STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345541	A. BUILDING: _____ B. WING _____	2/1/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLE	13825 HUNTON LANE HUNTERSVILLE, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 463	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH

The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.

This REQUIREMENT is not met as evidenced by:
Based on observations, resident and staff interviews and record review the facility failed to maintain call bells in 1 of 26 sampled resident rooms in working order (Resident #102).

Findings Included:

Resident #102 was admitted to the facility on 12/13/16 with diagnoses which included; lack of coordination, unsteadiness on feet, dementia and generalized muscle weakness.

Review of the admission Minimum Data Set assessment on 12/20/16 revealed Resident #102 had moderately impaired cognition. She needed extensive assistance with bed mobility, transfers, and locomotion on and off unit.

Review of the care plan dated 12/20/16 revealed staff were to remind Resident #102 to use call light for assistance with transfers. In addition, staff were to keep the call light within reach and answer any calls for help/call light promptly.

On 01/29/17 at 2:33 PM observations revealed two call bells (a gray bulb call bell and a white call bell with a red button) tied around one of the side rails of Resident #102's bed. Resident #102 was sitting in a wheelchair beside her bed. An attempt to activate both call bells was unsuccessful.

On 01/30/17 at 8:45 AM observations revealed two call bells (a gray bulb call bell and a white call bell with a red button) located in the resident's room. An attempt to activate both call bells was unsuccessful.

On 01/30/17 at 3:25 PM observations revealed two call bells (a gray bulb call bell and a white call bell with a red button) located in the resident's room. An attempt was made to activate both call bells was unsuccessful.

On 01/31/17 at 8:44 AM observations revealed two call bells (a gray bulb call bell and a white call bell with a red button) located in the resident's room. An attempt was made to activate both call bells was unsuccessful.

An interview on 02/01/17 at 9:09 AM with the Registered Nurse (RN) supervisor revealed on 01/31/17 she asked Resident #102 if she knew how to use the call bell. Resident #102 said yes and pushed the red call bell button. The RN supervisor explained the call bell was working because the RN supervisor heard the call bell alarm. The RN supervisor also stated when a call light is not working the maintenance director is called.

An observation on 02/01/17 at 9:26 AM revealed the RN supervisor called the maintenance director and

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 463	Continued From Page 1

reported Resident #102's call bells were not working.

An interview on 02/01/17 9:35 AM with the maintenance supervisor revealed the call lights were checked monthly to ensure they functioned properly.

An interview on 02/01/17 at 9:50 AM with the maintenance director revealed he replaced the call station switch in the wall and replaced the gray bulb call bell with a pancake call bell which alarmed when pressed. The maintenance director stated the circuit may have went "bad".

An observation on 02/01/17 at 10:52 AM revealed the pancake call bell in Resident #102's room worked when activated.

An interview on 02/01/17 at 3:29 PM with nurse aide #3 revealed Resident #102 was able to use the call bell to request assistance.

An interview on 02/01/17 at 3:32 PM with Resident #102 revealed she used the call bell to call the nurse for assistance.

An observation on 02/01/17 at 3:33 PM revealed Resident #102 pressed the pancake call bell and the call bell alarmed.

Review of the maintenance work order on 02/01/17 revealed the call bells in Resident #102's room were not working. The switch was bad and was changed.

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	345541	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

(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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and record review, the facility failed to give a choice of a shower or tub bath to 1 of 3 residents sampled for choices (Resident #29). The findings included: Resident #29 was admitted to the facility on 02/22/11. Review of Resident #29's annual Minimum Data Set (MDS) dated 08/14/16 revealed an assessment of intact cognition. The MDS indicated it was very important to Resident #29 to choose between a tub bath, shower, bed bath or sponge bath. Resident #29 required the physical assistance of one person with bathing. Review of Resident #29's quarterly MDS dated 11/10/16 revealed an assessment of intact cognition. The MDS indicated Resident #29 required physical help in part of the bathing activity. Review of Resident 29's care plan dated 11/10/16 revealed interventions for assistance with	F 242	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #29 is now offered a tub bath or shower on each scheduled bathing day per week to ensure resident choice. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Any resident has the potential to be affected by the alleged cited deficient practice. All residents will be offered a choice of bathing types on each bathing day. The language used during care plan meetings will be changed to reflect an inquiry into satisfaction with bathing in general, not just showers and frequency of showers.	2/27/17

