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	345384	A. BUILDING _____ B. WING _____	C 03/13/2014

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HERITAGE HEALTHCARE OF FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

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F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide nutritional supplements/interventions to promote wound healing for 2 of 3 sampled residents (Resident #20 and #30) with pressure ulcers. Findings included: 1. Resident #30 was admitted to the facility on 10/19/13, was discharged home on 11/05/13, was sent from home to the hospital, and was readmitted to the facility from the hospital on 11/20/13. The resident's documented diagnoses included diabetes, chronic kidney disease, osteoarthritis, and congestive heart failure. Per the resident's Yearly Weight Record he weighed 116 pound on admission. Resident #30's care plan identified "____ (name of resident) has a potential for alteration in skin integrity related to impaired mobility and incontinence" as a problem on 10/16/13. Approaches to this problem included, "Vitamins/Minerals as ordered".	F 314	Treatment/ Services to Prevent/Heal Pressure Sores Corrective Action for those residents that have been affected: Resident #20 and #30 have had the RD recommendations reviewed, discussed with MD and orders received and implemented where appropriate. Systemic Changes to Prevent Deficient Practice: Have reviewed current patient census for RD recommendations from prior RD visit. All noted recommendations reviewed with MD and ordered where appropriate. See Exhibit F. How measures will be implemented to prevent the reoccurrence of deficient practice:	4/4/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/04/2014

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F 314	Continued From page 1 Review of the resident's November 2013 Treatment Administration Record (TAR) and the treatment nurse's Documentation of Wound Observation revealed Resident #30 was readmitted to the facility on 11/20/13 with a stage II pressure ulcer which healed on 12/04/13. The resident's care plan was updated to reflect these developments. Review of the treatment nurse's Documentation of Wound Observation revealed on 01/13/14 Resident #30's sacrum re-opened, presenting as a stage II pressure ulcer measuring 1.5 x 0.8 centimeters (cm) with epithelial tissue in the wound bed. The resident was also found to have an unstageable pressure ulcer measuring 2.5 x 2.7 cm on his left heel. The wound bed was 100% eschar. Resident #30's care plan identified, "____ (name of resident) has an unstageable pressure ulcer left heel and has a Stage II coccyx pressure ulcer" as a problem on 01/13/14. Approaches to this problem included "Offer resident supplemental nutrition". The resident's 01/15/14 Quarterly Minimum Data Set (MDS) documented the resident's cognition was moderately impaired, he was on a therapeutic diet, he had one stage II and one unstageable pressure ulcer, he was 5' 7" tall and weighed 102 pounds, he experienced significant weight loss of at least 5% in the last month or at least 10% in the last six months, and he required limited assistance by a staff member for eating. Per the Documentation of Wound Observation on 01/31/14 Resident #30's sacral wound presented as a stage IV pressure ulcer measuring 1.8 x 0.8	F 314	With each RD visit, recommendations will be reviewed with DHS, Administrator, and Dietary Manager. All noted recommendations will be discussed with MD and orders implemented where appropriate. How Corrective action will be Monitored: RD to provide the list of recommendations to DHS, Dietary Manager, and Administrator. The list will be signed off by administrator after DHS has verified the timely completing of reviewed recommendations.This will be monitored through audit tool in a.m. meetings until recommendations addressed. See Exhibit C. This tool will be brought to monthly PI meeting that meets on the third Tuesday of each month with the MD and department heads. This process will be followed for sixety days and the PI committed to re-evaluated and developed as needed.	

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x less than 0.1 cm. The wound bed was 100% slough.

A 01/31/14 registered dietitian (RD) progress note documented Resident #30 was being reviewed for a significant weight loss of 16 pounds since admission and the development of a stage IV pressure ulcer. The RD documented, "Will provide Thera-M (multi-vitamin with zinc and vitamin C) 1 tab(let) PO QD (by mouth daily)-to assist with healing. Will provide Arginaid 1 packet PO BID (by mouth twice daily) ... Will provide a supplement Standard 2.0 120 ml (milliliters) PO QID (by mouth four times daily) with (symbol used) meds (medications)..."

