

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345514	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF NASH			STREET ADDRESS, CITY, STATE, ZIP CODE 1210 EASTERN AVENUE NASHVILLE, NC 27856		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to close the door, pull privacy curtain, and window blinds to provide for resident's privacy needs for a sacral pressure ulcer dressing change for 1 of 2 residents (Resident #35).</p>	F 164	For the resident affected(#35) and for those patients with the potential to be affected: Nursing staff received in-service training from 12/9-12/15/14 on resident privacy which includes but not limited to: pulling privacy curtain entire length of	12/15/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/15/2014

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 164	Continued From page 1 Findings included: Resident #35 was admitted to the facility on 05/3/11 with diagnoses including the presence of a stage 4 pressure ulcer. Resident #35's quarterly minimum data set (MDS) dated 09/4/14 revealed the resident's cognition was severely impaired. It revealed she needed total or extensive assistance with transfers, personal hygiene, and toileting. Resident #35's sacral pressure ulcer observation with nurse #1 on 11/19/14 at 1:25 PM, revealed one stage 4 sacrum ulcer. Prior to the ulcer observation, the nurse pulled the privacy curtain half way, did not close the door or the window blinds. Nurse #1 informed resident #35 that she was going to do a dressing change on her ulcer. Resident #35 was turned on her right side, and her adult brief was pulled down to reveal the sacral ulcer, exposing her buttocks to the hallway traffic, and to a staff member walking outside by the window. The nurse did close the door with her foot once she noticed she had exposed the resident's buttock to the hall traffic, but still left the blinds open to outside traffic. Interview with Nurse #1 and the assistant director of nursing (ADON) on 11/20/14 at 9:25 AM revealed that Nurse #1 made a few mistakes during resident #35's pressure ulcer dressing change. Nurse #1 said she was nervous and made mistakes. Nurse #1 said that the privacy curtain should have been pulled fully closed, that the window blinds should have been closed, and that the door should have been closed to prevent exposing the resident. Nurse #1 said she did not notice the staff member passing by the window	F 164	curtain track, closing the door and blinds prior to providing care to prevent exposing the resident. Systemic Changes: DON, ADON, SDC or designee will do direct observation with nurses and certified nursing assistants, completing a skills check sheet with each nurse and certified nursing assistant related to providing privacy to prevent resident exposure. Measures Put in Place: DON, ADON, SDC or designee will observe 2 nursing staff members weekly x 4 weeks, then monthly x 3 months, and then periodically thereafter to ensure that resident's privacy is maintained during care. Any area identified will be addressed by the observer at the time of occurrence. Monitoring: The QA committee will review results of findings weekly x 4 months. Any area of continued identified concern will be reviewed and addressed by the committee for further action plan to ensure that residents' privacy is maintained when providing care which exposes the resident.		

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F 164	Continued From page 2 during the dressing change. Interview on 11/20/14 at 9:15 AM with the ADON revealed it was her expectation that the resident's room door to be closed, window blinds closed, and privacy curtain fully closed while doing a sacral pressure ulcer dressing change. Interview with the director of nursing (DON) on 11/21/14 at 9:20 AM revealed that it was her expectation that the privacy of the resident be protected.	F 164			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to repair 17 of 25 cracked/worn/torn resident chairs or positioning devices on resident chairs and failed to repair nicks in the plaster or/and repair scuffed furniture in 27 of 41 resident rooms. Findings included: 1. At 4:20 PM on 11/19/14 the arm rest on Resident #20's chair was worn and sloughing off in places. Beginning at 9:15 AM on 11/20/14 a tour was conducted to view resident chairs in the facility. a. Resident #105's geri-chair had a pad in it, but the pad did not cover the left arm on which the vinyl was ripped and the foam was showing.	F 253	For the residents affected: All wheelchairs, geri chairs, walls and furniture noted in survey observations were repaired/stained/painted by 12/15/14. For the residents with the potential to be affected: All other wheel chairs and geri-chairs, rooms and furniture were evaluated by Housekeeping/Laundry supervisor and Maintenance Director, and plan was developed to complete repairs identified. Measures put in place: Maintenance Director tagged(with identifying number) all wheelchairs/geri-chairs. Each	12/15/14	

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F 253	Continued From page 3 b. The vinyl on the arms of Resident #47's wheelchair was cracked with the foam underneath showing. c. The vinyl on the arms of Resident #29's wheelchair was cracked. d. The cap was missing on the left arm of Resident #160's wheelchair. e. Resident #161 was sitting in a wheelchair at the nurse's station serving the 400/500/600 halls. The arm rest on the left arm of the wheelchair was frayed and sloughing off in places. f. The bilateral arms of Resident #60's wheelchair were frayed with the foam underneath showing in places. g. The vinyl on the arms of Resident #151's geri-chair was cracked and worn off in places. h. The vinyl on the bilateral arms of Resident #162's was cracking. i. The vinyl on the left arm of Resident #117's geri-chair was cracked. j. The vinyl on the right arm of Resident #21's wheelchair was cracked. k. The right arm of Resident #52's high back wheelchair was worn in places, and this arm was loose. l. The vinyl on the right arm of Resident #152's geri-chair was split, and the foam underneath was showing.	F 253	wheelchair number has been placed on a log for preventative maintenance. Maintenance Director will check all wheelchairs/geri-chairs on a quarterly basis for preventative maintenance. Nursing staff and housekeeping staff in-serviced 12/9/14 through 12/15/14 by administrator, Housekeeping/Laundry Supervisor, and ADON to complete work order when wheelchairs/geri-chairs are in need of repairs. In addition, Maintenance Director/Housekeeping/Laundry Supervisor will log each facility room and will review each room on a quarterly basis for rooms in need of repair/painting and any equipment/furniture in need of repair. Nursing staff and housekeeping/maintenance staff in-serviced from 12/9/14-12/15/14 by administrator, ADON, Housekeeping/Laundry Supervisor to complete work order when rooms are noted as needing repair of walls and /or equipment/furniture. Administrator in-serviced Maintenance Director on 11/25/14 on proper completion of work orders and process of logging repairs reported. Monitoring: Adminsitrator, Housekeeping/Laundry Supervisor or designee will audit 4 rooms weekly x 4 weeks, then monthly x 3 months to ensure walls, equipment, furniture, wheelchairs/geri-chairs are in good repair. In the event that an area is identified, a work order will be completed for repair to take place. Administrator will review preventative maintenance log weekly x 4		