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

Electronically Signed | 02/20/2017

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F 242	Continued From page 1 activities of daily living included provision of assistance with bathing. Interview with Resident #29 on 01/30/17 at 9:48 AM revealed staff did not offer a choice of a tub bath. Resident #29 explained she preferred to have a tub bath but staff could only assist with showers. Interview with Nurse #1 on 01/31/17 at 9:12 AM revealed Resident #29 received assistance with showers on the evening shift. Nurse #1 explained Unit Coordinator (UC) #1 developed the shower schedule. Interview with Nurse Aide (NA) #1 on 01/31/17 at 3:36 PM revealed Resident #29 required one person to set up bathing equipment for the shower. NA #1 reported Resident #29 did not ask for a tub bath. NA #1 explained all residents received showers. Interview with Unit Coordinator (UC) #1 on 01/31/17 at 3:46 PM revealed residents indicated the type of bath preferred upon admission. UC #1 reported staff would assist with a tub bath when a resident requested a tub bath. Interview with the MDS Nurse on 01/31/17 at 3:57 PM revealed residents received the choice of tub bath or shower upon admission to the facility. The MDS Nurse explained the care plan team addressed shower days and frequency during the quarterly care plan meetings but not type of bath preferred. Interview with the Director of Nursing (DON) on 01/31/17 at 4:01 PM revealed residents received a choice of bath type upon admission. The DON	F 242	All CNA□s will be in-serviced on February 22nd, 2017 on resident choice, including interacting with residents in a manner that allows the resident to choose their bathing preference and to make choices in their daily care. The Social Worker or Designee will conduct QA interviews on a weekly basis to ensure residents are receiving choice in terms of bathing, activities and food. These interviews will be modeled after the interview templates used in the Survey Process. The Administrator will review these interviews to ensure compliance. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR: The facility will continue to obtain bathing preferences from residents upon admission and during MDS assessments. At quarterly care plan meetings, the MDS nurse and care plan team will address bathing days and ensure that the type of bath being received is appropriate, that the resident is being offered a choice, and that the showers/tub baths/sponge baths received are to their satisfaction. If the resident declines to attend the care plan meeting, choice between bathing options will still be given by CNAs on each bathing day. Additionally, the social worker will interview the resident in his or her room concerning their choices being honored.	

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F 242	Continued From page 2 reported Resident #29 should receive a tub bath if desired.	F 242	INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The Nurse managers on 1st and 2nd shift are responsible for developing the bathing schedule. No showers/tub baths/sponge baths are given on 3rd shift unless requested by the resident. CNAs will be in-serviced to offer a choice of three options for bathing each time they provide this service to residents who are able to make the choice. Resident preference will continue to be documented in the MDS assessment and care plans. The Social Worker or Designee will review a summary of findings from the resident choice interviews at each monthly QA meeting. Resident choice will be addressed by the QA Committee for three (3) months to evaluate the facility□s progress toward implementation of corrective action(s) and the facility□s performance to ensure that corrective performance is achieved and sustained. At the conclusion of three (3) months of evaluation and assurance that resident	

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F 242	Continued From page 3	F 242	choice is being provided, the QA Committee may discontinue following the issue. Subsequently, the Social Worker or Designee will continue with resident interviews on a monthly basis. If any issues are identified through those interviews, the Social Worker or Designee will present them to the QA Committee at the next monthly meeting to ensure that corrective action is achieved and sustained.	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews with the family, nurse practitioner and staff and review of the medical record, the facility failed to obtain a blood sample for a complete blood count (a blood test that measures overall health) and a urine sample for a urinalysis with a culture specimen for 8 days after it was ordered by the physician for 1 of 6 sampled residents reviewed for a change in condition (Resident #166). Findings included: Resident #166 was admitted to the facility on	F 309	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: UA and CBC were drawn from Resident #166 (CBC AND UA C&S) on 2/01/17. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME	2/27/17

