STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	A. BUILDING _____ B. WING _____	C 03/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON REHABILITATION AND HEALTHCARE	**1000 TANDALL PLACE KNIGHTDALE, NC 27545**

(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 000	INITIAL COMMENTS On 2/23/15 to 2/25/15 and 2/26/15 to 3/2/15 a recertification and complaint survey was conducted..	F 000		
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, staff interviews and record reviews the facility failed to maintain resident rooms and handrails free from an accumulation of dirt and debris. (Rooms #119, #219, #220 and hallways on Station One, Station Two and Rehab Unit). The facility failed to maintain doors free from scratches and scuffed marks. (Room #119, #219 and #220). The facility failed to maintain heating and air-conditioning units free from an accumulation of dust and debris. (Room #119). The facility had fixtures, floor tiles, and furniture in resident rooms that were in disrepair. (Rooms #150B, bathrooms shared by 194-196 and 198-200, #200, #225 and dining room). The facility had furniture in resident rooms with veneer detached. (Room #119, #120, #219, #150, #220, 194 and #225). The findings included: 1. A. Observation on 02/24/2015 at 8:05 AM in Room #119 revealed an accumulation of dirt and debris on the floor under the head of the bed. B. Observation on 02/24/2015 at 8:58 AM in Room #219 revealed under the bed on the floor an accumulation of dirt, straw wrappers and	F 253	1. Dirt and debris were eliminated from the handrails from rooms 119, 219, 220 and hallways of Stations 1 and 2 and Rehab Unit. Doorways were repaired on rooms 119, 219, 220. Dust and debris was cleaned from the AC unit in room 119 and 219 on 3/19/15 by the housekeeper. The fixtures, floor tiles, and furniture in resident room number 150B bathrooms shared by 194-196 and 198-200, 200, 225 and dining room were repaired by the Maintenance Director. The furniture in resident rooms 119, 120, 219, 150, 220, 194, and 225 was ordered for replacement by the Executive Director on 3/5/15. The debris was cleaned from under the bed in rooms 119 and 219 on 3/19/15 by the housekeeper. The wall near the window was re-painted in room 219. The furniture in room 220 is the resident□s personal property and it is the resident□s preference to have it in the room in its current condition. The resident□s preferences were added to his	3/30/15

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

Electronically Signed | 03/26/2015

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F 253	Continued From page 1 crumbs resembling food. The heating and air-conditioning unit had an accumulation of dirt and debris inside the vents. C. Observation on 02/24/2015 at 9:19 AM revealed in Room #119B black colored markings along the wall near the window. D. Observation on 02/25/2015 at 11:59 AM in Room #220 revealed the top shelf flush with the television was observed scuffed on both front ends. 2. A. Observation on 02/24/2015 at 8:58 Am in Room #219 revealed the bathroom door and room door was scratched and marred. B. Observation on 02/24/2015 at 8:05 AM revealed the entrance door to the room, bathroom and closet were marred and scratched in Room #119. C. Observation on 02/25/2015 at 11:59 AM in Room #220 revealed the entrance door to the room was badly scuffed. 3. Observation on 02/24/2015 at 8:05 AM in Room #119 revealed an accumulation of dirt and debris on the heating and air-conditioning and heating unit. 4. A. Observation on 2/27/15 at 12:45 pm revealed an accumulation of dust, dirt, dried food debris, and candy wrapping between the wall and the handrails especially across the nursing station on Station One and the hallway of Rooms #114-124. B. Observation on 3/2/15 at 4:20 pm with the corporate representative and maintenance director revealed the accumulation of dust and dirt remained in the spaces between the wall and handrails. Record review of the daily work projects for the housekeeping staff (HK) indicated on	F 253	care plan by the MDS coordinator. The bathroom door for room 119 was re-sanded and a vinyl kick plate was ordered. The over bed table for room 120B was replaced. The wall was repaired in room 150. The hanging lamp in the dining room was repaired and light bulbs were replaced. The faucet was replaced in the dining room. The floor tiles in the dining room were replaced. The towel rack in the bathroom shared by rooms 194 and 196 was repaired. The floor tiles were replaced in the bathroom shared by rooms 198-200. The door was replaced on the bathroom door of room 200. The wall was repaired in room 200. The wall was repaired near the AC unit in room 225. 2. All repairs were completed by the Maintenance Director. All of the residents have the potential to be affected by this citation. An evaluation of the entire facility ensuring housekeeping and maintenance services are maintained and are sanitary, orderly and comfortable interior was completed 3/19/2015 by the Maintenance Director and Housekeeping Supervisor. A monthly schedule to replace over-bed tables and bed-side cabinets has been developed. An additional schedule to add a vinyl door protector to the resident rooms doors has been developed to prevent further damage from wheelchairs. 3. All staff will be in-serviced by the Executive Director on the facility maintaining a sanitary, orderly, and	