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F 253	<p>Continued From page 4</p> <p>m. The vinyl on the right arm of Resident #71's geri-chair was split open.</p> <p>n. The head positioner on Resident #62's wheelchair was fraying and sloughing off in places.</p> <p>o. The vinyl was split on the bilateral arms of Resident #56's geri-chair.</p> <p>p. The bilateral arms of Resident #67's wheelchair were cracked.</p> <p>At 2:00 PM on 11/20/14 the administrator stated she had seen a couple of wheelchairs that needed arm repairs. She reported the maintenance manager (who was on leave and not available for interview) ordered wheelchair arms on 11/08/14. The administrator commented staff could document chairs that required repair in the maintenance logs at the nurse's stations. (Review of the logs at both nurse's stations revealed no documented requests for chair repair other than fixing the brake on a wheelchair). According to the administrator, some "chair covers" were being utilized in the facility which had flaps which fit over chair arms to help protect resident's from possible skin tears.</p> <p>At 3:25 PM on 11/20/14 the environmental services manager stated the maintenance manager was responsible for repairing the arms of the resident chairs. However, she reported her department washed and cleaned resident chairs every six months or as needed. According to the manager, she had seen some chairs which needed repairs, especially to their arms. She commented any staff member, resident, or family</p>	F 253	<p>weeks and monthly x 3 weeks, and then ongoing periodically to ensure areas are being reviewed and repairs made as needed. Any areal of continued concern will be taken to the QA committee for further action plan.</p>		

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F 253	<p>Continued From page 5</p> <p>member could report needed repairs which were logged on a clipboard at the nurse's stations. She stated the maintenance manager crossed out repairs when they were completed.</p> <p>At 4:05 PM on 11/20/14 the administrator she had talked to the maintenance manager via phone, and he reported the wheelchair arms he ordered came in at the beginning of the week. He stated he had replaced the arms on a couple of wheelchairs, but had not completed the rest of the repairs.</p> <p>2. At 4:20 PM on 11/19/14 in room 308 the plaster under and to the side of the sink was chipped, the B bed bedside table was scarred and rough, and the bottom two drawers of the wardrobe were scarred.</p> <p>Beginning at 9:15 AM on 11/20/14 a tour was conducted to view the wall and furniture in resident rooms.</p> <p>a. There were nicks in the wall by the bathroom door in room 413, and spackling had been applied to the wall behind the bed, but had not been painted over.</p> <p>b. The bedside tables and wardrobes in room 304 were scarred, the plaster under and to the side of the sink was chipped, and the wall behind the B bed and the beside the bedside table was abraded.</p> <p>c. Bed A in room 303 had a scarred bedside table and wardrobe, the wall near the bed was abraded, and there were nicks in the plaster under and to the side of the sink.</p>	F 253			

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F 253	Continued From page 6 d. The second drawer of the bedside table belonging to Bed A in room 307 was cracked. e. In room 310 the B bed bedside table was scarred, the wardrobes were scarred, the plaster was abraded by the A bed, and there were nicks in the plaster under and to the side of the sink. f. There were nicks in the plaster behind chairs in room 312, and the bedside table was scarred. g. The beside table in room 309 was scarred, and there were nicks in the plaster to the left of the bed and bedside table. h. The bedside table in room 311 was scarred. i. There were handles off the wardrobes in room 306, the A bed bedside table was scarred, and there were nicks in the plaster under and to the side of the sink. j. The plaster to the left of the recliner in room 402 was abraded, and the top drawer of the wardrobe was scarred. k. The wall was abraded behind the visitor's chair in room 401, and the wardrobe was scarred. l. In room 403 the top drawer of the wardrobe was scarred, and there were nicks in the plaster under and to the side of the sink. m. The wall behind the bed in room 406 was patched with spackling, but had not been painted. There were also nicks in the plaster beside the room door and under and to the side of the sink. n. The handle on the second drawer of the	F 253			

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F 253	<p>Continued From page 7</p> <p>bedside table in room 407 was not securely attached, the wardrobe was scarred, and there were nicks in the plaster under to the side of the sink.</p> <p>o. The plaster was abraded above an electrical plug in room 409.</p> <p>p. The bottom of the wardrobe was scarred in room 411.</p> <p>q. Spackling had been applied to the plaster behind the bed in room 413, but the wall had not been repainted, and there were nicks in the plaster to the right of the bathroom door.</p> <p>r. The wardrobe in room 502 was scarred, and there were nicks in the plaster under and to the side of the sink.</p> <p>s. The plaster under and to the side of the sink in room 501 was nicked.</p> <p>t. The wardrobe and bedside table in room 506 were scarred, and there were nicks in the plaster under and to the side of the sink.</p> <p>u. Spackling had been applied to the plaster behind the bed in room 601, but the wall had not been repainted, and there were nicks in the plaster under and to the side of the sink. The bedside table in the room was also scarred.</p> <p>v. The bedside tables and wardrobes in room 602 were scarred.</p> <p>w. There was a hole in the plaster by the sink in room 604, and the plaster just inside the room door was abraded.</p>	F 253			

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F 253	<p>Continued From page 8</p> <p>x. There were nicks in the plaster just inside the room door, under and to the side of the sink, and behind A bed. A bedside table and wardrobe in the room were also scarred.</p> <p>y. Spackling had been applied to the plaster behind A bed in room 606, but the wall had not been repainted. There was also a small spot of abraded plaster behind the B bed, and a bedside table in the room was scarred.</p> <p>z. There were nicks in the plaster behind a bed in room 607 and under and to the side of the sink.</p> <p>At 2:00 PM on 11/20/14 the administrator stated to her knowledge the maintenance manager (who was on leave and not available for interview) did not conduct regularly scheduled rounds to inspect the walls and furniture in resident rooms. However, she reported any concerns about the furniture and the walls could be documented on repair request logs at the nursing stations. (Review of the logs at both nurse's stations revealed no documented requests to have any walls or furniture repaired). The administrator commented her expectation would be that any nicks or holes in the plaster that required spackling should be painted over to match the original color of the walls.</p> <p>At 3:25 PM on 11/20/14 the environmental services manager reported she had noticed some wear and tear on the furniture in resident rooms which was beginning to get some age on it. She stated the facility was in need of some new furniture, and if existing furniture could not be repaired then it was disposed of. The environmental services manager commented she</p>	F 253			