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F 309	Continued From page 4 01/18/17. Diagnoses included overactive bladder, constipation by delayed colonic transit, dementia with hallucinations and agitation, major depressive disorder, anxiety disorder, Parkinson's disease, age-related cognitive decline, shoulder fracture and a history of urinary tract infections (UTI). Medical record review revealed Resident #166 received Senna (laxative) 8.6 milligrams (mg) scheduled twice daily with routine bowel movements documented. Review of a nurse's note and physician's progress note, both dated 01/23/17 revealed a physician assessment of Resident #166 resulting from report of staff/family of mild dysuria (blood in the urine) and bright red blood per rectum (BRBPR) after a large bowel movement with straining. The physician's plan was to order a urinalysis (UA), treat only if colony count was 100,000, and check vitals each shift for the mild dysuria and to obtain a complete blood count (CBC), start Annusol (corticosteroid used to treat rectal discomfort) and increase Senna from 1 to 2 tablets twice daily. A physician's order dated 01/23/17 was written for UA C&S (culture specimen) for dysuria, vitals each shift, increase Senna to 2 tablets twice daily, Annusol HC 25 mg daily for 5 days and a CBC. A nurse's progress note dated 01/25/17 documented Resident #166 voided a large amount of dark red urine. An admission minimum data set dated 1/25/17 and the January 2017 care plan and Care Area Assessment assessed Resident #166 with	F 309	DEFICIENT PRACTICE: Any resident has the potential to be affected by the alleged cited deficient practice. A 3rd shift (11p-7a) nurse will complete an audit of physician□s telephone orders nightly to ensure compliance with regulatory requirements. The nurse will double check physician telephone orders for that day to ensure they are processed timely. The nurse will initial and date the physicians telephone order (green slip) when completed, which will indicate that the order is entered into the computer and scheduled for lab draw, and that family has been notified of the order. The green slip attachment to the physician□s telephone order will be initialed and placed in the DON□s box for review. This QA process will be checked off by the DON daily. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR: DON or Designee will in-service all nurses on proper procedure for entering and processing lab orders. This in-service will be completed on February 22nd, 2017, including all nurses and nurse managers. All physician□s telephone orders (green slips) will be dated and initialed once all of the following are completed: the order is	

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F 309	Continued From page 5 impaired cognition, frequently incontinent of bowel/bladder, at risk for UTI and constipation related to the daily use of psychoactive medications related to dementia with behaviors and pain medications related to a shoulder fracture. Interventions included medications/labs as ordered for monitoring. A nurse's progress note dated 01/27/17 documented a report from Resident #166's family which described pink liquid in the toilet. Resident #166 was assessed by nurse #2, without signs of pink urine in the toilet or the resident's vaginal cavity. During a family interview conducted on 01/29/17 at 6:13 PM, a family member stated that Resident #166 was noted with blood in her urine/stool for the past 4-5 days, the physician was notified, assessed the Resident and ordered some tests, but the family member did not know the results. The family member requested follow-up to the test results. Review of Resident #166's medical record, lab computer system and lab requisitions revealed no lab results for the 01/23/17 physician's order for a UA C&S and CBC for Resident #166. During an interview conducted on 02/01/17 at 10:40 AM, Unit Coordinator (UC) #1 (7 AM - 3 PM shift), stated that when a physician's order for lab tests was received, the order was put into the lab service computer system, the facility notified the family and the specimen was obtained on the next lab day (Monday, Wednesday or Friday) unless the lab was ordered for immediate completion. UC #1 reviewed the medical record for Resident #166 and the lab service computer	F 309	verified and entered into the computer and laboratory system, the resident□s family is notified, and the lab is scheduled for draw and pickup. INDICATE HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The QA Committee will review timely physician order processing to evaluate the facility□s progress towards implementation of corrective action(s) and the facility□s performance is achieved and sustained. The DON or designee will address physician order processing during monthly QA meetings for six (6) months. Any issues will be reviewed by the QA Committee at that time and the current auditing process will be reviewed for effectiveness to ensure that corrective action is integrated into the system and is sustain or revised as needed to achieve and maintain corrective solutions. The 3rd shift audits will continue as permanent policy.	

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system and stated that the lab order dated 01/23/17 for Resident #166 had not been entered into the computer system and the specimen had not been drawn. UC #1 looked at the calendar and stated this lab should have been completed on Wednesday, 01/25/17. UC #1 further stated that nurse #3 processed the physician's order and should have entered the lab order into the computer and a nurse on the 11-7 shift should check to make sure lab orders are put into the system and completed. UC #1 stated she would notify the physician that the lab order had not been completed.

During an interview conducted on 02/01/17 at 10:47 AM, nurse #2 stated that a family member of Resident #166 reported seeing "pink" in the toilet and asked about lab results, but that there was not a physician's order to draw labs for Resident #166 since admission. Nurse #2 further stated that Resident #166 was assessed without pain, burning on urination or signs of "pink" urine. The nurse stated she had just returned from leave and was not aware of a physician's order to draw labs for Resident #166.

