STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	**1086 MAIN STREET NORTH YANCEYVILLE, NC 27379**

(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 No deficiencies were cited as a result of the complaint investigation survey of 3/19/15. Event ID# BF2011.	F 000		
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on resident interview and staff interviews, the facility failed to deliver residents' mail on Saturdays. The findings included: Resident # 123, the resident council representative, who was alert and oriented, stated during an interview on 3/18/15 at 2:18PM the activity director only collects the mail and delivers it Monday through Friday. He further indicated that he was not aware of any resident receiving their Saturday mail on the weekends. During an interview with the Activity Director on 03/19/2015 at 9:06AM, she indicated that she goes to the post office every day, picks up the mail, and delivers it to the residents in their home location (nursing home). When asked about Saturday delivery to the residents, she stated that whenever she is the weekend manager on duty, she would get the mail from the post office and deliver it to residents, but stated that not all other weekend managers did the same. During this interview, the Activity Director further indicated that mail was not delivered every Saturday, only "	F 170	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. This plan of correction is the facility□s allegation of compliance. F 170 It is the practice of the facility to ensure that residents have the right to send and promptly receive mail. Corrective Action The facility Administrator met with Resident #123 on 4/20/15 to ensure him that moving forward the facility activity department or the manager on duty will be	4/13/15

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

Electronically Signed | 04/10/2015

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F 170	Continued From page 1 every now and then " . She stated that when she picks the mail up on Monday from the post office, the mail from the weekend is sitting in the box at the post office. She further stated that she knew the residents should have been receiving their Saturday mail on the weekends. During an interview with the Administrator on 3/19/15 at 2:09PM, she indicated that the activity staff should have been delivering the mail each Saturday. She stated she had the impression that mail was being delivered 6 days each week by the activity staff. The administrator further indicated that her expectations were for mail to be delivered on Saturdays, and that they will begin doing so.	F 170	responsible to deliver the mail to the residents on Saturdays. The facility Administrator provided education to the Activity staff and the department managers on 4/6/2015 concerning the proper resident mail delivery process for Saturdays. The department managers that received the education included the Director of Nursing, the Assistant Director of Nursing, the Activities Director, the Social Services Director and the Director of Rehab Services. Newly hired activity staff and/or department managers will be oriented to the facility process regarding mail delivery on Saturdays. Identification of Others The facility Administrator and the Activity Director met with the Resident council on 4/11/2015 to review the facility process regarding mail delivery on Saturdays. Systemic Changes The facility activity staff will pick up mail at the local post office and deliver mail to residents each Saturday. The Saturday Manager of Duty will ensure the mail is delivered by the Activity Staff and serve as back up to the delivery system. Monitoring The facility Administrator will conduct 1-2 random resident interviews to ensure that resident mail was delivered on Saturday. The interviews will be conducted weekly times 4 weeks and bi-monthly times 2 months and documented on resident	

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F 170	Continued From page 2	F 170	interview form. The facility Administrator will report findings of the interviews to the Quality Assurance and Performance Improvement committee monthly. Any negative findings or trends will be addressed and intervention will be implemented as recommended by the QAPI committee with ongoing evaluation of effectiveness.	
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 interview and record review, the facility failed to repair furniture in 6 out of 70 residents ' rooms. The facility failed to maintain the window blinds in operational condition in 7 out of 70 residents ' rooms, while one room had no blinds at all. The facility failed to repair loose toilet seats in 2 out of 70 residents ' rooms, as well as a broken door lock in 1 out of 70 residents ' rooms. The findings included: 1. On 03/17/15, during the observation 400 hall at 7:45AM, 500 hall at 7:55 AM and 600 hall at 8:05 AM there were 7 resident rooms with broken window blinds. The window blinds in Room # ' s: 409, 420, 425, 501, 507, and 603 had many	F 253	F253 It is the practice of the facility to ensure that housekeeping and maintenance services are provided to maintain a sanitary, orderly, and comfortable interior. Corrective Action Window Blinds in Resident Rooms # 409, 420, 425, 501, 507, 603 and 419 were replaced on 3/23/2015 by the facility Maintenance Director. Bedside tables in Resident Rooms #603, 606,610,616, and 618 were repaired on 3/23/2015 by the facility Maintenance Director.	4/13/15

