored around 20 resps/min. The pts lung sound were diminished in the lower lobes bilaterally . The EMS run sheet documented dispatch received the call from the facility at 6:56 AM on 8/15/20 and arrived on the scene at 7:05 AM. It was documented R#611 was transported with lights and sirens to the local emergency room . A review of hospital records for R#611 was conducted and revealed the following: An ED (emergency department) Provider Note dated 8/15/20 documented R#611 presented with shortness of breath and according to the resident was increasing for the past four days. It was documented that R#611 had tachypnea (fast shallow breathing) and respiratory distress present with Wheezing and rales (abnormal sounds in the lungs) present. The ED note further documented, .Concern for COVID exacerbation and possible superinfection (an infection occurring on top of an earlier infection). Initially together, placed on 15 L nonrebreather with moderate improvement in work of breathing .Patient presents plan with admission to ICU (intensive care unit) for continued care .Disposition: Admission .Final Impression: Covid Pneumonia . A Internal Medicine Consult Note dated 8/19/20 documented, .Impression: Acute resp (respiratory) failure requiring [MEDICAL CONDITION] .Pt continues care in icu and on [MEDICAL CONDITION] . A Care Management note dated 8/19/20 documented, Patient on ventilator on [MEDICAL CONDITION] settings .Mental status not improving . Further review of R#611's clinical record revealed there was no documentation by Nurse S and Nurse T from the night shift on 8/14/20 and 8/15/20. The last documented blood pressure and temperature was 8/12/20 at 10:03 AM, the last documented pulse and respiratory rate was 8/13/20 at 5:17 PM, and the last documented oxygen saturation level (prior to NP R's documentation of 50%) was 8/14/20 at 11:14 AM. Physicians Order revealed active orders (as of 8/14/20 and 8/15/20) for COVID-19 screen - Are there any of the following symptoms present? .cough .new shortness of breath . and COVID-19 screen: Monitor VS (vital signs) every shift . The Medication Administration Record [REDACTED]. However, the abnormal oxygen saturation reported during their interview was not documented anywhere in the clinical record. The clinical record also included an order for [REDACTED].Our facility shall promptly notify the resident, his or her Attending Physician .of changes in the resident's medical/mental condition and/or status .The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): .significant change in the resident's physical/emotional/mental condition .need to transfer the resident to a hospital/treatment center .specific instruction to notify the Physician of changes in the resident's condition .A 'significant change' of condition is a major decline or improvement in the resident's status that: .Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions .Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider .The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status . A facility provided document titled, Oxygen Administration Policy & Procedure (revised 9/17/19) was reviewed and it documented, .Oxygen shall only be administered by physician order, except in an emergency. In an emergency situation, oxygen can be administered without physician's orders [REDACTED].Pulse oximetry levels are to be obtained every shift and prn basis for signs/symptoms of shortness of breath . A policy regarding assessment and monitoring of residents with confirmed COVID-19 was requested. A policy was provided by the facility. However, it did not include assessment and monitoring of residents with COVID-19. A review of Centers for Disease Control and Prevention (CDC) guidance dated 4/2020 titled, Responding to Coronavirus (COVID-19) in Nursing Homes documented, .Response to Newly Identified [DIAGNOSES REDACTED]-CoV-2-infected HCP or Residents .Resident with new-onset suspected or confirmed COVID-19 .Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections .
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) This citation pertains to MI 0: Based on interview and record review the facility failed to properly transcribe and administer Temozolomide, a [MEDICAL CONDITION] medication, per the dosage and schedule recommended during an outside consult for one (R#608) of three residents reviewed for mediations, resulting in the resident receiving one third of the dosage recommended for only one day of the five day course the resident was to receive the medication. Findings include: A complaint was received by the State Agency which alleged Temozolomide 100 mg (milligram) capsules with a quantity of fifteen capsules had been dropped off at the facility on April 5 to be administered to R#608. Per the complaint, R#608 was to receive three 100 mg capsules (300 mg) total for three days. It was alleged when the resident was discharged from the facility on April 22, only one capsule had been removed from the total quantity of fifteen pills. The complaint also explained R#608 had aggressive [MEDICAL CONDITION]. Review of the clinical record for R#608 revealed the resident had been admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. Per review of R#608's admission minimum data set assessment dated [DATE], the resident scored fourteen out of fifteen on a brief interview for mental status exam, which indicated the resident was cognitively intact. Review of a CONSULTANT'S FORM dated 3/18/20 (not timed) documented, in part, Reason for Consultation: Dr. Appt .CONSULTANT'S REPORT RECOMMENDATIONS/INSTRUCTIONS .(Brand Name Temozolomide) 100 mg (symbol to indicate three) Q (every) Day x (for) 5 days start 4/5/2020 . Review of a nursing progress note dated 3/18/20 at 7:59PM documented, Res (resident) returned from oncologist appt with new orders for (Brand Name Temozolomide) 100 mg Q day for 5 days and CBC (complete blood count) to be drawn Q2 (every two) weeks while on (Brand Name Temozolomide). all orders and labs put in and transcribed. It was not documented why the dosage of the medication was different than the dosage of the medication documented on the consultation form. Review of a physician order [REDACTED]. It was documented this order was scheduled to start 4/5/20. However, this order had been discontinued on 4/1/20 for a reason of clarification order requested. Review of a physician order [REDACTED].