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F 253	Continued From page 9 had recently found a can of stain, and she was going to talk to the maintenance manager about using it to help improve the look of some of the scarred furniture. According to the environmental services manager, anyone could log concerns about walls and furniture into repair logs at the nurse's stations.	F 253			
F 313 SS=E	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to make a referral for hearing assessment, per order by the medical provider, for 1 of 1 resident (Resident #29) reviewed for hearing. Findings included: Resident #29 was admitted to the facility with diagnoses which included: altered mental status, metabolic encephalopathy, and vertigo. A quarterly Minimum Data Set (MDS), dated 10/1/2014, noted Resident #29's cognition was moderately impaired, hearing was highly impaired, and the resident did not use an assistive device for hearing.	F 313	For the resident affected: On 11/20/14, the ADON called ENT for resident #29 and scheduled an appointment for a hearing consult on 12/9/14. For residents with the potential to be affected: DON, ADON, and SDC audited all residents' records on 12/12/14 to determine if there were any other residents with outstanding orders for consults. Measures put in place: During morning and clinical meeting, all new physician orders will be reviewed by DON, ADON	12/15/14	

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F 313	<p>Continued From page 10</p> <p>The resident's care plan, completed in April 2014, included a focus for the resident's communication needs which included the resident's need for cueing, adequate time for resident response, elimination of unnecessary noise, facing the resident when speaking, and adjusting tone as needed, related to hearing deficit and cognitive impairment.</p> <p>On 6/18/14 at 12:07 PM, a nursing entry noted: "New order received in reference to c/o (complaint of) cough and c/o ears being full. Start Levaquin 500 mg (milligrams) QD (each day) x (times) 10 days, Prednisone 20 mg BID (twice a day) x 5 days, monitor ear status and if no better after ABT (antibiotic) tx (treatment) to send to ENT (Ear, Nose, and Throat) for possible irrigation. POA (Power of Attorney) and pharmacy made aware."</p> <p>On 6/25/14 at 3:12 PM, a nursing note specified: "After ABT tx completed if hearing no better refer to ENT for possible irrigation - remains on antibiotic."</p> <p>On 6/28/14 at 2:49 PM, a nursing note stated: "After ABT tx completed if hearing no better refer to ENT for possible irrigation. Resident stated she doesn't hear well and would like for a Dr to check her ears. Will leave a note for permanent nurse to make appt (appointment) Monday and will pass on to oncoming shift."</p> <p>On 7/1/14 at 8:15 PM, a nursing note stated: "Alert and verbally responsive to verbal stimuli, though communication with her is difficult due to her extreme hardness of hearing."</p> <p>On 7/2/14 at 5:00 PM, a nursing note indicated:</p>	F 313	<p>and SDC to ensure any order which includes consults/referrals has had appointment scheduled. In-services completed by ADON from 12/12-12/15/14 for nurses as it relates to physician orders for consults/referrals to ensure appointments are made as ordered.</p> <p>Monitoring: DON, ADON and SDC will review all new physician orders during morning clinical meetings ongoing to ensure any order for consult/referral has been completed by scheduling appointments as appropriate.</p> <p>QA: During morning clinical meeting review of new physician ordres, any area of identified concern will be addressed at that time. If continued area of concern is identified, the QA committee will review for further action plan to ensure sustained compliance.</p>		

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F 313	<p>Continued From page 11</p> <p>"Alert and verbally responsive to verbal stimuli, though communication with her is difficult due to her extreme hardness of hearing. Pt. (patient) responds, "What do you do when you can't hear the fire whistle blow?" "</p> <p>On 7/3/14 at 9:29 AM, a nursing note specified: "Resident is alert and up in wheelchair. Pleasant and engages in conversation and attends activities. Is extremely hard of hearing which makes communication difficult. Speaker needs to speak very loudly to her and she is then able to understand."</p> <p>On 7/3/14 at 8:30 PM, a nursing note indicated: "Alert and verbally responsive to verbal stimuli though communication with her is difficult due to her extreme hardness of hearing."</p> <p>On 7/4/14 at 8:30 PM, a nursing note stated: "Alert and verbally responsive to verbal stimuli, though communication with her difficult due to her extreme hardness of hearing."</p> <p>On 7/7/14 at 5:00 PM, a nursing note specified: "Wheeling herself to the dining room for dinner, and tolerating well upon approach. Alert and verbally responsive to verbal stimuli, though communication with her is difficult due to extreme hardness of hearing. Feeds herself."</p> <p>At 12:30 PM on 11/17/14, during observation of the lunch meal and an interview with the resident and a family member, Resident #29 stated that her lunch was fine, but she wished someone would check her ears. Her family member stated that she hadn't had her hearing checked since she was admitted in April, but had requested an appointment to have it checked.</p>	F 313			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345514	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2014
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F 313	<p>Continued From page 12</p> <p>On 11/20/14 at 9:00 AM, Resident #29 was observed in bed, dressed. She communicated well, but was hard of hearing. Resident reported that she wished someone would look into her ears. She said, "I can't hear thunder." She also reported that there was an itching in her ear and she just wanted to take a toothpick or something and scratch it.</p> <p>On 11/20/14 at 9:08 AM, Nurse #5 stated that when she became the permanent nurse on Resident #29's hall, at the end of August, she recalled there being some conversation about her hearing, but her family member didn't want to have anything done at that time. She stated that Resident #29 had always been hard of hearing for as long as she had been assigned to her. She reported that the resident could hear and communicate with you if you were right there in her face, but you would have to be in front of her. She also reported that Resident #29 had a hard time hearing you when you knocked on the door or if you talked to her from the hallway. Nurse #5 reported that Resident #29 had not had an ENT assessment since she had been admitted to the facility. She reported that she wrote a note on 6/28/14 for her permanent nurse, at that time, to request a referral for hearing assessment, but did not see anything in the computer about her getting it.</p> <p>At 9:15 AM on 11/20/14, Nurse #5 asked for assistance from the Medical Records nurse to find any evidence in the computer or other records of Resident #5 being seen by ENT for hearing issues. The Medical Records nurse stated that she did not think Resident #29 had been seen by ENT since she had been here.</p>	F 313			