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F 253	Continued From page 2 Wednesdays dusting and disinfecting the hallways and handrails. Interview on 2/27/15 at 1:01 pm with HK #1 revealed she conducts a walk-through of resident rooms and the unit on initial arrival for duty. During the interview HK #1 observed the accumulation of dust, dirt, dried food debris, and candy wrapping between the space of wall and the handrails across Station One ' s nursing station and in the hallway near Rooms #114-124. Further interview revealed HK #1 was unsure who was responsible for cleaning the space between the handrails and wall but believed it was the floor technician ' s responsibility. Interview on 2/27/15 at 1:20 PM with the floor technician revealed the housekeeping staff assigned to each unit was responsible for the cleaning of the handrails and that if he works the weekend and observed dirty handrails then the space of the handrails would cleaned. The floor technician indicated this task was not on his routine list to complete. Interview on 2/27/15 at 1:05 pm with the housekeeping supervisor revealed the floor tech conducts twice a week detail cleaning of the hallway which included the space between the wall and the handrails but was unsure when the last time the space between the rails had been cleaned. During the interview the housekeeping supervisor observed the accumulation of dust, dirt, dried food debris, and candy wrapping between the wall and the handrails Station One nursing station and the hallway of Rooms #114-124. 5. A. Observation on 02/24/2015 at 8:58 AM revealed in Room #219 the middle draw of the night stand was missing a large piece of veneer. B. Observation on 02/25/2015 at 11:00 AM revealed in Room #120 B the veneer around the	F 253	comfortable environment by 3/26/15. The Housekeeping personnel will be in-serviced by the Housekeeping Supervisor on the Routine Screening Protocols and scheduled cleaning for the handrails and AC units throughout the facility on 3/12/15. 4. The Maintenance Director and Housekeeping Supervisor will conduct Quality Improvement monitoring of 6 resident rooms and or common areas to ensure the facility is maintaining a sanitary, orderly, and comfortable interior five times a week for one week, three times a week for three weeks, three times a week for two months, two times a week for one month and one time a week for 1 month. The results of QI monitoring will be reported to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained. The results of the QI monitoring will be reported monthly in the QI meeting by the Housekeeping Supervisor/and or Maintenance Director.	

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F 253	Continued From page 3 over bed table was missing. C. Observation on 02/24/2015 at 8:05 AM revealed in Room #119 missing veneer on the bedside table. D. Observation on 02/25/2015 at 11:41AM revealed in Room #150B the veneer was peeled off the front of the bedside cabinet. E. Observation on 02/25/2015 at 11:59 AM and on 2/27/15 at 12:20 pm in Room #220 revealed missing veneer on the bedside cabinet and TV stand. F. Observations on 2/27/15 at 12 noon revealed in Room #194A peeling veneer on the bedside cabinet. H. Observations on 2/27/15 at 12:25 pm revealed in Room #225 peeling veneer on two (2) of the three (3) bedside cabinet drawers. 6. A. Observation on 02/25/2015 at 11:41AM revealed rough unfinished plaster on the wall near the window in Room #150B B. Observations on 2/27/15 at 11:50 am revealed 3 of the 3 lights in the hanging lamp located in the dining room were non- functioning. The faucet at the sink continuously dripped and would not shut off. There were 17 floor tiles in the dining room that were cracked. C. Observations on 2/27/15 at 12 noon revealed in the bathroom shared by Rooms #194 and 196 a broken towel rack with a missing bar. The wall paint was peeling. D. Observations on 2/27/15 at 12:10 PM revealed in the bathroom shared by Rooms #198-200 separated floor tile near the base of the commode. E. Observations on 2/27/15 at 12:12 pm revealed three (3) holes in the bathroom entrance door of Room #200. There was also a torn wall near the window in Room #200.	F 253		

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F 253	Continued From page 4 F. Observations on 2/27/15 at 12:25 pm revealed peeling paint and crumbling wall near the heating and air-conditioning unit which measured approximately 12 inches long in room #225. Interview on 3/2/15 at 5:30 pm was held with the administrator, director of nurses and 2 corporate representatives. The administrator indicated her expectations for the facility were to have clean handrails that were free of chips and splinters. The administrator also indicated that she expected the outlets and other equipment to be in safe working order. Continued interview with the administrator revealed the facility purchased 5 three drawer cabinets (referring to the bedside cabinets). At the time of the survey the administrator was unable to determine when the bedside cabinets were ordered and to be delivered. As a result the administrator indicated she would email additional information which was not received.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who	F 278		3/30/15

