STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105454	A. BUILDING _____ B. WING _____	**08/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES SARASOTA	**5511 SWIFT ROAD SARASOTA, FL 34231**

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 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, residents and staff interview, the facility failed to maintain documentation of interventions and efforts to resolve multiple dietary concerns for 1 (Resident #2) of 5 sampled residents. The findings included: Review of the facility's process for concerns with a creation date of 1/10/19 revealed documentation Concerns/grievances were documented using a Concern Form and were tracked and trended using the concern log. Concerns/grievances were resolved through use of the investigation process. On 8/4/20 at 9:20 a.m., during an interview, Resident #2 said she had voiced several grievances over the past few months about dietary services. She said it was an on-going problem. She did not get what she ordered from the menu. Resident #1 said she frequently resorted to eating frozen dinners. She explained she was not able to eat pork, eggs, or fish and she frequently got those items on her tray. On 8/4/20 at 12:45 p.m., Resident #2 said about two weeks ago she collected 21 meal tickets, and only once she received what she requested. The resident said she gave the meal tickets to the Social Worker. She said she requested her meat without gravy, and she got gravy. Resident #1 said she had seen little improvement since she reported it to the Social Worker. Review of the concern forms revealed the following: 1. On 2/21/10 Resident #2 complained the food was often served cold and she did not always receive items that she requested on her tray. On 2/26/20 during a one-to-one discussion with the resident the facility explained they reviewed the select menu trays before the carts left the kitchen. They also would start to cross out and write in substitutions and continued to review the temperature of the food during tray line. 2. On 3/10/20 Resident #2 complained the food was cold. She filled out choice menus, but staff did not send what she asked for. She complained that something was missing from her tray for each meal. During a one-to-one discussion on 3/11/20 the Dietary Manager documented they would continue taking temperature of the food prior to mealtimes. They would write on her ticket if substitutions needed to be made. They also provided contact information so Resident #1 could call directly when issues arised. 3. On 5/14/20 Resident #2 reported the kitchen didn't follow the diet or the tray was always missing something. The resident said she didn't ring or ask for help because the aides were busy. Resident #2 also complained food items were not hot enough. The Food Service Director documented she educated staff to microwave lunch and dinner meals. If substitutions must be made the Food Service Director or the Assistant would call her ahead of time to discuss options. During a one-to-one discussion with the resident dated 5/14/20 the Food Service Director documented additional follow up was needed. Resident #2's response was Let's wait and see if it gets better. 4. On 6/23/20 the Registered Dietician documented Resident #2's concern as follows Same old problems. She does not receive what she selects. There are errors every meal. The resident said she ordered a Mediterranean plate and got a sandwich. She said it happened all the time. The Food Service Director documented, review the resident's preferences and see what items were missing consistently. Upped the Periodic Automatic [MEDICATION NAME] (par#) for yogurt so we would not run out. Will continue to notify resident when substitutions must be made to the menu, so resident knows what the options were. On 6/26/20 the resident was notified during a one-to-one discussion. 5. On 7/2/20 the Social Worker documented on a concern form, Resident stated with a few exceptions, received wrong meal orders from the kitchen. Resident gave Social Worker meal tickets for the last week with notation on the back of what was missing/wrong. The follow up included, if substitutions have to be made the dietary aids will write the substitutions on the ticket so patient was aware of changes. The Assistant Food Service Director checked a box on the form indicating additional follow up was needed. He documented check back to see if write-ins have been happening. 6. On 8/4/20 at 1:30 p.m., during an interview the Registered Dietician said Resident #2 had complained about her meals. She said when she was in the building, she sporadically checked Resident #1's tray and they were accurate. She said she did not have documentation of the audits she completed. The Registered Dietician said she could not locate a copy of the meal tickets Resident #1 gave to the Social Worker and didn't know what the Resident's complaints were. 7. On 8/4/20 at 4:00 p.m., during an interview, the Assistant Food Service Director said he did not have documentation the kitchen had addressed the Resident's complaints. He said the facility did not have any tray audits to ensure Resident #2 consistently received the food items she requested. He said sometimes Resident #2 did not receive what she asked for because they did not have the food item on hand, or the item was not available to them. He did not keep documentation the facility notified Resident #2 when food items were not available. He said she did not have documentation the facility offered substitutions for the missing food items. He said the resident saved all her meal tickets and came forth with everything. He said he could not locate that documentation. 8. On 8/4/20 at 4:15 p.m., during an interview Certified Nursing Assistant (CNA) Staff I said Resident #2 always complained about the food. She said sometimes the food was cold. She also had some health conditions and could not eat certain food items. She said very often the resident got food items on her tray she did not want or did not order. Sometimes items she requested were missing. CNA Staff I said she frequently went to the kitchen and retrieved something else for the resident to eat because the kitchen did not send what the resident selected. She said Resident #2 kept soup and pasta in her room and she warmed it up for her when she did not get what she ordered from the kitchen or when she gets food she cannot eat. CNA Staff I said, someone should be in there to make sure everything she requested is on the tray before sending it up. 9. On 8/4/20 at 4:30 p.m., the Registered Dietician said she didn't have documentation of tray audits. She said she could not locate the meal tickets where the resident wrote her complaints or any documentation showing the resolution of the complaints.