Review of the resident's January and February 2014 Medication Administration Record (MAR) revealed the resident was never started on the the multi-vitamin with minerals, Arginaid, or the 2.0 liquid supplement.

Review of progress notes revealed during January 2014 the facility staff began talking to Resident #30's family about possibly initiating hospice services.

Hospital records documented Resident #30 was hospitalized between 02/04/14 and 02/10/14 when he was sent from a physician's office due to hypotension and lethargy.

Upon readmission to the facility on 02/10/14 the Documentation of Wound Observation form revealed Resident #30's stage IV pressure ulcer measured 1.8 x 0.5 x 0.1 and his unstageable pressure ulcer to the left heel measured 1.8 x 0.8 cm.

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A 02/20/14 re-admission progress note by the RD documented Resident #30 had two pressure ulcers, weighed only 102 pounds, and his diet was being clarified to regular. She documented the facility would provide a multi-vitamin daily and 120 ml of standard 2.0 liquid supplement three times daily (TID) with medication pass.

Review of the resident's February and March 2014 MAR revealed the resident was never started on the the multi-vitamin with minerals or the 2.0 liquid supplement.

Lab results documented on 02/23/14 Resident #30's albumin level was low at 3 grams per deciliter (g/dL) with normal being 3.4 - 4.9 g/dL, and his total protein was low at 6.1 g/dL with normal being 6.2 - 8.3 g/dL.

Resident #30 was admitted to hospice on 03/06/14.

At 11:50 AM on 03/12/14 the treatment nurse measured Resident #30's sacral wound. She documented it was 2.4 x 1.5 cm. There was some redness around the edge of the sacral wound. Some eschar was noted on the left side of the wound, and a small amount of yellow slough was noted on the right side of the oval shaped ulcer. The treatment nurse stated the sacral pressure ulcer was a stage IV. The left heel presented as 100% hard black eschar.

At 12:50 PM on 03/12/14 the treatment nurse and director of nursing (DON) stated standard procedure when a resident developed a pressure ulcer was to start the resident on a multi-vitamin with zinc and vitamin C, Arginaid, and check the resident's albumin and total protein levels. If the

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protein levels were low, they reported the RD usually recommended extra protein in the form of liquid nutrition supplements or protein powder. They commented the RD was in the building once or twice a month, would make recommendations, and the hall nurse or the DON would notify the physician to get orders to carry out the RD's recommendations. They stated the RD provided a list of her recommendations before she left the building on each of her visits.

At 5:50 PM on 03/12/14, during a telephone interview, the RD confirmed she was in the building 1 - 2 days a month. She reported she left a written copy of her recommendations when she exited the building, and then e-mailed the recommendations to the administrator, DON, and dietary manager (DM). She commented it was the facility's responsibility to obtain the physician orders necessary to carry out her recommendations.

2. Resident #20 was admitted to the facility on 11/19/13, and expired in the facility on 01/23/14. The resident's documented diagnoses included diabetes, peripheral vascular disease, iron deficiency anemia, and chronic kidney disease.

Review of the resident's November 2013 Medication Administration Record (MAR) revealed she entered the facility on a multi-vitamin daily. Review of the Admission Body Audit Form also revealed the resident entered the facility on 11/19/13 without any pressure ulcers.

The resident's 11/26/13 Admission Minimum Data Set (MDS) documented she had short and long

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term memory impairment, was severely impaired in decision making, was dependent on a staff member for eating, had not experienced any significant weight loss, was on a therapeutic diet which was mechanically altered, and was at risk for pressure ulcers but had no unhealed pressure ulcers (this pressure ulcer risk was captured on the resident's care plan).