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F 278	Continued From page 5 willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) to reflect the dental status for 1 resident (#91) and the active diagnosis for 5 of 19 residents. (Resident # 27, 2, 57, 50, and #278) Findings include: A. Resident #91 had cumulative diagnoses which included Alzheimer ' s ' disease and diabetes mellitus. Review of the quarterly MDS assessment tool dated 11/13/14 and the annual MDS dated 1/8/15 under the Section L oral/ dental status revealed the resident was coded as not having obvious or likely cavity or broken natural teeth. Observation of the resident with Nurse #4 and MDS nurse #1 on 3/2/15 at 10:17 am revealed resident had 11 upper teeth and 5 bottom teeth. The teeth were discolored and with visible plague. A second observation was made on 3/2/15 at	F 278	1.The annual MDS, Section L for resident #91- dated January 8, 2015 was reviewed and corrected by the current MDS coordinator to accurately describe resident #91□s dentition. A care plan was put in place to address resident #91□s dental care and need for supervision and encouragement to complete his oral care. The quarterly MDS assessment dated 12/4/2014 for resident # 2 was reviewed and corrected by the current MDS coordinator on 3/2/2015 to include a diagnosis of anxiety. The quarterly MDS assessment dated 2/1/2015 for resident # 57 was reviewed and corrected by the current MDS coordinator on 3/2/2015 to include a diagnosis of anxiety and dementia with behaviors. The admission MDS assessment dated 12/5/2014 for resident # 50 was reviewed and corrected by the current MDS	

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F 278	Continued From page 6 10:35 am with the director of nurses (DON) revealed on the inside upper jaw 3 teeth were brown /black colored along the gum line suggestive of cavities. Interview on 3/2/15 @11:45 am with MDS #2 (who conducted the 1/6/15 annual MDS assessment of the resident ' s mouth) revealed she did not see any issues with his mouth. B. During a review of resident # 2 MDS dated 9/3/14, documentation indicated that the resident was admitted to the facility on 10/9/13 with active diagnoses that included depressive disorder, hypertension and diabetes mellitus. Review of resident # 2 MDS dated 12/4/14 revealed the assessment was coded as a quarterly assessment. The assessment indicated resident # 2 received antianxiety medication for 7 of the 7 days of the assessment period. Under the active diagnosis section anxiety was not marked as a current diagnosis. During an interview with the facility MDS nurse #1 on 3/2/15 at 2:40PM, the MDS nurse #1 stated that she did not do either assessment. She indicated that she does not know why anxiety disorder was not coded on the MDS report for resident # 2. C. Review of resident # 27 most recent comprehensive MDS was dated 1/31/15 and the assessment revealed the resident was admitted to the facility on 1/24/15 with diagnoses which included diabetes type II, hypertension, atrial flutter, unspecified congestive heart failure and dementia. The assessment indicated resident # 27 was cognitively impaired, and the medical record revealed no supporting documentation with the diagnosis of anxiety disorder and depression. During an interview with the facility MDS nurse #1	F 278	coordinator on 3/2/2015 to include diagnoses of diabetes, CHF, CAD, Atrial Fibrillation, depression, and malnutrition. The quarterly MDS assessment dated 12/22/14 for resident #278 (* #94) was reviewed and corrected by the current MDS coordinator and the incorrect active diagnosis of volume depletion was removed. (There was no resident #278 on the survey sample this resident was identified as resident #94.) 2. An audit was done March 3, 2015 through March 16, 2015 by the DCS, ADCS, and the current MDS coordinator that included reviewing all dental consultations dated 1/15/2015 and reviewing and correcting the MDS to accurately describe residents dentition. An audit was done 3/16/2015 through March 20, 2015 to ensure diagnoses were included on the most recent MDS assessments done for January and February 2015 by the MDS coordinator. These audits included psychotropic and anxiety diagnoses as appropriate for residents taking these medications. 3. The current MDS coordinator and traveling MDS coordinator has received training from the DCS in regards to accurate MDS coding. Additional in-servicing was provided on 3/18/2015 by the DCS regarding Diagnoses for the MDS assessment. 4. The MDS coding accuracy relating to diagnoses for residents will be monitored by the current MDS coordinator and the	