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F 253	Continued From page 3 plastic slats that were bent, cracked, broken or missing. Room #419 which was located on the first floor, had no window blinds at all. The inside of room #419 was clearly visible through the big window from the outside of the building. On 3/19/15 at 8:10 AM, during an interview, the maintenance director indicated all the broken window blinds needed to be repaired or replaced. On 3/19/15 at 2:35 PM, during an interview, the administrator stated that her expectation the maintenance staff to keep all the window blinds in good functional condition all of the time. 2. On 03/17/15 at 7:55 AM, during the observation of 600 hall, there were 6 residents ' rooms with broken drawers (Room # ' s 603, 606, 610, 616 and 618). The nightstand drawers were observed in crooked position, with loose front panels which prevented them from being operational. During the observations on the 600 hall on 3/17/15 at 8:05 AM and on 3/18/15 at 2:20 PM, broken drawers were noted in the rooms 603, 606, 610, 616 and 618. On 3/19/15 at 8:10 AM, during an interview, the maintenance director indicated all the broken drawers needed to be repaired or replaced. On 3/19/15 at 2:35 PM, during an interview, the administrator stated that her expectation the maintenance staff to keep all the furniture in good functional condition all of the time. 3. On 03/17/15 at 8:10 AM, during the observation of 600 hall, loose toilet seats were	F 253	Toilet seats in the Resident bathrooms for Rooms #603 and 610 were tightened on 3/20/2015 by the facility Maintenance Director. Door lock on Resident bathroom for Room 606 was repaired on 3/20/2015 by the facility Maintenance Director. Identification of Others Facility Administrator conducted an audit of all Resident Rooms to ensure window blinds are in good repair on 3/23/2015. Facility Administrator conducted an audit of all resident rooms to ensure bedside table drawers are functioning properly on 3/23/2015. Facility Administrator conducted an audit of all resident room bathrooms to ensure toilet seats are in good functional condition on 3/23/2015. Facility Administrator conducted an audit of all resident room bathroom door locks to ensure all are in good working order 3/23/2015. Systemic Changes The facility staff was in-serviced on 4/2/2015 by the Staff Development Coordinator on the proper use of the maintenance log work order system in the identification and reporting of maintenance issues. The facility Administrator provided education to the Maintenance Director concerning the timely completion of	

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F 253	Continued From page 4 observed in the bathrooms of room 603 and 610. When pressure was applied to the toilet seats they shifted 2-3 inches. On 3/19/15 at 8:10 AM, during an interview, the maintenance director indicated all the toilet seats holders needed to be tightened with bolts or repaired/replaced. On 3/19/15 at 2:35 PM, during an interview, the administrator stated that her expectation the maintenance staff to keep all the bathroom equipment in good functional condition all of the time. 4. On 03/17/15 at 8:15 AM, during the observation on 600 hall, room 606 had a shared bathroom, between two residents ' rooms. The bathroom door of room 606 was observed to have a broken door lock. This door could not be locked while the resident used the bathroom. On 3/19/15 at 8:10 AM, during an interview, the maintenance director indicated all the bathroom doors needed to have an option to be locked. The door locked needed to be adjusted or replaced for room 606. On 3/19/15 at 2:35 PM, during an interview, the administrator stated that her expectation the maintenance staff to keep all the door locks in good functional condition all of the time.	F 253	issues identified in the Maintenance Log on 4/2/2015. Monitoring The facility Administrator will check the maintenance log Monday through Friday for 30 days to ensure work orders are completed in a timely manner. The audit will be conducted weekly thereafter for 4 weeks. The facility Administrator will report findings of the audits to the Quality Assurance and Performance Improvement committee monthly. Any negative findings or trends will be addressed and intervention will be implemented as recommended by the QAPI committee with ongoing evaluation of effectiveness.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		4/13/15