In her 12/20/13 nutritional assessment the registered dietitian (RD) documented, " Pt (patient) is not receiving nor at need for any additional supplements to increase (symbol used) calories or protein."

In her Documentation of Wound Observation reports the treatment nurse documented on 12/24/13 Resident #20 developed a stage II pressure ulcer to her sacrum.

The resident's care plan identified, "____ (name of resident) has a sacral pressure ulcer" as a problem on 12/24/13. Approaches to this problem included, "Offer resident supplemental nutritional support."

Lab results documented on 01/08/14 the resident's total protein was low at 5.9 grams per deciliter (g/dL) with normal being 6.2 - 8.3 g/dL.

Documentation of Wound Observation reports revealed on 01/13/14 Resident #20's sacral pressure ulcer worsened, and presented as a stage IV wound with slough, and a stage II pressure ulcer was found on the resident's left buttock.

In her 01/17/14 progress note the dietary manager (DM) documented, "She (Resident #20)

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has a stage IV pressure ulcer on her sacrum. Will continue to monitor..."

Record review revealed there were no further nutritional assessments for Resident #20 after 01/17/14.

Review of the resident's November 2013 - January 2014 MARs revealed, other than the multi-vitamin she was receiving on admission to the facility, Resident #20 did not receive any nutrition supplements to help promote wound healing.

At 12:50 PM on 03/12/14 the treatment nurse and director of nursing (DON) stated standard procedure when a resident developed a pressure ulcer was to start the resident on a multi-vitamin with zinc and vitamin C, Arginaid, and check the resident's albumin and total protein levels. If the protein levels were low, they reported the RD usually recommended extra protein in the form of liquid nutrition supplements or protein powder. They commented the RD was in the building once or twice a month, would make recommendations, and the hall nurse or the DON would notify the physician to get orders to carry out the RD's recommendations. They stated the RD provided a list of her recommendations before she left the building on each of her visits. The DON reported Resident #20 was very debilitated during her facility stay, and probably should have been a candidate for hospice services.

At 2:12 PM on 03/12/14 the DON stated the RD was available by phone between her visits to the facility. She reported the RD should have access to wound information if the facility provided it on-site or sent it to her. According to the DON,

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F 314	Continued From page 7 the RD was supposed to assess wounds when they developed and again if they worsened. At 5:07 PM on 03/12/14 the DM stated the RD was in the building once a month, but she could call her anytime in between monthly visits. The DM reported the RD automatically assessed wounds, new admits, dialysis residents, residents with weight loss and weight gain, and residents fed by tube. She explained the treatment nurse provided the RD with wound information. At 5:50 PM on 03/12/14, during a telephone interview, the RD confirmed she was in the building 1 - 2 days a month. She reported she assessed residents with new wounds, but might not assess them again unless the wounds declined or new wounds were identified. She commented the treatment nurse notified her if new wounds were identified or wounds worsened.	F 314		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by:	F 325		4/4/14