#608 was to receive (Brand Name Temozolomide) 100 mg capsule with directions to give 1 capsule by oral route once daily for 5 days Family to supply. This order was scheduled to start 4/1/20. However, this order had been discontinued on 4/1/20 for a reason of clarification order requested. Review of an additional physician order [REDACTED]. Documented on the order sheet was the following: Discontinued by: Automatic D/C (discontinue) Service on 04/06/2020 09:59 am. Review of R#608's Medication Administration Record [REDACTED].give 1 capsule by oral route once daily for 5 days Family to supply. Per the MAR indicated [REDACTED]. Per the MAR indicated [REDACTED]. Review of documentation present at the bottom of the April 2020 MAR for R#608 pertaining to administration of (Brand Name Temozolomide) 100 mg revealed the following: 4/2/20 9:00a (am): Not Administered .Other: awaiting <sic> on pharm (pharmacy) for delivery 4/3/20 9:00a: Not Administered .Other: Not delivered. 4/4/20 9:00a: Not Administered .Other: (Family member) stated he will bring medication in tonight or tomorrow 4/6/20 9:00a: Not Administered .Not Available The medication had been initialed as administered on 4/5/20, and the dates following 4/6/20 pertaining to administration of this medication had a symbol present in each box (4/7/20-4/30/20) to indicate the medication was not scheduled. Review of a progress note dated 4/5/20 at 5:53PM documented as a late entry note for 4/4/20 7a-3p documented, in part, Writer spoke with (Family member name redacted) regarding supplying (Brand Name Temozolomide) stated he would bring medication to facility either tonight or tomorrow 4/5 morning . On 8/19/20 at approximately 1:40PM the facility's Director of Nursing (DON) was queried regarding the process if a resident came in with an order related to a consult, and the DON explained the nurse would call the doctor, and say there was a recommendation for an order to make sure the Primary Care Physician/facility approved. At this time the consult (from 3/18/20), including the medication dosage, was reviewed with the DON. When queried if this had been brought to the DON's attention, the DON explained this concern had not been brought up per what she recalled. On 8/19/20 at 3:36PM Physician 'A' was queried in regards to the discrepancy in the dosage of R#608's [MEDICAL CONDITION] medication, and explained he did not recall. Review of a facility policy titled, Administering Medications dated 10/19 documented, in part, Medications shall be administered in a safe and timely manner, and as prescribed.
F 0806 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 8: Based on interview and record review, the facility failed to follow dietary allergy orders for one (R#603) of two residents reviewed for food allergies, resulting in the potential for a severe allergic reaction. Findings include: Review of a complaint filed with the State Agency alleged, (R#603) was served cherry pie in his room. The entire staff was notified of (R#603's) allergy to cherries. Despite the notifications (clearly noted on (R#603's) chart and on each and every food receipt he gets for each meal . highlighted with a pink highlighter and has a sticker which reads Allergy in bright orange on the left side of the paper/receipt) he was still served cherry pie which he could have easily died from! The potentially deadly cherry pie passed through three different sets of hands which (sic) should have known the risks involved in serving that to a patient allergy (sic) to cherries yet all three individuals continued to serve the cherry pie to (R#603) . Review of the closed record indicated R#603 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS) assessment dated [DATE], R#603 scored ,[DATE] on the Brief Interview for Mental Status (BIMS) exam, indicating intact cognition. The MDS assessment also indicated R603 required the assistance of staff for meal set up. Review of physician orders [REDACTED]. On [DATE] at 9:48 AM, an interview was conducted, and Dietary Manager E was queried about how food allergies are handled at the facility. Dietary Manager E explained when the meal tickets were printed out, the Dietary Clerk went through and highlighted if a resident had an allergy, put an orange Allergy sticker on the ticket and ensured none of the food listed on the ticket contained the allergen. Then the person working the tray line in the kitchen read the ticket and wouldn't put anything with the allergen in it on the tray, and the person who delivered the tray would see the Allergy sticker and would make sure there was nothing on the tray that had the allergen. Dietary Manager E continued to explain that each tray would pass through at least three different people before it got to the resident, each was responsible for looking for the allergen. Dietary Manager E was asked how R#603 received cherry pie when allergic to cherries. Dietary Manager E explained it had happened on a Sunday, Dietary Clerk F (who no longer worked at the facility) was in charge at that time, and Food Service Assistant G (who had worked the tray line) was written up for the incident. On [DATE] at 10:56 AM, a phone interview was conducted, and Food Service Assistant G was asked about R#603 receiving cherry pie when allergic to cherries. Food Service Assistant G explained they had gotten in trouble and had been written up for putting food a resident was allergic to on a tray. Review of a facility provided Employee Counseling & Corrective Action Record form revealed Food Service Assistant G received a 1st Written Warning on [DATE] for, Carelessness or negligence in the performance of the job assignment. (Food Service Assistant G) served a resident cherry pie with an allergy to cherries. He didn't check the ticket correctly. (Food Service Assistant G) put the resident at risk of an allergic reaction. On [DATE] at 2:35 PM, an interview was conducted, and the Administrator was asked about R#603 receiving cherry pie when allergic to cherries. The Administrator explained they had no knowledge of the incident. Review of a facility policy titled, Food Allergies and Intolerances dated ,[DATE] read in part, .Residents are assessed for a history of food allergies and intolerances upon admission . Meals for residents with severe food allergies are specially prepared so that cross-contamination with allergens does not occur . Residents with food intolerances and allergies are offered appropriate substitutions for foods that they cannot eat .