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F 279	Continued From page 5 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record reviews, the facility failed to develop a care plan with the goals and interventions of splint application for 2 of 3 residents with contractures (Residents # 93 and 125). The findings included: 1. Resident #93 was admitted to the facility on 1/15/11 with diagnoses that included cerebrovascular accident (CVA), hemiplegia, depression and anxiety. Review of residents Minimum Data Set (MDS), dated 12/13/14, revealed resident #93 was cognitively impaired, and required extensive and total assistance with activities of daily living (ADL). Resident #93 had functional limitations with range of motion (ROM) of his left hand and received restorative nursing	F 279	F279 It is the practice of the facility to ensure that a comprehensive care plan is developed for each resident that will meet the resident□s needs. Corrective Action The comprehensive care plans for Resident #93 were updated on 3/18/2015 by the Resident Care Management Director (RCMD) to reflect the resident□ preference in using a hand splint. A new referral was made to Therapy Department to access the resident for appropriate interventions. Evaluation was completed on 3/18/2015 by the facility Occupational Therapist. The staff assignment sheet for Resident #93 was update on 3/18/2015 by	

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F 279	Continued From page 6 for ROM and application of a splint to his left hand for six days a week. On 2/27/15 the care plan was updated and the statement " resident refused to wear a hand splint " was added. The care plan was revised on 3/15/15 and revealed to clean and dry his contracted left hand daily. During an observation on 3/17/15 at 3:40 PM, Resident #93 was in his bed, his left hand was contracted and no hand splints applied. No splints were observed in the room. Resident #93 indicated he had a splint for his left hand but could not remember when he used it last time. During an observation on 3/18/15 at 8:35 AM, Resident #93 was in bed no splint was observed applied to the contracted left hand. During an interview he indicated he received physical therapy (PT) 2-3 times a week and restorative staff used to apply a splint to his left hand. On 3/18/15 at 8:40 AM, during an interview, aide #4, restorative aide, stated that Resident #93 had a splint for his left hand when he received a restorative nursing. She was not aware of the time and frequency of splint application. On 3/18/15 at 10:30 AM, during an observation in the room of Resident #93, nurse #3 came to the room, took a hand roll out of the nightstand drawer and showed aide #5 the right orthotic device to apply on the resident ' s left hand. The nurse applied a hand roll and Resident #93 accepted the hand roll application without any problems. On 3/18/15 at 10:35 AM, during an interview, aide	F 279	the Charge Nurse to reflect proper care of resident'□s left hand. The comprehensive care plans for Resident #125 were updated on 3/18/2015 by the Resident Care Management Director to reflect the resident□s preference in using a hand splint. A new referral was made to Therapy Department to access the resident for appropriate interventions. Evaluation was completed on 3/18/2015 by the facility Occupational Therapist. The staff assignment sheet for Resident #93 was update on 3/18/2015 by the Charge Nurse to reflect proper care of resident'□s left hand. Identification of Others The facility Resident Care Management Director conducted an audit of care plans for resident□s using splints to ensure the plans accurately reflect the resident□ preferences and plan of care. Systemic Changes The Resident Care Management Director will receive any recommendations for residents indicating a need for use of splints. The RCMD will develop care plans for the identified residents. The RCMD will meet with the Restorative Aides/Direct Care Nursing Staff to develop plans and update assignment sheets to reflect the care plan. Monitoring The facility Director of Nursing/Assistant Director of Nursing will conduct an audit of	

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F 279	Continued From page 7 #5 stated that nobody mentioned anything about the hand roll for Resident #93 to her, when she received her assignment this morning, and she did not recall that the resident previously had a splint on his left hand. Also, the aide did not know the time and frequency of the splint application for the resident. On 3/19/15 at 4:40PM, during an interview, nurse #5 stated that she was told by the nursing staff that Residents #93 had refused splint applications and she added it to care plan with no goals or interventions. She confirmed there was no documentation that resident ' s #93 refused to wear the splints. 2. Resident # 125 was admitted to the facility on 9/29/14 with diagnoses included CVA and hemiplegia. Review of resident minimum data set (MDS), dated 12/17/14, revealed that the resident had severe impaired cognition and required extensive to total assistance with activities of daily living (ADLs). The resident had a functional limitation in ROM of his left hand. Review of resident ' s plan of care, dated 7/11/14, revealed that Resident #125 was required assistance with ADLs and with one of the approaches as referred to therapy service as indicated. On 2/27/15 the care plan was updated and the statement " resident refused to wear a hand splint " was added. On 3/17/15 at 9:26 AM, during the observation, resident #125 was in his room, the contracture on his left hand was noted and splint was observed on the bed side table. On 3/18/15 at 1:00 PM, during an	F 279	the splint care plans and assignment sheets for accuracy. The facility Director of Nursing will report findings of the audits to the Quality Assurance and Performance Improvement committee monthly. Any negative findings or trends will be addressed and interventions will be implemented as recommended by the QAPI committee with ongoing evaluation of effectiveness.	