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F 325	Continued From page 8 Based on resident interview, staff interview, and record review the facility failed to put in place nutrition interventions for 1 of 2 sampled residents (Resident #10) who experienced significant weight loss and failed to put in place protein recommendations for 1 of 1 sampled residents (Resident #75) with a non-pressure wound. Findings included: 1. Resident #10 was admitted to the facility on 10/22/13. The resident's documented diagnoses included altered mental status, anemia, multiple cerebrovascular accidents, and hypertension. The resident's Yearly Weight Record documented he weighed 170.8 pounds on admission. Upon admission the resident was receiving all nourishment through a feeding tube with physician orders for Jevity 1.5 one can six times daily. A 10/24/13 physician order began Resident #10 on pleasure foods (no-added salt, mechanical soft foods, any liquids requested by resident). On 10/29/13 "____ (name of resident) has potential for nutrition and hydration deficits related to the use of a feeding tube" was identified as a problem in Resident #10's care plan. Approaches to this problem included "RD (registered dietitian) review every month and PRN (as needed)." The resident's Yearly Weight Record documented he weighed 167 pounds on 11/04/13. A 11/06/13 physician order clarified Resident #10's pleasure foods as no-added salt with	F 325	Treatment/ Services to Prevent/Heal Pressure Sores Corrective Action for those residents that have been affected: Resident #10 has had the RD recommendations reviewed, discussed with MD and orders received and implemented where appropriate. Systemic Changes to Prevent Deficient Practice: Have reviewed current patient census for RD recommendations from prior RD visit. All noted recommendations reviewed with MD and ordered where appropriate. See Exhibit F. How measures will be implemented to prevent the reoccurrence of deficient practice: With each RD visit, recommendations will be reviewed with DHS, Administrator, and Dietary Manager. All noted recommendations will be discussed with MD and orders implemented where appropriate. How Corrective action will be Monitored: RD to provide the list of recommendations to DHS, Dietary Manager, and Administrator. The list will be signed off by administrator after DHS has verified the timely completing of reviewed	

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F 325	Continued From page 9 chopped meats and thin liquids. The only nutrition assessment by the facility's RD was completed on 11/06/13. It documented that Resident #10's tubefeeding with flushes and his pleasure foods met all his calorie, protein, and fluid needs. Review of hospital records revealed Resident #10 was hospitalized between 11/23/13 and 11/29/13. His Yearly Weight Record documented he weighed 167 pounds on readmission. Resident #10 was also readmitted on tubefeeding (Jevity 1.5 one can bolus six time daily) and pleasure foods (no-added salt with chopped meats and thin liquids). The dietary manager (DM) completed progress notes for Resident #10 on 12/06/13, 12/13/13, 12/24/13, and 01/24/14. She documented the resident was stable, and the facility would continue to monitor the resident. The resident's Yearly Weight Record documented he weighed 160 pounds on 01/06/14. The resident's 01/24/14 Quarterly Minimum Data Set (MDS) documented his short and long term memory was impaired, he was moderately impaired in decision making, he was dependent on a staff member for eating, he had no significant weight loss, and 51% or more of his nutrition was supplied by tubefeeding. The resident's Yearly Weight Record documented he weighed 153 pounds on 02/03/14. (This represented a significant weight loss of over 7.5% in three months--actual loss of 14 pounds between 11/04/13 and 02/03/14 or a 8.4% weight	F 325	recommendations.This will be monitored through audit tool in a.m. meetings until recommendations addressed. See Exhibit C. This tool will be brought to monthly PI meeting that meets on the third Tuesday of each month with the MD and department heads. This process will be followed for sixety days and the PI committed to re-evaluated and developed as needed.	

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loss).

Record review revealed there were no RD or DM assessments or nutritional supplementation for Resident #10 at the time of or after his significant weight loss.

The resident's Yearly Weight Record documented he weighed 152 pounds on 03/03/14.

At 4:18 PM on 03/12/14 the director of nursing (DON) stated Resident #10 would only eat a couple of bites of his pleasure foods or a couple sips of beverage, and then stated he was full. She reported she expected the RD to assess all residents who experienced significant weight loss. She commented she expected some type of recommendations be made to prevent further weight loss.

At 5:07 PM on 03/12/14 the DM stated the RD was in the building once a month, but she could contact her by phone between visits. She reported the RD was automatically supposed to assess residents with new or deteriorating wounds, new admits, dialysis residents, those residents who experienced significant weigh loss or gain, and residents fed by tube. The DM commented she supplied the RD with information about resident weights.

At 5:50 PM on 03/12/14, during a telephone interview, the RD confirmed she was in the building 1 - 2 days a month. She reported both she and the DM looked at computer reports with weights which flagged for significant weight loss at 30, 90, and 180 days. According to the RD, she assessed all residents who experienced significant weight loss.