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation and staff interview the facility failed to maintain an infection prevention and control program related to COVID-19 recommendations including the use of facemasks and physical distancing during activities. The findings included: 1. On 8/4/20 at 9:30 a.m., during an observation of the laundry room, Laundry aide Staff C had a surgical mask on, under her chin, exposing her mouth and nose. On 8/4/20 at 9:40 a.m., during an observation of the kitchen, Dietary Staff E, Dietary Staff F, and Dietary Staff G were wearing face masks positioned only over their mouth and chin, exposing their nose. On 8/4/20 at 9:40 a.m., Dietary Staff D was observed washing dishes and had no mask on. CDC guidance (6/25/20) Preparing for COVID-19 in Nursing Homes: Implement Source Control Measures. HCP should wear a facemask at all times while they are in the facility. Refer to: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html CDC guidance (7/14/20) Using Personal Protective Equipment (PPE): Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Refer to: https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html 2. On 8/4/20 at 9:15 a.m., during an observation in the Thalia Memory Care Unit dining room, the residents were seated 4 to a table and were seated 2- 3 feet from one another. Three staff members were observed in the dining room and they did not assist the residents to maintain social distancing. On 8/4/20 at 9:20 a.m., in an interview the Licensed Practical Nurse (LPN) / Infection Preventionist said the facility had attempted to provide social distancing by adding a 2nd seating to the dining schedules

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) to decrease the number of residents in the area at one time. The LPN said it did help maintain social distancing of the residents in the Thalia dining room. On 8/4/20 at 9:15 a.m., during a tour of the second floor of the facility with the Assistant Director of Nursing the following observations were made: Resident #3 was in the hallway with a surgical mask covering his mouth. The mask did not cover the resident's nose. Resident #4 was observed wheeling himself in the hallway with a surgical mask in his hand. He did not apply the mask to his face. Resident #6 was sitting in a wheelchair in a hallway with a face mask below his nose. Resident #7 was sitting in a wheelchair in the hallway with a face mask below his nose. Several staff members were observed coming in and out of residents' rooms and in the hallway. The staff did not encourage the residents to wear their face masks. On 8/4/20 at 9:30 a.m., during an interview Certified Nursing Assistant Staff H said she was aware the residents are supposed to wear a mask when they leave their rooms. She verified she placed Resident #7 in the hallway and did not encourage the resident to wear a mask. She said she should ensure the residents wear a face covering when leaving their rooms. On 8/4/20 at 11:00 a.m., observation of the Thalia memory care unit revealed several residents sitting next to each other in a circle participating in an activity. The residents were placed within 4 feet of each other. The activity assistant did not attempt to keep a minimum of 6 feet space between residents. On 8/4/20 at 7:30 p.m., during a review of the facility's infection prevention and control program the Infection Preventionist verified the facility was not enforcing a minimum of 6 feet social distancing in the memory care unit. She said they had tried alternate dining times. She said it's very difficult to keep the residents separated. The Infection Preventionist said they can probably do a better job of social distancing during activities. She said they should have tried smaller groups for activities and should try to maintain social distancing. The Infection Preventionist said they've tried to social distance residents during activities and dining in the memory care unit. On 8/4/20 at 8:25 p.m., during an interview the Activity Director said they try to do smaller groups and keep everything as sanitary as possible in the memory care unit. She told her staff to try to keep the residents distanced as much as possible, but with only one activity assistant it's difficult to have separate groups. She said she instructed the activity assistant to limit the number of residents who participate in activities at a time to maintain social distancing in the memory care unit. The Activity Director provided a copy of each resident's participation in activity for 8/4/20. She said the physical activity documented on the daily recreation/activity participation form represented the ball tossing activity. She verified 20 residents participated in the ball tossing activity in the memory care unit. She said she will revise the plan and come up with something to do smaller group activities. CDC guidance (5/12/20) Considerations for Memory Care Units in Long-term Care Facilities, nursing homes and assisted living facilities providing memory care should consider the following: Routines are very important for residents with dementia. Try to keep their environment and routines as consistent as possible while still reminding and assisting with frequent hand hygiene, social distancing, and use of cloth face coverings (if tolerated). Continue to provide structured activities, which may need to occur in the resident's room or be scheduled at staggered times throughout the day to maintain social distancing. Provide safe ways for residents to continue to be active, such as personnel walking with individual residents around the unit or outside. Limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common area, and gently redirect residents who are ambulatory and are in close proximity to other residents or personnel. Refer to: https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html?deliveryName=USCDC_425-DM