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F 313	Continued From page 13 At 9:20 AM on 11/20/14, after looking in the electronic medical records system, the Medical Records nurse could not find evidence that Resident #29 had been evaluated for hearing. On 11/20/14 at 3:40 PM, the Assistant Director of Nursing (ADON) stated that the referral to the ENT should have been done if resident was still having hearing issues after the course of antibiotics was completed on 6/28/14, per the order by the provider. She stated that she looked in the computer and did not see evidence that this resident had ever been seen by ENT, but she would make sure the referral was made immediately.	F 313			
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, record review, and staff interviews, a facility staff member failed to ensure that all stool was cleaned before initiating the wound care and to clean inside a pressure ulcer for 1 of 2 residents observed for pressure ulcer care, Resident #69. Findings included:	F 314	For Resident Affected: Nurse #2 who provided treatment to resident #69 during survey observation received individual training by ADON on 11/26/14 related to wound care technique. Nurse #2 was observed by ADON on 12/2/14 and	12/15/14	

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F 314	<p>Continued From page 14</p> <p>A review of the Minimum Data Set Assessment dated 10/23/2014 indicated Resident #69 was totally dependent upon staff for transfers, dressing, eating, personal hygiene, and bathing, and that extensive assistance was necessary for toileting. Also, the same assessment indicated Resident #69 had a stage IV sacral pressure ulcer.</p> <p>The resident's nursing care plan which was last updated 10/28/2014 included interventions related to wound care with a goal that the resident would not develop any complications such as drainage, odor, or infection to the sacral wound, and that the resident would not experience any further skin breakdown.</p> <p>A review of the physician's orders revealed there was a current order for Resident #69's sacral pressure ulcer as follows: "Wound care qd (every day) as scheduled. Schedule Note: Clean stage IV non-healing wound to coccyx with soap and water. Fluff piece of Xeroform gauze into wound bed and cover with dry dressing." The original date of the order was 06/03/2014.</p> <p>A review of the wound assessment dated 11/18/2014 revealed the measurements of the sacral pressure ulcer were 4.0 centimeters (cm) long, 1.0 cm wide, and 1.0 cm deep, and that there was no drainage present, and that granulation tissue was present with no necrosis visible.</p> <p>An observation of wound care provided by Nurse #2 and Nursing Assistant (NA) #1 was made on 11/19/2014 at 11:14 AM. Nurse #2 and NA #1 washed their hands, donned clean gloves, and</p>	F 314	<p>12/9/14 while providing wound care to ensure proper technique was used and included ensuring that resident was cleaned of incontinence prior to provision of wound care.</p> <p>For residents with potential to be affected: ADON provided in-service from 12/7-12/13/14 for licensed nurses related to wound care technique and included ensuring that residents were cleaned of incontinence prior to wound care. Return demonstrations were completed with licensed nurses from 12/7-12/13/14 by ADON, DON and SDC.</p> <p>Measures put in place: SDC, ADON, or DON will be required to do direct observation of licensed nurses quarterly to ensure proper technique in used during wound care and ensure that resident is cleaned of incontinence prior to providing wound care x 3 quarters.</p> <p>Monitoring and QA: SDC, ADON or DON will observe 1 resident weekly x 3 weeks, then monthly x 3 months to ensure proper wound care technique is used and that resident is cleaned of incontinence prior to providing wound care. Any identified concern will be addressed at the the time of treatment. Any area of continued identified concerns will be brought to the QA meeting to review concern for further action plan.</p>		

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F 314	<p>Continued From page 15</p> <p>then proceeded to remove the resident's disposable adult brief while he was lying on his left side. As the brief was partially removed, Nurse #2 noted the resident's brief was soiled with stool and that the sacral wound dressing also had stool on it. Nurse #2 stated that the resident would need to be cleaned before wound care could proceed. Nurse #2 and NA #1 cleaned the stool from the back and then the front of the resident. A clean adult brief and draw mat was placed under the resident. Nurse #2 dampened 4-inch by 4-inch gauze pads (4 by 4's) with warm water at the resident's sink in order to wash the sacral wound as ordered. Nurse #2 approached the bedside and reached down to clean the sacral pressure wound as ordered. The surveyor stopped Nurse #2 due to observation of more stool and asked her to check between the gluteal folds. Nurse #2 discovered there was more stool that needed to be cleaned. Nurse #2 used the dampened 4 by 4's to clean the resident of stool, then went removed her gloves, washed her hands, and donned clean gloves. Nurse #2 then dampened clean 4 by 4's with warm water, went back to the bedside, placed some soap on the 4 x 4, and started to clean around the outside of the sacral wound in a circular manner once. Nurse #2 used a second dampened 4 by 4, added soap, and cleaned outside the first circled area. The surveyor asked to see inside the wound, and the nurse spread apart the skin around the pressure wound. Nurse #2 did not use any dampened 4 by 4's or soap to clean inside the wound. The nurse then packed the wound lightly with xeroform gauze, and folded a dry 4 by 4 gauze to cover the wound.</p> <p>In an interview with Nurse #2 after the wound treatment at 12:00 PM on 11/19/2014, she stated</p>	F 314			