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2. Resident # 75 is a 64 year old who was admitted to the facility on 01/28/14 with diagnoses which included, but were not limited to, malnutrition, a mass of the colon, hypertension, and hyperlipidemia.

A review of the 5 Day Minimum Data Set (MDS) Assessment dated 02/04/14 revealed Resident #75 had two Stage II pressure ulcers and one skin tear upon admission to the facility, and that she required extensive assistance with most activities of daily living. The same admission assessment indicated that Resident #75's nutritional status and pressure ulcers were problems which should be addressed in a nursing care plan.

Review of the resident's nursing care plan initiated on 02/04/14 and last revised on 02/25/14 revealed there were measureable goals and interventions to address the resident's potential for alteration in her nutritional status. Some of the interventions included, but were not limited to: weighing the resident per the healthcare facility protocol, monitoring the intake of her diet, providing food according to her preferences, monitoring her lab work as needed, consulting a Registered Dietician, and providing dietary supplements as ordered.

Resident #75's Nutritional Screening and Assessment Form dated 01/31/14 revealed the resident's body weight was 149.6 pounds, that

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F 325	Continued From page 12	F 325		

she was on a regular diet, and that she was independent with eating, consuming 75% to 100% of her meals. Further review of the same assessment revealed she had open areas on her buttocks (Stage II pressure ulcers), and that she was taking a multi-vitamin with minerals. It also indicated that the resident was not in need of any additional supplements and that she would be offered snack and hydration three times per day. The form was signed by the Registered Dietician on 01/31/14.

A review of a Dietary Progress Note dated 02/20/14 indicated the resident had a Stage II pressure ulcer on her left buttock which measured 2 centimeters by 1.5 centimeters, by 0.1 centimeters. It further indicated the resident was receiving Megace, Thera-M multi-vitamin and that she should begin taking Med Pass 2.0 three times per day which would provide 540 kilo calories and 22.5 grams of protein. (Note: Megace is a medication to treat loss of appetite and weight loss. Med Pass is a nutritional supplement to treat unintended weight loss.) In addition, the same dietary progress note indicated the following: "Will also provide Pro-Stat Sugar Free, 30 milliliters TID (three times per day) with meals to provide 300 kilocalories, 45 grams of protein, for 60 days due to low albumin of 1.7." (Albumin levels are measured in grams per deciliter, and the normal range is 3.4 to 5.4 grams per deciliter. Albumin is a protein which is important to promote repair and growth of healthy tissues.) The progress note was signed by the Registered Dietician.

Another Dietary Progress Note dated 02/25/14 which was signed by the dietary Manager indicated the resident's nutritional intake was

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poor, that she ate 0 % to 25 % of her meals, and that she vomited a lot. The note also stated she was placed on Standard 2.0 (Med Pass) due to her poor appetite. The progress note was signed by the Dietary Manager.

In a review of the resident's lab work dated 02/17/14, the resident's albumin level was low at 1.7, and her total protein level was low at 4.3. (The normal range is 6.2 to 8.3.) Also, the resident's Hemoglobin was low at 7.8 and her hematocrit was low at 23.3. (The normal range for Hemoglobin is 12.1 to 15.1, and the normal range for hematocrit is 36 % to 46 %.)

A review of Resident #75's weight record revealed the following:

On 01/28/14 - a weight of 149.6 pounds
On 02/03/14 - a weight of 144 pounds
On 03/03/14 - a weight of 132 pounds

A review of Resident # 75's medical record revealed that a Weight Loss Notification Form was completed on 02/28/14. The Weight Loss Notification indicated Resident #75 had a 7.6 % weight loss over the past 30 days and that the resident's weight had decreased from 144 pounds to 133 pounds. In addition, the notification revealed the following: "She (Resident #75) doesn't eat her food at meal times. She has been on medications to increase her appetite but she doesn't eat. She does get Standard 2.0 (Med Pass 2.0), 90 milliters to increase her weight. She will be placed on weekly weights for any sig (significant) change/loss." The form was signed by the Dietary Manager on 02/28/14.