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F 278	Continued From page 7 on 3/2/15 at 2:40PM the MDS nurse stated that she did not do this assessment. She indicated that she does not know why anxiety disorder or depression were not coded on the MDS report for resident # 27. D. Resident #57 was admitted on 4/21/2014 with an active diagnosis of hip fracture. Review of resident #57 most recent MDS was coded as a quarterly assessment and was dated 2/1/15. The assessment did not include any psychiatric diagnoses but indicated the resident had received both antipsychotic and antianxiety medications daily. During an interview with the facility MDS nurse #1 on 3/2/15 at 9:06AM, the MDS nurse stated she did not complete this assessment and that she had only been working at this facility for two weeks. She indicated that she did not know why psychiatric diagnoses were not included for resident #57. E. Resident #50 was admitted on 11/28/14 with diagnoses that included: Methicillin Susceptible Staph infection, diabetes, hypertension, edema, adult failure to thrive. Review of resident #50 most recent MDS was coded as the admission assessment and was dated 12/5/14. The assessment did not include any diagnoses and indicated the resident had received daily: insulin injections, antidepressant, anticoagulant, antibiotic and diuretic medications. During an interview with the facility MDS nurse #1 on 3/2/15 at 9:06AM, the MDS nurse stated she did not complete this assessment and that she had only been working at this facility for two weeks. She indicated that she did not know why there were no diagnoses included for resident #50.	F 278	DCS using the Coding Accuracy QI tool weekly for 8 weeks then every month for 10 months to ensure compliance and accurate MDS coding. The results of the QI monitoring will be reported monthly in the QI meeting by the DCS/designee.	

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F 278	Continued From page 8 F. Review of resident # 278 most recent comprehensive MDS dated 9/22/14 had the assessment coded as an annual assessment. The assessment revealed the resident was re-admitted to the facility on 1/6/14 with active diagnosis that included Atrial Fibrillation, Dementia, and Hypertension. Review of resident # 278 most recent MDS was coded as a quarterly assessment and was dated 12/22/14. The assessment had the resident ' s active diagnosis listed as 276.5 (Volume Depletion). Review of resident #278 medical record revealed no supporting documentation of the diagnosis of Volume depletion. During an interview with the facility MDS nurse #1on 3/2/15 at 9:06AM, the MDS nurse #1 stated that she did not do either assessment and that she was new. She indicated that she does not know why volume depletion would be included in the active diagnosis section. She stated that the MDS had been coded incorrectly. An interview was conducted with the DON (Director of Nursing) on 3/2/15 at 4:05PM regarding MDS accuracy. The DON stated that she expects the MDS to be coded accurately. An interview with the administrator on 3/2/15 at 4:10PM regarding MDS accuracy. The administrator indicated that she expects the MDS to be coded accurately.	F 278		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		3/30/15

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F 323	Continued From page 9 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interviews with staff the facility to maintain electrical outlets in a safe working manner. (Station One, Station Two and Main dining room). The facility failed to have handrails in hallways free from rough and splintered surfaces. This was evident in 3 of 3 resident care areas. (Station One, Station Two and Rehab Units) Findings included: 1. A. Observation on 02/24/2015 08:58 AM revealed in room 219 the electrical outlet and plate were partially separated from the wall. The phone line and phone jack were partially detached out of wall hanging approximately 6 inches down to the floor. B. Observation on 02/24/2015 9:11AM in room 121 A revealed a broken electric plate cover, a cracked outlet with the electrical cord to the bed extending out. When the bed ' s height was increased the bed hit against the electrical cord attached to the bed. Interview on 02/24/2015 9:15 AM with nursing assistant (NA) #3 revealed the outlet breaks as a result of moving the bed up and down but she had not reported the issue. C. Observations on 2/27/15 at 11:50 am revealed a cracked electrical outlet in the dining room. 2. Observations on 2/27/15 at 12:30 pm in the hallway Station 2 revealed handrails were chipped and rough especially near room 225.	F 323	1. The handrails were re-sanded and painted throughout the entire facility. The electric plate cover was replaced in room 219. The electric plug was moved to another outlet at the end of the bed to prevent further issues. The cracked electrical outlet was replaced in the dining room. 2. All residents have the potential to be affected by this citation. An audit of 325 electrical outlets in resident rooms and handrails in the hallways was conducted by the Director of Maintenance on 3/5/2015. 50 of the 325 electrical outlets were replaced by the Maintenance Director and the handrails in the hallways were repaired by sanding and painting to assure a smooth surface by the Maintenance Director. 3. All staff will be in-serviced on proper reporting of safety and environmental hazards and or repairs by 3/26/15 by the Executive Director. 4. The Maintenance Director will conduct Quality Improvement monitoring of 6 resident rooms and/or common areas to ensure the facility maintains a safe environment daily five times a week for one week, three times a week for three	