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F 314	Continued From page 16 that she did not think there was any more stool present when she started to clean the resident's sacral wound care. She stated she should have noted this and stated that if the stool was not cleaned prior to the dressing change, there would be risk of contamination of the dressing and possible infection of the wound. Nurse #2 also stated she did not remember the last time she was provided any in-service training regarding wound care or infection control. In an interview with the Director of Nursing (DON) and the Assistant DON (ADON) on 11/20/2014 at 9:35 AM, the DON stated that clean technique should be used whenever a wound is washed and that all incontinent stool and urine should be cleaned prior to the treatment of a pressure ulcer in the sacral area. She also stated that she expected the wound to be cleaned completely as ordered and that all nurses should be aware of proper wound care techniques. She added that in this case, in-service education regarding wound care and infection control practices would be needed.	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.	F 325		12/15/14	

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F 325	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to assess the effectiveness of a nutrition supplement put in place for 1 of 3 sampled residents (Resident #107) who experienced weight loss. Findings included: Resident #107 was admitted to the facility on 06/03/14 and readmitted on 08/28/14 and 08/31/14. The resident's documented diagnoses included dysphagia, reflux, cerebrovascular accident with hemiplegia, hyperlipidemia, hypertension, and constipation. The resident's weight record documented she weighed 142.6 pounds on 06/05/14. The resident's 06/09/14 Admission Minimum Data Set (MDS) documented her cognition was severely impaired, she was 4' 11" tall and weighed 143 pounds, she required extensive assistance from a staff member at meals, and experienced no significant weight loss or weight gain. On 06/11/14 the resident's care plan identified her need for extensive assistance at meals as a problem. Interventions to the problem included cueing with set-up assistance, allowing the resident the chance to feed herself followed by staff assistance, and promoting rest breaks during meals and staff encouragement to increase intake. On 06/25/14 concern for the resident's nutritional status was updated on her care plan, and	F 325	For the resident with the potential to be affected: Resident #107 was assessed for the need of supplement ordered on 10/27/14. Physician's order was received to discontinue the supplement on 12/1/14. For other residents with the potential to be affected: All other residents with orders for supplements were reviewed and evaluated related to intake percentage and/or consistent refusal of supplement by ADON and Regional Dietician. This was completed 12/12/14. Measures put in place: In-servicing of nursing staff completed by ADON from 12/12/14-12/15/14 related to residents with orders for supplements and decreased intake and/or refusal of same. A list of current supplements will be maintained by DON and in addition, physician orders will be reviewed during morning clinical meeting to note any new supplements added. Monitoring and QA: A review of 2 residents weekly x 4 weeks, then monthly x 3 months will be completed by DON or designee for intake percentages and/or refusal of supplement to ensure residents refusing supplements are being addressed timely. Any areas of continued concern will be addressed by the QA committee for further action plan.		

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F 325	<p>Continued From page 18</p> <p>potential for weight loss was identified as a problem. Interventions included offering adequate fluids and snacks.</p> <p>The resident's 09/02/14 Quarterly MDS documented her cognition was severely impaired, she weighed 146 pounds, she required set-up assistance with meals only, and she experienced no significant weight loss or gain.</p> <p>The resident's weight record documented she weighed 143 pounds on 09/17/14 and 137.8 pounds on 10/15/14.</p> <p>A 10/23/14 nutritional assessment by the facility's registered dietitian (RD) documented Resident #107 experienced gradual weight loss x 30 days with meal intake averaging 10 - 50% at breakfast and lunch and 25 - 100% at supper. The RD recommended 90 cubic centimeters (cc) of 2.0 liquid nutrition supplement twice daily (BID) with medication pass to halt weight loss and help meet nutritional needs.</p> <p>The resident's weight record documented she weighed 134.8 pounds on 10/25/14.</p> <p>A 10/27/14 physician order put the RD's recommendation into place.</p> <p>The resident's weight record documented she weighed 133.6 pounds on 10/28/14.</p> <p>On 11/17/14 the resident's care plan identified not meeting nutritional needs as a problem. Interventions to this problem included quarterly assessment by dietary/RD and provision of supplement BID.</p>	F 325			

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F 325	<p>Continued From page 19</p> <p>The resident's weight record documented she weighed 133.8 pounds on 11/18/14.</p> <p>Review of Resident #107's medication administration records (MARs) revealed she refused her nutritional supplement once on 10/27, twice on 10/28/14, once on 10/29/14, twice on 11/03/14 through 11/05/14, once on 11/06/14 and 11/07/14, twice on 11/08/14, once on 11/10/14, twice on 11/12/14 and 11/13/14, and once on 11/14/14 and 11/18/14 and 11/19/14 (22 refusals out of 47 opportunities to drink the supplement for a refusal rate of 47%). In addition, according to the MARs, the resident drank less than half of her supplement on five occasions between 10/27/14 and 11/19/14.</p> <p>At 10:40 AM on 11/20/14 the dietary manager (DM) stated a lot of residents in the building did not care for the 2.0 liquid nutrition supplement so those residents were frequently switched to Ensure or Mighty Shakes. She reported that she and the assistant director of nursing (ADON) followed up on weight loss interventions to make sure they were effective. The DM commented they reviewed refusal rates of supplements and the ccs or percent of intake to decide if nutritional supplements were effective. According to the DM, if refusal rates of a supplement product were close to 50% then the current product needed to be replaced with an alternative product. She explained the dangers of not identifying ineffective supplement products included the potential for significant weight loss, for problems with skin integrity, and for the development of abnormal lab values.</p> <p>At 11:40 AM on 11/20/14 Nurse #2, who cared for Resident #107 on first shift, stated the resident</p>	F 325			

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F 325	<p>Continued From page 20</p> <p>did not like the 2.0 liquid nutrition supplement. She explained the resident refused it a lot, and at other times would only drink 20 - 30 cc of the 90 cc which were offered. The nurse reported she had not told other staff members about this problem since all dietary staff had access to electronic records which documented the resident's refusals and percent of intake for the nutritional supplement.</p> <p>At 1:25 PM on 11/20/14, during a telephone interview, the RD stated she was told that the DM followed up on all new supplements to make sure they were effective. She reported if a resident was refusing a supplement close to 50% of the time, it was time to consider using a different product to prevent further weight loss.</p> <p>At 2:18 PM on 11/20/14 the ADON stated nutritional supplements were followed up on in weekly patient at risk (PAR) meetings. (There were no PAR notes in Resident #107's electronic record since being placed on the 2.0 liquid supplement on 10/27/14). The ADON reported the PAR committee could view resident refusals and supplement intake in the facility's electronic record system. She commented if a resident had been on a supplement for close to a month and was refusing it close to half of the time, it was time to change the supplement product.</p> <p>At 4:23 PM on 11/20/14 Nurse #4, who cared for Resident #107 on second shift, stated at first the resident would drink 10 - 30 cc of the 2.0 liquid supplement, but within the last three weeks the resident was totally refusing it. She explained she could just walk into the resident's room with the supplement, and the resident would say, "no". According to Nurse #4, she would educate the</p>	F 325			