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A review of the Physicians' Orders dated revealed an order was made on 02/27/14 to administer Med Pass 2.0, 90 milliliters with each meal at 8:00 AM, 12:00 PM, 4:30 PM, and 9:00 PM. There was also an order on 01/29/14 for Megace, 400 milligrams daily, and for a Ther-M multivitamin by mouth daily. There was no physician's order for Pro-Stat to be administered to Resident #75 during the months of February 2014 or March 2014 to reflect the RD's recommendation to add Pro-Stat Sugar Free, 30 milliliters three times per day with meals.

A review of the Medication Administration Record for February 2014 and March 2014 revealed the resident had received her prescribed Thera-M multivitamin daily, Megace 400 milligrams daily, and Med Pass 2.0 daily with meals as ordered. The resident had not received Pro-Stat per the recommendation dated 02/20/14 by the Registered Dietician.

In an interview with Resident #75 on 03/11/14 at 4:08 PM, she stated she felt okay but that she had abdominal pain earlier in the afternoon. She also stated she ate only a small amount of food at lunch time because she had no appetite. She explained that nothing seemed to help her appetite.

An interview was conducted with the facility's Registered Dietician on 03/12/14 at 4:45 PM. During the interview, she stated that she routinely made visits to the facility one to two days per month and that she reviewed all residents who had pressure ulcers, all residents who had a significant weight loss, and all newly admitted residents to the facility. She explained that when she made her recommendations for dietary

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supplements for residents, she would type them up and email three copies to the facility. She stated that the Dietary Manager, the Director of Health Services, and the Administrator all received her recommendations on the same day via email. In addition, she stated that she always left a copy of the recommendations at the facility.
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In an interview with the Administrator and the Director of Health Services (DHS) on 03/13/14 at 5:00 PM, the Administrator stated the recommendation by the Registered Dietician (RD) for Pro-Stat should have been brought to their attention by the Dietary Manager (DM). The Director of Health Services stated that when the RD came to visit the facility monthly, she typically wrote her recommendations and communicated her recommendations to a nurse. She explained that sometimes when things were very busy in the facility, it was possible for the RD's recommendations to become lost. The Administrator further explained that the RD routinely communicates with the Dietary Manager and gives information and recommendations to her.

An interview was conducted with the Dietary Manager on 03/13/14 at 5:18 PM with the DHS and Administrator present. During the interview, the DM stated she did not remember RD stating anything about adding Pro-Stat to resident's treatment plan. She explained that when the RD came to the facility, the RD would consult with her to determine how a resident was eating and then the RD would write a progress note with her recommendations in it. She further stated the RD would send her recommendations to the DHS, the Administrator, and herself (the DM.) She stated the nurse would then put the RD's

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F 325	Continued From page 16 recommendations into action. In an interview with the DHS on 03/13/14 at 5:23 PM, she stated that the DM is the only one who receives the recommendation (Progress Note) from the RD and that the DM is supposed to give the recommendation to the DHS and to the Administrator so the recommendations can be put into action. She also stated that the RD's recommendation to add Pro-Stat to the resident's plan of care should have been initiated by the nursing staff. She added that a nurse would contact the physician's office to obtain an order for the dietary recommendation.	F 325		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the strength of the sanitizing solution (per manufacturer recommendation) at a low temperature dish machine and in the sanitizing sink of the three-compartment sink system . The facility also failed to make sure kitchenware was dry before stacking it in storage on top of one another, failed	F 371	Food Procure, Store/Prepare/Server-Sanitary Corrective Action for those residents that have been affected: No specific residents were cited in this	4/4/14