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F 323	Continued From page 10 There were chipped and splintered handrails noted under the black board on Station One. Continued observation revealed throughout Station One and Rehab unit handrails were chipped and rough. Observations on 3/2/15 at 4:15 pm with the maintenance director revealed the handrails remained chipped, rough and splintered. Interview during the observations with the maintenance director indicated that the handrails are an ongoing problems of being chipped from chairs and carts hitting the rails. Interview on 3/2/15 at 5:30 pm was held with the administrator, director of nurses and 2 corporate representatives. The administrator indicated her expectations were handrails be free of chip, rough edges and splinters and the electrical outlets be in a safe working order.	F 323	weeks, three times a week for two months, two times a week for one month and one time a week for 1 month. The results of QI monitoring will be reported by the Maintenance Director or designee to the Quality Assurance Performance Improvement Committee for 6 months and/or until substantial compliance is obtained.	
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 observations, record review, and staff interviews, the facility failed to store uncooked lasagna noodles in a sealed container, failed to store 13 of 13 beverage pitchers in a manner to	F 371	1. No residents were injured related to this citation. The tea pitchers that were stacked and stored inappropriately were re-washed, allowed to dry completely, and	3/30/15

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F 371	Continued From page 11 allow air drying, failed to clean the meat slicer after use, and failed to maintain 9 of 9 cups of coffee on the steam table according to the facility policy of 135 - 140 degrees. The facility also failed to clean 2 of 2 nourishment room refrigerators and one microwave oven, and failed to monitor the temperature of 1 of 1 nourishment room refrigerator freezer by not keeping a thermometer in the freezer. Findings included: 1. During the Initial Kitchen/Food Service observations conducted on 02/23/15 at 9:30 AM, one ten pound box of uncooked lasagna noodles was observed in the dry storage area, stored opened and not sealed in the box. According to the date written on the box, the box had been opened since 02/10/15. A staff interview was conducted with the Dietary Manager on 2/23/15 at 9:45 AM regarding the reason the lasagna noodles were not sealed before being stored. The Dietary Manager revealed the box which contained the lasagna noodles should have been resealed after being opened. The Dietary Manager was not aware of the reason the lasagna noodles had not been sealed after being opened. Review of the facility policy entitled Food Storage - Dry Goods dated May 2014 indicated, " The Food Services Director ensures that all packaged food items shall be kept properly sealed. " 2. During continued Kitchen /Food Service observations on 02/23/15 at 9: 40 AM, eight of eight beverage pitchers were observed stored for service inverted on an institutional sized	F 371	stored appropriately per policy. The improperly sealed box of pasta was discarded immediately. The slicer was immediately cleaned thoroughly by the Food Service Manager. The 9 coffee cups on the tray line were immediately poured out and fresh coffee was poured at the appropriate temperature per policy. 2. All residents have the potential to be affected by this citation. A walk through was conducted of all dish storage areas to ensure that dishes were stored in a manner that prevents wet nesting on 2/23/15. An audit was completed of all food storage areas, checking for proper sealing and storage on 2/23/15 by the Food Service Manager. An audit was completed to check all food preparation equipment for properly cleanliness per protocol on 2/23/15. The tray line was monitored to ensure that coffee was being poured appropriately per policy on 2/25/15. 3. The Food Service Manager in-serviced all dietary aides and cooks on proper storage of dishes on 3/18/15. An in-service regarding the proper sealing and storage of all foods was conducted for all staff on 3/20/15. An in-service was also conducted for all staff by the Food Service Manager on the proper cleaning and sanitation of the slicer on 3/20/15. A procedure for preparing coffee for resident meal trays that optimizes coffee temperature per policy was implemented on 3/20/15.	