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F 325	Continued From page 21 resident about the importance of drinking the supplement, but Resident #107 would still refuse it. This nurse stated she informed the oncoming nurses about the problem, but had not told the DM or RD because the ccs of intake and refusal of the supplement were documented in the electronic medical record.	F 325			
F 371 SS=F	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 sanitizing solutions at an effective strength, failed to air dry kitchenware before stacking it in storage, failed to sanitize meal carts which were previously in resident care areas and commons areas, failed to discard damaged kitchenware or rewash kitchenware contaminated by dried food particles, and failed to monitor storage areas for labeling/use-by dates/contamination. Findings included: 1. At 9:28 AM on 11/19/14 the cook began rinsing raw chicken in the one-compartment sink in the food preparation area. The chicken was in a strainer with cool water running over it.	F 371	For the residents affected and for those with the potential to be affected: Dietary staff was inserved on correct sanitizing of kitchen equipment and use of sanitizing solutions, storage of dishware, pots/pans, appropriate use of Dinex small wares, and storage of small ware and pans for optimal drying, appropriate labeling/use-by dates/contamination. Measures put in place: Regional dietician implemented Dietary Department Quality Assurance Report check off sheet on 11/24/14 which includes: Walk-in freezer/walk-in refrigerator-proper storage	12/15/14	

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F 371	<p>Continued From page 22</p> <p>At 9:48 AM on 11/19/14 the cook finished prepping the raw chicken, and began sanitizing the sink where the chicken was rinsed. She stated she was using quaternary sanitizing solution dispensed from the three-compartment sink system. According to the cook, she made the solution up around 7:30 AM that morning.</p> <p>At 9:50 AM on 11/19/14 a strip used to check the strength of this sanitizing solution only registered 100 parts per million (PPM). Even though the cook reported the solution was strong enough to kill any bacteria, she made up a new bucket of quaternary solution at the three-compartment sink dispensing station which registered 250 - 300 PPM.</p> <p>At 10:40 AM on 11/20/14 the dietary manager (DM) stated sinks were to be sanitized with a quaternary sanitizing solution, the buckets containing the solution were to be made up fresh after each meal, and strips were to be used to check the strength of the solution each time buckets were made up. She reported that the strips should register at least 150 - 200 PPM to sufficiently kill all bacteria.</p> <p>At 3:48 PM on 11/20/14 a cook stated red buckets of quaternary sanitizing solution were used to sanitize food preparation surfaces. She reported the buckets were made up three times daily, and each time they were prepared, the strength was monitored using strips. According to the cook, the sanitizing solution should always register at least 200 PPM in order to completely destroy bacteria.</p> <p>2. During initial tour of the kitchen, beginning at</p>	F 371	<p>items and items labeled and dated; dry storage-items dated and labeled; sanitizing of tray carts after use with appropriate solution; sanitizing tables/work spaces with appropriate solution added; inspecting pots and pans for moisture; and inspecting of small wares for stains, wear and moisture.</p> <p>Monitoring a QA: Cook will complete check list 3 times daily x 14 days, then weekly x 3 weeks, then monthly x 3 months, then periodically thereafter. Dietary manager will review checklist weekly x 3 weeks, then monthly x 3 months to ensure sustained compliance. Any area of continued concern will be brought before the QA committee for further action plan.</p>		

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F 371	<p>Continued From page 23</p> <p>9:55 AM on 11/17/14, 4 of 15 tray pans stacked on top of one another in storage were wet, and had moisture trapped between them. Dietary staff reported these tray pans were stacked into storage the night before.</p> <p>At 9:10 AM on 11/19/14, during a follow-up tour of the kitchen, 2 of 10 tray pans stacked on top of one another in storage were wet, and had moisture trapped between them. 14 of 14 four-ounce juice cups were stacked on top of one another in storage, and were wet. Dietary staff reported both the tray pans and cups were stacked into storage the night before.</p> <p>At 10:40 AM on 11/20/14 the dietary manager (DM) stated no kitchenware was to be stacked into storage unless it was free from food particles and dry. She reported moisture trapped between kitchenware overnight could lead to the development of harmful bacteria.</p> <p>At 3:48 PM on 11/20/14 a cook stated kitchenware was to be checked to make sure it was clean and was air dried before stacking it into storage. She reported stacking kitchenware wet could cause bacteria to grow.</p> <p>3. On 11/19/14 between 9:35 AM and 10:23 AM four meal carts were emptied in the kitchen. The carts were only wiped down with a dishwashing solution.</p> <p>At 10:40 AM on 11/20/14 the dietary manager (DM) stated since meal carts had been out in resident care areas and common areas of the facility they should be washed down and sanitized. She reported the carts were to be sanitized using quaternary solution dispensed at</p>	F 371			