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F 279	Continued From page 8 observation/interview, Resident #125 was in wheelchair in his room. The resident ' s left hand was contracted and a splint was observed on the nightstand near the bed. The resident stated that he could apply a splint himself and he used it once a week not every week. The staff had never applied the splint. On 3/18/15 at 1:00 PM, during an interview, aide #6 stated that she was aware of the resident ' s left hand contracture. She could remember that Resident #125 used the splint about three times in the last six months. The aide did not apply a splint to the resident ' s hand today, because she did not have it in her assignment sheet. On 3/19/15 at 4:30PM, during an interview, the district director of care management stated that MDS nurse and the interdisciplinary team were responsible for the care plan. On 3/19/15 at 4:40PM, during an interview, nurse #5 stated that she was told by the nursing staff that Residents #125 had refused splint applications and she added it to care plan with no goals or interventions. She confirmed there was no documentation that resident ' s #125 refused to wear the splints. On 3/19/15 at 4:50 PM, during an interview, the DON's indicated her expectation of the staff was to have a detailed plan of care for splint applications with duration and frequency. When the resident refused to wear a splint, the staff should notify the physician, rehabilitation department and family.	F 279		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION	F 318		4/13/15

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F 318	Continued From page 9 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record reviews, the facility failed to apply a splint for a hand contracture correction for 2 of 3 residents (Residents # 93 and 125) The findings included: 1. Resident #93 was admitted to the facility on 1/15/11 with diagnoses that included cerebrovascular accident (CVA), hemiplegia, depression and anxiety. Review of residents Minimum Data Set (MDS), dated 12/13/14, revealed resident #93 was cognitively impaired, and required extensive and total assistance with activities of daily living (ADL). Resident #93 had functional limitations with range of motion (ROM) of his left hand and received restorative nursing for ROM and application of a splint to his left hand for six days a week. On 2/27/15 the care plan was updated and the statement " resident refused to wear a hand splint " was added. The care plan was revised on 3/15/15 and revealed to clean and dry his contracted left hand daily. During an observation on 3/17/15 at 3:40 PM,	F 318	F318 It is the practice of the facility to ensure that residents with limited range of motion receive appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion. Corrective Action The facility Occupational Therapist reassessed resident #93 for decline in range of motion and the functionality of the current splint on 3/18/2015. The facility Occupational Therapist reassessed resident #125 for decline in range of motion and the functionality of the current splint on 3/18/2015. Facility nursing staff was in-serviced to proper use and placement of splints, and the proper procedure for monitoring splint use by the Staff Development Coordinator on 4/2/2015. Identification of Others The residents identified with declines in	

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F 318	Continued From page 10 Resident #93 was in his bed, his left hand was contracted and no hand splints applied. No splints were observed in the room. Resident #93 indicated he had a splint for his left hand but could not remember when he used it last time. During an observation on 3/18/15 at 8:35 AM, Resident #93 was in bed no splint was observed applied to the contracted left hand. During an interview he indicated he received physical therapy (PT) 2-3 times a week and restorative staff used to apply a splint to his left hand. Record review revealed occupational therapy (OT) progress notes, dated 8/10/14, indicated that the hand roll was applied at all times, except during bathing and exercising. The OT discharge note dated, 8/10/14, recommended to wear a splint and finger separator on left hand. Record review of multiple nurses ' notes for the months of February and March 2015, revealed no documentation of splint application to the resident ' s left hand. Record review of aides ' assignment sheet revealed that Resident #93 was required to wear left hand roll daily after the left hand was washed and dried. On 3/18/15 at 8:40 AM, during an interview, aide #4, restorative aide, stated that Resident #93 had a splint for his left hand when he received a restorative nursing. She was not aware of the time and frequency of splint application. On 3/18/15 at 10:20 AM, during an interview, physical therapy (PT) manager stated that Resident #93 was in PT in 2013 for leg pain and	F 318	range of motion over the last 60 days were evaluated by the Rehab Department to ensure that current interventions were appropriate on beginning 3/20/2015 and completed on 4/10/2015. Systemic Changes The assigned facility nurse will validate that residents requiring use of splints have proper placement of splints and will document placement on the treatment record. Monitoring The facility Director of Nursing will review 1-2 sample resident care plans and records to ensure that placement of splints or refusal is documented. The review will be weekly times 4 weeks and monthly thereafter. The facility Director of Nursing will report findings of the audits to the Quality Assurance and Performance Improvement committee monthly. Any negative findings or trends will be addressed and intervention will be implemented as recommended by the QAPI committee with ongoing evaluation of effectiveness.	