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F 371	Continued From page 17 to clean the filters above the stove/oven and clean the back panel of the ice machine, and failed to monitor storage areas for labeling and dating of opened food items and leftovers. Findings included: 1. At 9:08 AM on 03/12/14 the dietary aide operating the low temperature dish machine ran a rack through several times to make sure the wash and final rinse temperatures registered at least 120 degrees Fahrenheit. However, the aide failed to check the strength of the sanitizing solution using a strip. At 9:12 AM on 03/12/14 the aide began running racks of kitchenware through the dish machine. At 9:20 AM on 03/12/14, after running five racks of kitchenware through the dish machine, the dietary aide used a strip to check the strength of the sanitizing solution feeding into the dish machine. The strip did not change color, meaning no sanitizing solution was reaching the dish machine. The aide stated these strips were supposed to register at least 50 parts per million (PPM) of sanitizing solution. At 9:24 AM on 03/12/14 the dietary manager (DM) stated the strip readings from the dish machine were supposed to be recorded on a log posted on the wall. Review of this log revealed the last time any dish machine strip readings had been recorded was on 03/08/14. The DM reported this was not acceptable. At 9:26 AM on 03/12/14 the DM began running kitchenware through the three-compartment sink until the problem at the dish machine could be fixed.	F 371	alleged deficient practice. Systemic Changes to Prevent Deficient Practice: Dietary staff has been in serviced on sanitations of low temp sink and 3 sink compartment sanitation. In addition Dietary staff has been in serviced on drying of kitchenware, cleaning ice machine back panel , filters above the stove, and proper dating of opened foods and leftovers. How measures will be implemented to prevent the reoccurrence of the deficient practice: The DM and/or Administrator or their designee will ensure the areas of concern are performed according to policy. This will be recorded on the audit sheets sheets provided on EXHIBIT A. This will be documented daily for 30 days. Then 3 X weekly for 60 days. How Corrective action will be Monitored: Administrator or his designee will initial the Exhibit weekly to verify audits. This will be in effect for 60 days and brought to monthly PI to determine changes or completion. PI consisists of department heads and MD, that meets the 3rd Tuesday of each month.	

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F 371	Continued From page 18 At 10:33 AM on 03/12/14 the cook removed two tray pans and the Robot Coupe chamber and blade from the sanitizing sink. She utilized this kitchenware in her food preparation for the lunch meal. At 10:43 AM on 03/12/14 the cook once again removed the Robot Coupe chamber and blade and a chopper from the sanitizing sink. She utilized this kitchenware in her food preparation for the lunch meal. At 10:45 AM on 03/12/14 a strip used to test the strength of the sanitizing solution in the three-compartment sink system only registered 50 -100 PPM hyperchlorite. The DM stated the strip should register 150 - 200 PPM. At 3:42 PM on 03/12/14 the facility provided a copy of the service report which documented the service representative had to replace the squeeze tubes in the dish machine system in order for the sanitizer to reach the proper strength. At 2:36 PM on 03/13/14 the DM stated strips were to be used to check the dish machine sanitizing solution as dishes were being washed after each meal. She reported the results were supposed to be recorded on a log. She also commented that she only required strips to be used right after the sanitizing solution was made up each time in the three-compartment sink. 2. During an observation of the kitchen, beginning at 8:57 AM on 03/12/14, 2 of 6 tray pans were stacked wet on top of one another on a storage rack. At this time the cook stated these	F 371		

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had to have been stacked wet the night before because she had not yet begun to wash any kitchenware from the breakfast meal. 8 of 15 small china bowls/side dishes, found stacked on top of one another, were wet. Again, the cook stated these bowls must have been stacked on top of one another the night before.

At 2:36 PM on 03/13/14 the dietary manager (DM) stated kitchenware was to be clean, dry, and free of grease before it was stacked in storage. She reported leaving kitchenware wet for long periods of time could cause bacteria to form.

3. During initial tour of the kitchen, beginning at 10:37 AM on 03/10/14, there was a pink film on the back panel of the ice machine. Ice inside the machine was making contact with the back panel. In addition, the filters above the stove/oven were dirty/dusty and greasy.