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F 371	<p>Continued From page 24 the three-compartment sink.</p> <p>At 3:48 PM on 11/20/14 a cook stated germs could be on meal carts returning from the halls and dining rooms so, once emptied in the kitchen, they should be wiped down on the outside and inside with quaternary sanitizer.</p> <p>4. During an inspection of kitchenware, beginning at 10:42 AM on 11/19/14, 3 of 20 plates to be utilized at the lunch meal were contaminated by dried yellow food particles, 5 of 17 sectional plates were contaminated by dried tan/brown/yellow food particles, 6 of 18 plastic soup/cereal bowls were abraded inside, 1 of 18 plastic soup/cereal bowls was contaminated by dried green food particles, and 3 of 10 china bowls were contaminated by orange/yellow/tan food particles.</p> <p>In all 18 of 87 pieces of kitchenware which were examined, or 21%, were compromised by abraded surfaces or dried food particles.</p> <p>At 10:40 AM on 11/20/14 the dietary manager (DM) stated kitchenware was not to be placed in storage unless it was clean. She also reported that damaged kitchenware, including items with chips/cracks/abraded surfaces were to be discarded after she was notified of the damages.</p> <p>At 3:48 PM on 11/20/14 a cook stated the dietary aide working the sanitized end of the dish machine was supposed to see to it that kitchenware with dried food particles was run back through the dish machine until clean. She explained that kitchenware contaminated by dried food was not supposed to be placed in storage to be used at upcoming meals. According to the cook, kitchenware that was</p>	F 371			

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F 371	<p>Continued From page 25</p> <p>chipped/cracked/abraded was supposed to be thrown away, and the dietary staff notified the DM when they were low on inventory.</p> <p>5. During initial tour of the kitchen, beginning at 9:55 AM on 11/17/14, an eight-ounce container of barbecue sauce which was opened was being stored in the dry storage room rather than in refrigerated storage as specified on the label. Also in the dry storage room there was no label or open date on a plastic bag of opened fruit punch and drink mixes. In the walk-in refrigerator half of a cucumber had no date indicating when it was cut, a five-pound container of cottage cheese had a use-by date of 10/18/14, and another five-pound container of cottage cheese had a use-by date of 10/26/14. In the walk-in freezer a ham which had been removed from its original packaging and wrapped in foil had no label or date on it.</p> <p>At 9:28 AM on 11/19/14 an opened package of hamburger buns in the dry storage room had no label or date on it.</p> <p>At 10:13 AM on 11/19/14 the top layer of cups of pre-poured water in the reach-in refrigerator was not covered.</p> <p>At 10:15 AM on 11/19/14 a tray pan containing a variety of sliced meats and a bag of diced ham which had been opened had no labels or dates on them.</p> <p>At 10:40 AM on 11/20/14 the dietary manager (DM) stated all dietary staff who entered and exited food storage areas were supposed to check to make sure all opened or repackaged food items were labeled and dated, all food items</p>	F 371			

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F 371	Continued From page 26 were covered or packaged to prevent contamination, and all expired or out of date foods were removed and disposed of. She reported when she got the chance she checked behind the dietary staff to make sure they were maintaining all storage areas as trained. At 3:48 PM on 11/20/14 a cook stated all dietary staff were to monitor storage areas on a daily basis as they went in and out of them. She reported staff disposed of items past their use-by dates, applied labels and dates to all leftovers/opened foods/foods removed from their original packaging, and read labels to make sure food items were being stored as the manufacturer instructed. The cook commented the DM checked behind the staff to make sure the storage areas were being maintained the way she liked for them to be.	F 371			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		12/15/14	

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F 441	<p>Continued From page 27</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon observation, policy review, and staff interviews, the facility failed to follow infection control techniques when 1) a staff member failed to clean and disinfect a pair of scissors before and after use for 1 of 2 residents observed for pressure ulcer treatment, Resident #35, and 2) a staff member placed soiled care items on top of the resident's bed while providing wound and incontinent care for 1 of 2 residents observed for pressure ulcer treatment, Resident #69, Findings included:</p> <p>1. Review of facility policy/procedure dated 11/1/2013 titled "F-441 Nursing - Infection Control", policy/procedure read in part under Indirect Transmission, "Resident care devices</p>	F 441	<p>For the resident affected: Nurse #1 who provided treatment to resident #35 during survey observation received individual training by ADON on 11/26/14 related to wound care technique and maintaining infection control while providing care, including proper cleaning of scissors, handwashing. Nurse #1 was observed by ADON on 11/26/14 while providing wound care to ensure proper technique and maintaining proper infection control while providing care, including proper handwashing and cleaning of equipment. Nurse #2 was in-serviced and later observed by ADON on 11/26/14 to ensure proper wound technique, including linen</p>		

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F 441	<p>Continued From page 28</p> <p>may transmit pathogens if devices contaminated with blood or body fluid are shared without cleaning and disinfecting between uses for different residents. This facility will reduce and/or prevent infections through indirect contact by requiring the decontamination (i.e., cleaning, sanitizing, or disinfecting an object to render it safe for handling) of resident equipment, medical devices, and the environment."</p> <p>Observation of resident #35's sacral pressure ulcer dressing change was made at 1:25 PM on 11/19/14. The observation revealed one sacral pressure ulcer without drainage or odor. Observed nurse #1 first clean resident #35's pressure ulcer with hydrogen peroxide, then she packed the wound with a ¼ inch gauze packing. After packing the wound, Nurse #1 pulled scissors out from her scrub pocket, cut off the end of the wound packing, and then placed the scissors back into her scrub pocket. Nurse #1 did not clean her scissors prior to or after resident # 35's dressing change.</p> <p>Interview with Nurse #1 and the assistant director of nursing (ADON) on 11/20/14 at 9:25 AM revealed that Nurse #1 made a few mistakes during resident #35's pressure ulcer dressing change. Nurse #1 said she was nervous and made mistakes. Nurse #1 said she realized that after clipping the wound packing with her scissors, she should have cleaned the scissors first and then after the dressing change, which she said she did not do. Nurse #1 said it was her expectation that her scissors should be cleaned before and after each use.</p> <p>Interview on 11/20/14 at 9:15 AM with the assistant director of nursing (ADON) revealed</p>	F 441	<p>handling and to ensure resident cleaned of incontinence prior to providing wound care of Resident #69.</p> <p>For residents with the potential to be affected: ADON provided in-service on 12/7/14-12/13/14 for licensed nurses related to wound care technique, maintaining infection control, and included ensuring that residents were cleaned of incontinence prior to wound care. Return demonstrations were completed with licensed nurses on 12/7-12/13/15 by ADON, DON, and SDC.</p> <p>Measures put in place: SDC, ADON or DON will be required to do direct observation of licensed nurses quarterly to ensure proper technique is used during wound care while maintaining infection control and ensure that resident is cleaned of incontinence prior to providing wound care x 3 quarters.</p> <p>Monitoring and QA: SCD, ADON or DON will observe 1 resident weekly x 3 weeks, then monthly x 3 months to ensure proper wound care technique is used while maintaining infection control and that resident is cleaned of incontinence prior to providing wound care. Any area of identified concern will be addressed at the time of treatment. Any area of continued identified concerns will be brought to the QA committee to review concerns for further action plan.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 29 that it was her expectation that nurses' private scissors must be cleaned with sanitation wipes prior to use.</p> <p>Interview with the director of nursing (DON) on 11/21/14 at 9:20 AM revealed that it was her expectation that all nurses' personal items such as scissors were to be cleaned before and after patient contact or use.</p> <p>2) On 11/19/2014 at 11:14 AM, an observation of Resident # 69's sacral pressure ulcer care was made. Nurse #2 and Nursing Assistant (NA) #1 proceeded to remove the resident ' s disposable adult brief to access the sacral wound. As the brief was partially removed, Nurse #2 noted the resident ' s brief was soiled with stool and that the sacral wound dressing also had stool on it. Nurse #2 stated that the resident would need to be cleaned before wound care could proceed. Nurse #2 and NA #1 cleaned the stool from the back side and then the front side of the resident, then removed the soiled diaper and wipes from under the resident and placed it on the top of the resident's bed. NA #1 retrieved a plastic bag and then disposed of the items in the bag and tied it. While the NA and the nurse were turning the resident, 2 pillows fell from the Resident #69's bed to the floor. Nurse #2 reached down to the floor, picked up the pillows, then placed them on top of the bed, and then later placed them on top of the resident's recliner beside the bed.</p>	F 441			