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(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
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ROM due to left hand contracture. He had a splint on the left hand. The resident received OT on 6/12/14 - 7/18/14 for left hand contracture. The splint application time on his left hand was gradually increased to 8 hours per day, 5 days a week. The resident could tolerate it well during the therapy but sometimes refused to wear it after the therapy.

On 3/18/15 at 10:25 AM, during an interview, aide #5 stated that she received an assignment at the beginning of her shift this morning. The aide showed a one page assignment sheet that was used for Resident #93. The assignment indicated that the resident required an " L Mod hand " . The aide explained that it was an abbreviation for the left hand modification splint. Aide #5 pointed to the splint lying on the nightstand near resident ' s bed. It was a full size blue leg brace. Aide #5 indicated she wasn ' t sure if it was the device was for the resident ' s hand, she replied that she needed to clarify it with the nurse.

On 3/18/15 at 10:30 AM, during an observation in the room of Resident #93, nurse #3 came to the room, took a hand roll out of the nightstand drawer and showed aide #5 the right orthotic device to apply on the resident ' s left hand. The nurse applied a hand roll and Resident #93 accepted the hand roll application without any problems.

On 3/18/15 at 10:35 AM, during an interview, aide #5 stated that nobody mentioned anything about the hand roll for Resident #93 to her, when she received her assignment this morning, and she did not recall that the resident previously had a splint on his left hand. Also, the aide did not know the time and frequency of the splint application for

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	345265	A. BUILDING _____ B. WING _____	C 03/19/2015

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F 318	Continued From page 12 the resident. On 3/18/15 at 10:40 AM, during an interview, nurse #3 stated that Resident #93 worn a left hand roll every day for left hand contracture. The left hand roll must be in place all the time day and night, except during bathing and personal hygiene. She indicated he had refused to use a splint, but if the hand roll was applied, he was able to tolerate it day and night. Nurse #3 indicted she unaware aide #5 had not applied the splint, could recall that the resident #93 refused the splint applications several times but could not provide nurses ' notes or any other documentation confirming same. 2. Resident # 125 was admitted to the facility on 9/29/14 with diagnoses included CVA and hemiplegia. Review of resident minimum data set (MDS), dated 12/17/14, revealed that the resident had severe impaired cognition and required extensive to total assistance with activities of daily living (ADLs). The resident had a functional limitation in ROM of his left hand. Review of resident ' s plan of care, dated 7/11/14, revealed that Resident #125 was required assistance with ADLs and with one of the approaches as referred to therapy service as indicated. On 2/27/15 the care plan was updated and the statement " resident refused to wear a hand splint " was added. On 3/17/15 at 9:26 AM, during the observation, resident #125 was in his room, the contracture on his left hand was noted and splint was observed on the bed side table.	F 318		

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F 318	Continued From page 13 On 3/18/15 at 1:00 PM, during an observation/interview, Resident #125 was in wheelchair in his room. The resident ' s left hand was contracted and a splint was observed on the nightstand near the bed. The resident stated that he could apply a splint himself and he used it once a week not every week. The staff had never applied the splint. Record review of occupational therapy (OT) notes, dated 10/7/13, revealed that Resident #125 received therapy and made a progress. Resident #125 was discharged from therapy on 12/13/14 with recommendation for splint application to the left hand. The aides received training in splinting application, splinting schedule and splint care. Record review of multiple nurses ' notes for February and March 2015 revealed no documentation of splint application to the resident ' s left hand. Record review of the aides ' assignment sheets revealed that the resident #125 had no splint application documented. On 3/18/15 at 1:00 PM, during an interview, aide #6 stated that she was aware of the resident ' s left hand contracture. She could remember that Resident #125 used the splint about three times in the last six months. The aide did not apply a splint to the resident ' s hand today, because she did not have it in her assignment sheet. On 3/18/15 at 1:05 PM, during an interview nurse #4, assistant director of nursing, stated that she was aware of the resident ' s left hand contracture, she was unaware of a splint.	F 318		