During a follow-up observation, beginning at 8:57 AM on 03/12/14, the back panel of the ice machine still had a pink film on it, and the ice inside was making contact with this panel.

At 2:36 PM on 03/13/14 the dietary manager (DM) stated the maintenance manager cleaned all aspects of the ice machine. She also reported that the filters above the stove/oven were supposed to be run through the dish machine daily.

4. During initial tour of the kitchen, beginning at 10:37 AM on 03/10/14, there were opened and stored food items in storage areas which were not labeled and dated. In storage bins opened bags of fetuccini and spaghetti noodles were found

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F 371	Continued From page 20 without labels and dates. Also in the dry storage room a 13 3/8 ounce package of brown gravy mix was found opened and in a baggie, but without label and date. In the walk-in refrigerator three pitchers of tea and two of water were not labeled and dated, a storage container of leftover tomato soup was dated 02/26/14, a large container of vanilla yogurt had a use-by date of 03/09/14, and there was another storage container of what resembled tomato soup which was totally without a label and date. During a follow-up tour of the kitchen on 03/12/14, beginning at 8:57 AM, spaghetti noodles in a storage bin which were opened were without label and date. In the walk-in refrigerator the leftover tomato soup with a date of 02/26/14 was still present as well as the second storage container of what resembled tomato soup which was totally void of label and date. At 2:36 PM on 03/13/14 the dietary manager (DM) stated she and the cooks monitored the storage areas, the cooks usually monitoring the walk-ins and she usually monitoring the dry storage room. She reported the date on leftovers represented the date they were placed in storage. She commented leftovers should be kept no more than 5 - 7 days before being disposed of. The DM stated the facility did not use any food items past their use-by date. She also reported pitchers of tea and water were prepared daily and stored in the walk-in refrigerator. According to the DM, all opened food items, leftovers, and food items removed from original packaging should have labels and dates on them.	F 371		
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY	F 372		4/4/14

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F 372	Continued From page 21 The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to reduce the chance of infestation by insects, rodents, and vermin by allowing ruts near the dumpster area to fill with stagnant brackish water. Findings included: During initial tour of the kitchen and associated food storage and food disposal areas, on 03/10/14 beginning at 10:37 AM, there were ruts in front of the dumpster area which contained stagnant brackish water which had turned green. The ruts were approximately 14 feet long and 8 feet wide. During a follow-up observation on 03/12/14 at 11:12 AM there were still ruts in front of the dumpster area which contained stagnant brackish water which had turned green. The ruts were approximately 14 feet long and 8 feet wide. At 4:53 PM on 03/12/14 the maintenance manager (MM) reported in the 15 years he had worked at the facility this area in front of the dumpsters had gotten progressively worse. He stated the ruts were caused by heavy delivery trucks breaking down the pavement on the driveway behind the building. He reported it was not unusual to find stagnant water in the ruts since they had gotten so large. According to the MM, it might take two loads of gravel to fill the ruts in so that standing water would not be breeding grounds for insects and rodents.	F 372	Dispose of Garbage & Refuse Properly Corrective Action for those residents that have been affected: No specific residents were cited in this alleged deficient practice. Systemic Changes to Prevent Deficient Practice: The rut was filled and graded while survey was present. How measures will be implemented to prevent the reoccurrence of the deficient practice: The Maintenance Director and/or administrator or their designee will make weekly rounds of the facility to determine any new potential risk of ruts. This will be documented on an audit sheet 3 times weekly for 30 days and then 1 times weekly for 30 days. See exhibit B. How Corrective action will be Monitored: Administrator or his designee will initial the Exhibit weekly to verify audits. This will be in effect for 60 days and brought to	

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F 372	Continued From page 22	F 372	monthly PI to determine changes or completion. PI consists of departments heads and MD that meets the third Tuesday of each month.	