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F 441	Continued From page 30 In an interview with Nurse #2 at 12:00 PM on 11/19/2014 after the wound care was provided, she stated that she typically would not place a soiled disposable adult brief or soiled disposable wipes on top of the bed. She explained that she and the nursing assistant were not expecting to provide incontinent care and did not have a trash bag readily available for discarding the soiled items. In an interview with the Director of Nursing (DON) and the Assistant DON (ADON) on 11/20/2014 at 9:35 AM, the DON stated she stated it was her expectation that all soiled items, such as a soiled adult briefs and wipes, be disposed of properly in a plastic bag, and that these items should not be placed on top of the bed.	F 441			
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee	F 520		12/15/14	

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F 520	<p>Continued From page 31 except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to develop a quality assurance (QA) action plan for kitchen sanitation issues which were identified in 2014 by the facility's registered dietitian (RD). The facility was previously required to develop a plan of correction for kitchen sanitation citations in 2011 and 2012. Findings included:</p> <p>This tag is cross referenced to:</p> <p>F371: Kitchen Sanitation: Based on observation and staff interview the facility failed to maintain sanitizing solutions at an effective strength, failed to air dry kitchenware before stacking it in storage, failed to sanitize meal carts which were previously in resident care areas and commons areas, failed to discard damaged kitchenware or rewash kitchenware contaminated by dried food particles, and failed to monitor storage areas for labeling/use-by dates/contamination.</p> <p>During an interview with the director of nursing (DON) and assistant director of nursing (ADON) at 10:05 AM on 11/21/14 they stated when an issue was "run through" the quality assurance (QA) program it was identified as a problem, staff members with expertise in the area of the</p>	F 520	<p>For the residents affected and for the residents with the potential to be affected: On 12/12/14, the Regional QA Nurse and Regional Dietician provided in-service education to Facility QA committee members related to QA, including facility policy and video presentation from Institute for Healthcare Improvement, "New Whiteboard Video that Introduces the Concepts of Quality Improvement in Healthcare," and video from Advancing Excellence/Resource-QI, "PDSA."</p> <p>Measures put in place: Regional Dietician implemented Dietary Department Quality Assurance Report check off sheet on 11/24/14 which includes: Walk-in freezer/walk-in refrigerator-proper storage, items dated and labeled; dry storage-items dated and labeled; sanitizing tray carts after use with appropriate solution; sanitizing tables/work spaces with appropriate solution added; inspecting pots and pans for moisture; and inspecting small wares for stains, wear and moisture.</p> <p>Monitoring and QA: Action plan</p>		

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F 520	<p>Continued From page 32</p> <p>problem helped develop interventions to rectify the problem, auditing and monitoring were conducted to help decide if the interventions were effective, and if they were not, new interventions were developed and monitored. They reported kitchen sanitation had not been identified as a problem that needed to be run through the QA process since their last annual survey.</p> <p>At 10:24 AM on 11/21/14 the administrator stated the facility had completed several plans of correction for citations received in years past related to kitchen sanitation (the facility received citations at F371 in 2011 and 2012). She reported the RD did kitchen audits during her monthly visits, and in-servicing was frequently provided to correct problems. According to the administrator, results of the audits were discussed in the QA meetings. However, she commented the QA committee as a whole had not developed an action plan to address kitchen sanitation concerns identified by the RD in 2014.</p> <p>At 11:28 AM on 11/21/14 the dietary manager (DM) provided documentation of a 08/13/14 in-service about covering and dating food items in storage with follow-up audits on the problem which were conducted on 09/07/14, 09/16/14, and 09/30/14. The DM stated this problem was identified during an audit completed by the RD on her monthly visit.</p>	F 520	<p>developed to address areas found deficient so that work will be completed by dietary aide and cook will follow up to check that work was completed. Cook will complete check list 3 times daily x 14 days, then weekly x three weeks, then monthly x 3 months, and then periodically thereafter. Dietary manager will review check lists weekly x 3 weeks and then monthly x 3 months to ensure sustained compliance. Dietician will also monitor monthly to ensure continued compliance. Any area of continued concern will be brought before the inderdisciplinary team during morning meetings for any needed action. Results also will be brought to quarterly QA meeting for any further needed action. Any areas of repeated deficiencies will be reviewed by QA/interdisciplinary team to examine and to determine what further action plan needs to be put in place and to set goals to gain and sustain compliance.</p>		