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F 371	Continued From page 12 aluminum baking pan. There was very little space for the pitchers to air dry. The pitchers were observed to have moisture/water droplets on the inside and were not air dried. A staff interview was conducted with the Dietary Manager on 2/23/15 at 9:45 AM regarding the reason the beverage pitchers had not been stored for air drying. The Dietary Manager stated the beverage pitchers should have been stored on a regular drying rack. The Dietary Manager also indicated the Dietary staff would be in-serviced on the correct procedures for air drying beverage pitchers. Review of the facility policy entitled Ware Washing dated May 2014 indicated, " The Food Services Director ensures that all dishware is air dried and properly stored. " 3. The meat slicer was observed on 02/23/15 at 9:50 AM, covered and stored for service with dried accumulated food debris on the slicer blade. The food debris had a light brown appearance. A staff interview with the AM Cook was conducted on 02/23/15 at 9:55 AM regarding when the slicer was last used this morning and the reason it had not been cleaned. The AM Cook stated, "I needed to clean it better than that. I couldn't get one of the knobs off." The Dietary Manager indicated it was the facility policy for all kitchen equipment to be thoroughly cleaned after each use. 4. A follow-up observation was conducted on 02/27/15 at 11:40 AM in the kitchen. Five of five beverage pitchers were observed stored in a	F 371	4. The Executive Director and/or Food Service Manager will conduct Quality Improvement Monitoring of the dish storage 5 times per week for 1 weeks, 3 times per week for 3 weeks, 3 times per week for 8 weeks and 1 time per week for 4 weeks and until substantial compliance is obtained. The results of the QI monitoring will be reported monthly in the QI meeting by the Food Service Manager.	

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washing rack. The rack was stored on a metal shelf flush with the metal shelf, which prevented total air drying.

An interview with the Dietary Manager conducted on 03/02/15 at 9:50 AM regarding the reason the Dietary Aides stored the beverage pitchers on the same metal shelf, flush with the metal shelf, which did not allow air circulation for air drying. The Dietary Manager revealed that it was a practice for the Dietary Aides to store the beverage pitchers on that metal shelf. The Dietary Manager also indicated that as of Friday 02/27/15, when the surveyor observed the rack of beverage pitchers stored on the metal shelf, the Dietary Manager decided to change the storage placement to the drying rack.

5. During the observations of the steam table temperatures for the lunch meal on 02/27/15 at 11:50 AM, 9 of cups of pre- poured coffee covered with lids were observed on the shelf of the steam table. The pre- poured coffee was observed not used for one half hour. A temperature was taken at 12:20 PM of the cup of coffee which had been poured first. The temperature read 127 degrees, and was not held at the range of 135 -140 degrees according to the facility policy. When asked the reason so much coffee was being pre poured. Dietary Aide #1 and the Dietary Manager did not know why the coffee was being pre-poured.

An additional interview was conducted on 03/02/15 at 12:50 PM regarding the reason the coffee was pre-poured at lunch on 02/27/15. The Dietary Manager indicated it was a practice that the Dietary Aides pre-poured at least 9 cups of coffee on the line. The Dietary Manager also

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indicated, "In the morning, the second Dietary Aide pre-pours for each hall in the morning. I started in-servicing my staff that we no longer pre-pour the 12 cups of coffee at breakfast, and the 9 cups at lunch and dinner. We can use our large carafe on the end of the line, starting at breakfast tomorrow." When asked what temperature the coffee was to be held on the serving line, the Dietary Manager revealed the facility policy was, " The coffee should be 135 degrees and no greater than 140 degrees. "

6. Observation of the nourishment room on the 100 Hall on 03/02/2015 at 9:15 AM revealed the microwave oven was soiled with splattered accumulated brown food debris on the middle of the turn table and on the top sides and bottom of the oven. The whole inside and door were soiled with a dark brown burnt on stain. In the nourishment room refrigerator one opened container of thickened water was observed dated 02/20/15.

An interview conducted on 03/02/15 at 3:40 PM with the Dietary Manager indicated it was her expectation that the outdated thickened water found in the 100 Hall refrigerator should have been discarded. She also stated she was responsible for making sure all outdated items and outdated foods for residents brought from family members be discarded after seven days. The Dietary Manager was not aware of the unsealed vanilla ice cream and the unsealed nutritional treat found in the 200 hall refrigerator/freezer. She was also not aware of the sticky yellow spills on the refrigerator and freezer shelves.