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F 318	Continued From page 14 On 3/18/15 at 1:10 PM, during an interview, director of nursing (DON) indicated that her expectation of the staff was to care plan and apply the splint. If the resident refused a splint application, the aide should document it and notify the nurse. The nurse should communicate with physician if the resident constantly refused splint applications. The DON stated while in the restorative program, the restorative aides were applying his splint. When the resident was discharged from a restorative program, the responsibility of splint application was transferred to the floor aides. On 3/19/15 at 2:35 PM, during an interview, the administrator stated that her expectation of the staff was to know the diagnoses and follow physician orders in regards to residents with contractures. The administrator ' s expectation of the staff was to communicate with therapy department in providing a consistent care with splint application and reevaluation when it is needed.	F 318		
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	F 371		4/13/15

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F 371	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to clean the plate warmer, two muffin tins, two plastic racks with meal trays, and separate nine (9) racks of coffee cups during the drying process. The findings included: On 3/16/15 at 3:15 PM, observation of the kitchen ' s plate warmer revealed it was dirty with dried food debris inside. On 3/16/15 at 3:15 PM, during an interview, the dietary manager observed the plate warmer and indicated that the plate warmer needed to be cleaned before use. On 3/16/15 at 3:20 PM, observation of the drying rack revealed there were two muffin tins stacked inside each other while drying. Both of these muffin tins were observed to be unclean with food debris. On 3/16/15 at 3:25 PM, observation revealed there were four (4) coffee cup racks stacked on top of each other on the clean side of the dish washer machine. They were wet, with dripping water from the top of the racks. On 3/16/15 at 3:25 PM, during an interview, the dietary manager observed the drying racks and stated that all the dishes needed to be cleaned and placed separately on the drying rack and indicated that the coffee cups could not be stacked on top each other in the drying rack. He removed and separated all of the coffee cup racks during the interview.	F 371	F371 It is the practice of the facility to ensure that food is stored, prepared, distributed and served under sanitary conditions. Corrective Action The identified plate warmer was cleaned on 3/18/15 by the Dietary Manager. The identified muffin tins were rewashed on 3/18/15 by the Dietary Manager. The identified delivery carts were cleaned on 3/18/15 by the Dietary Manager. The identified coffee cups were rewashed and dried on 3/18/15 by the Dietary Manager. Identification of Others The dietary manager completed a kitchen sanitation audit on 3/18/15, which included the facility plate warmer, pans, dishes and coffee cups. Systemic Changes Dietary staff was in-serviced on the cleaning schedule and proper drying of coffee cups on 3/17/2015 by the Dietary Manager Region Support. Newly hired dietary staff will be provided the education during orientation. Monitoring The facility Dietary Manager will audit the kitchen Monday through Friday for 1 month and then weekly for 4 weeks to	

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F 371	Continued From page 16 On 3/16/15 at 5:15 PM, during a dinner observation in the main dining room, two plastic racks full of meal trays were observed with food debris on them. On 3/16/15 at 5:20 PM, during an interview, the dietary manager indicated that all the meal tray racks needed to be cleaned before use. On 3/18/15 at 3:10 PM, during the observation of the kitchen, there were five (5) wet coffee cup racks observed stacked on top of each other, with water dripping from the top. On 3/18/15 at 3:15 PM, during an interview, the dietary manager indicated that the coffee cup racks needed to be placed separately to dry. On 3/19/15 at 2:35 PM, during an interview, the administrator stated that her expectation of the kitchen staff was to provide palatable food, which has to be stored and prepared in sanitary conditions.	F 371	ensure compliance with cleaning schedule and proper drying of coffee cups. The facility Administrator will complete a kitchen sanitation audit weekly for 4 weeks and twice monthly thereafter. The facility Administrator will report findings of the audits to Quality Assurance and Performance Improvement committee monthly. Any negative findings or trends will be addressed and intervention will be implemented as recommended by QAPI committee with ongoing evaluation of effectiveness.	