An interview with Charge Nurse #2 on 03/02/15 at

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F 371	Continued From page 15 9:25 AM indicated the microwave is used for both residents and staff. The Charge Nurse indicated it was the Housekeeping staff's responsibility to clean the microwave ovens. Interview with the Housekeeping Manager on 3/02/15 at 10:05 AM indicated the Housekeeping Aide #1 was responsible for cleaning the microwave. The microwave gets used a lot. It shouldn't look that way. She hasn't gotten to it yet on her shift. The microwave was shown to the Housekeeping Manager at 10:10 AM. When asked if the condition of the microwave met his expectations, the Manager stated, "Absolutely not. It looks like soot. We do not use a strong degreaser, but it needs to be degreased, and cleaned better than that. I spoke with the Housekeeper and the Maintenance Director, and she stated it was discolored, so we have taken it out and will use the spare. We have already switched it out. " Review of the housekeeping policy entitled Housekeeping - Cleaning Schedule dated 01/99, indicated the refrigerators and stoves/microwave ovens in the diet kitchens/nourishment rooms were to be wiped down with an approved disinfectant and cleaning solution. An additional interview on 03/02/15 at 10:50 AM with the Housekeeping Manager indicated, "Our policy is to clean everything in our designated areas, including the nourishment rooms. We are having a new policy drafted now, that will outline specific job responsibilities in regards to microwave and refrigerator cleaning. The current policy does not outline when to clean the nourishment refrigerator. It will be cleaned at some point during the day. The new policy will	F 371		

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F 371	Continued From page 16 outline the expectation of when/time it will be cleaned." A staff interview with the Housekeeping Aide on 03/02/15 at 11:00 AM revealed the Aide, " normally cleans the microwave between 8:30 -8:45 AM. I did not wipe it out today. I just opened it up, and I did not see any food in it. I know I should have been wiped out. Is there a specific time I am supposed to clean it out? We did not have any specific instructions on what to use to clean it. I just used what I use at home to clean it." Observations on 03/02/15 at 11:40 AM of the 200 Hall refrigerator/freezer unit revealed the top door shelf had a red sticky substance on the bottom of the shelf. The second door shelf was observed to have a sticky yellow substance on the bottom of the shelf. The bottom drawer was observed to have a orange spill which was approximately 3 inches in length and 1 inch in width. There was a resident's food container dated 02/24/15 with noodles in it. There was no temperature gauge in the freezer compartment. The bottom shelf of the freezer door had sticky dark brown and yellow spills on it. On the same shelf, there was one vanilla ice cream lid that was cracked/not sealed, and one Nutritional Treat which had the lid popped open and was not sealed. These observations were conducted in the presence of the MDS Nurse. A staff interview was conducted on 03/02/15 at 1:45 PM with the Dietary Manager, who indicated the responsibility was assigned to the Dietary to maintain a thermometer in the nourishment room freezers. When asked the reason there was no thermometer in the 200 hall nourishment freezer	F 371		

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F 371	Continued From page 17 compartment, the Dietary Manager indicated she was not aware the temperature gauge was missing, and could not give a reason why the thermometer was missing. An interview with the Housekeeping Manager on 03/02/15 at 4:15 PM indicated, " the expectation was for Housekeeping Aide #2 for the 200 hall to have cleaned the refrigerator. We now have a new policy that will identify the times the refrigerators should be cleaned. The resident's food should have been discarded. " Housekeeping Aide #2 was unavailable for interview. An Administrative interview was conducted on 03/02/15 at 4:35 PM regarding expectations related to the Dietary and Nourishment refrigerator concerns. The Administrator and the Director of Nurses (DON) stated, "It should be done in compliance with the Regulatory Requirements. Packages should be sealed, refrigerators cleaned with thermometers placed in the freezers, food dated and discarded by the use by date. Cracked and unsealed foods should be discarded. Temperatures of the coffee should be between 135 and 140 degrees according to our facility policy. "	F 371		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for	F 412		3/30/15

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F 412	Continued From page 18 transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff, resident, family and consultant dental office manager interviews the facility failed to address the resident ' s complaints of dental discomfort and ensure that the dental consultation form filed was accurate. This was evident in 1 of - resident in the sample reviewed for dental services. (Resident #91) Resident #91 had cumulative diagnoses which included Alzheimer ' s ' disease and diabetes mellitus. Review of the quarterly Minimum Data Set (MDS) assessment tool dated 11/13/14 and the annual MDS dated 1/8/15 under the Section L oral/ dental status revealed the resident was coded as not having obvious or likely cavity or broken natural teeth. The MDS indicated that that the resident had impaired cognition and required limited to extensive assistance with activities of daily living. There was no care plan addressing dental care. Observation of the resident with Nurse #4 and MDS nurse #1 on 3/2/15 at 10:17 am revealed resident had 11 upper teeth and 5 bottom teeth. The teeth were discolored and with visible plague. The resident indicated to the nurse that the teeth were not currently hurting but does hurt sometimes during the day and night.	F 412	1. On 3/2/2015 a dental appointment was made for resident #91 with a different dentist for 3/4/2015. Resident #91 received a dental evaluation on 3/4/2015 and the report was reviewed by the DCS. Follow up appointments were made for resident #91 with the dentist as recommended. Resident #91 is able to make his needs known and will continue to receive Tylenol as needed for mouth pain due to its effectiveness. The annual MDS, Section L - dated January 8, 2015 was corrected to accurately describe resident #91□s dentition. A care plan was put in place to address resident #91□s dental care and need for supervision and encouragement to complete his oral care. 2. An audit and review of 31 of 36 residents (5 are no longer in the facility) who received dental services from the dentist in the facility on 1/15/15 was conducted by the DCS and ADCS to ensure accuracy of the reports and ensure any follow up recommendations were done. Outside dental appointments were made for 3 of 31 residents (one resident/RP declined outside dental consult)based on nursing assessments and or complaint of mouth pain. The dental consult reports dated 1/15/2015	

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F 412	Continued From page 19 A second observation was made on 3/2/15 at 10:35 am with the director of nurses (DON) revealed on the inside upper jaw 3 teeth were brown /black colored along the gum line suggestive of cavities. Review of the dental history and record dated 1/15/15 from the consultant dentist visit revealed in part Resident #91 had full upper and lower dentures. The treatment recommendation was to remove dentures at night and clean. This assessment was not consistent with Resident #91 oral and dental status. Interview on 3/2/15 at 3:29 pm with the office manager of the consultant dentist revealed a mistake was made in documentation and the information about the dentures were actually of Resident #91 ' s roommate. Review of the corrected dental history and record dated 1/15/15 from the consultant dentist visit revealed the resident with poor oral hygiene with plague. Interview on 1:20 PM on 2/27/15 with a family member revealed Resident #91 complained about his teeth hurting since his admission. Anytime a staff person came in the room no manner the reason he told the staff his teeth hurt. The family member could not state any staff names. Interview with the resident at this time revealed his upper right remaining teeth felt hollow and his left lower teeth often hurt. Resident #91 indicated his teeth were hurting then he indicated that they did not. Resident #91 then stated he had a headache in which Tylenol was provided with relief.	F 412	were reviewed by the MDS nurse to ensure accuracy on those residents for Section L (Dental/Oral) and corrections and care plans were updated for 4 of the 31 residents. 3. Certified Nursing Assistants were in-serviced on reporting any obvious abnormalities in teeth and any complaints of mouth pain to the nurse by the Executive Director or designee. In-servicing will be completed by March 26, 2015.Medical Records was in-serviced by the Executive Director on March 19, 2015 to give dental provider consultation reports to the nurse to ensure accuracy and follow up. The MDS Nurse and MDS Consultant Nurse were in-serviced by the DCS on dental assessment and updating care plans to describe dental / oral care needs. In-servicing will be completed by March 26, 2015. 4. A new dental provider contract will be obtained for this facility □interviews in process. Dental care and issues will be monitored by the DCS or designee by using a QI Monitoring tool for Dental Services for 6 residents every week for 6 months to include observations of oral care provided by certified nursing assistants, interviews with residents or observations of residents for signs and symptoms of mouth pain, and follow up with dental services will be arranged as appropriate. In addition, the MDS Section L and care plans for dental services for all residents due for quarterly assessments will be reviewed with DCS/ designee and	

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F 412	Continued From page 20 Interview on 3/2/15 at 9:39 am with nursing assistant #4 (NA) revealed Resident #91 required limited assistance with his oral care but needed encouragement to brush his teeth. NA #4 indicated she noticed a black area on his teeth but never reported it because Nurse #4 was aware. Interview on 3/2/15 at 11:05 am with the medical record staff member (MRSM) in the presence of a corporate representative and administrator revealed after dental visits she would decide which consultant forms to file or which consult forms to be forwarded to the nurses. During the continued interview with MRSM indicated that should a recommendation be made for basic oral care to be performed by the NA she would just filed the completed consultant form in the medical record. Any recommendation such as extractions or further dental intervention she would highlight the recommendations on the form then provide to the nurse. Interview on 3/2/15 at 2:32 PM with director of nurses and a corporate representative was held. The corporate representative indicated that the facility expectations was for the assessments to be accurate. The director of nurses indicated her expectation was for MRSM provide her with the completed dental consultant form. Later the director of nurses indicated an appointment was made for a different dental consultation on 3/4/15 at 12 noon. Interview on 3/2/15 at 5:30 pm was held with the administrator, director of nurses and 2 corporate representatives was held. The administrator indicated her expectations were appropriate resident and the consultant reports go directly to	F 412	MDS coordinator to ensure accuracy. The results of the QI monitoring will be reported monthly in the QI meeting by the DCS/designee.	

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F 412	Continued From page 21 the nurses.	F 412		