During an interview conducted on 02/01/17 at 11:11 AM, the nurse practitioner (NP) stated that she expected physician order's to be followed and would re-order the CBC for Resident #166 because of constipation and the UA C&S if the Resident was symptomatic (burning on urination or blood in urine). The NP stated the lab service had already come that day, but she would request to have them return to complete the order that day.

During an interview conducted on 02/01/17 at 11:59 AM, the director of nursing (DON) stated

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that she expected physician's orders to be followed, the nurse to process the order, place the lab order into the computer system, the lab service should complete the order the next lab day, provide the results and the nurse should notify the physician/family of the results. The DON stated she also expected the unit coordinators to audit lab orders to make sure they were followed and call the physician if a lab needed to be re-ordered.

During a telephone interview conducted on 02/01/17 at 1:10 PM, UC #2 (11 PM - 7 AM shift) stated when a lab order was received the nurse who signed/processed the lab order was responsible for entering the lab order into the lab computer system so it could be drawn and she (UC #2) was responsible for verifying lab orders were entered into the computer system and completed. UC #2 further stated that other nurses on the 11 PM - 7 AM shift also verified lab orders were put into the lab computer system, but if the lab order was signed by a nurse that should mean that the lab order was processed and entered into the computer by the nurse who signed the order.

During a telephone interview conducted on 02/01/17 at 2:11 PM, nurse #3 stated when lab orders were received, the nurse entered the lab request into the lab system, printed the lab requisition slip, placed the requisition into the lab book by date order, separated the lab order into 4 copies (white copy to physician, yellow copy to medical records, green copy to box for auditing and pink copy to nurse for notification). Nurse #3 stated a nurse on the 11 PM - 7 AM shift used the green copy for audit checks. Nurse #3 stated she processed the 01/23/17 lab order for Resident

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F 309	Continued From page 8 #166 to have a CBC and UA C&S completed but had difficulty entering the lab requisition into the lab system so she reported to the oncoming nurse (3 PM - 11 PM) for completion. Surveyor attempts to reach this nurse were unsuccessful. A follow-up interview and medical record review on 02/01/17 at 4:20 PM with UC #1 revealed the NP re-ordered both the CBC due to BRBPR and UA C&S due to dysuria for Resident #166 and that the labs had been drawn.	F 309		
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 ensure: foods were dated and covered when stored, dishware was dry when stored, and a container of expired sour cream in 1 of 2 nourishment room refrigerators was discarded (500/600/700 hall nourishment room). Findings included: 1. Observations of the kitchen's walk-in	F 371	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Any resident has the potential to be affected by the alleged cited deficient practice. All opened but not properly labeled, dated	2/27/17

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OLDE KNOX COMMONS AT THE VILLAGES OF MECKLENBURG	13825 HUNTON LANE HUNTERSVILLE, NC 28078

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F 371	Continued From page 9 refrigerator on 01/29/17 from 10:30 AM to 10:38 AM revealed the following problems: The following foods were stored open to air: a bag of mild shredded cheddar cheese not dated when opened, a package of white sliced cheese, and a package of pre-sliced roast beef not dated when opened. An interview on 01/29/17 at 10:43 AM with the cook/supervisor revealed that foods in the kitchen's walk-in refrigerator were supposed to be completely closed, labeled, and dated when opened. An interview on 01/29/17 at 12:58 PM with the regional dietary director revealed she expected that opened food be sealed in an airtight container, labeled, and dated when opened. If foods could not remain in the original packaging it was supposed to be placed in a plastic re-sealable bag or airtight container labeled and dated when opened. 2. Observations of the kitchen food prep area on 01/29/17 from 11:25 AM to 12:16 PM revealed the following problems: a. 2 packages of brown gravy mix, 1 package of cheese sauce, 1 canister of oatmeal and 2 packages of potato flakes not dated when opened. An interview on 02/01/17 at 8:33 AM with the dietary manager revealed the lead cook was responsible for labeling, dating and sealing food packages. She stated she checked the kitchen's walk-in refrigerator twice daily, when she comes in and before she leaves. The assistant dietary	F 371	or stored food in the kitchen was disposed off on day of survey. The container of sour cream was disposed of on 02-01-2017. A mandatory in-service was conducted on January 29, 2017 for all dietary staff on proper storage (labeling, dating and proper sealed containers) of all food especially foods that have been opened and not totally used as well as proper washing, sanitizing, air drying and storage of plates, domes, trays and glasses and proper storage of ice scoop. Charge Nurses and Nurse Supervisors will be in-serviced on February 22, 2017 on properly storing of food in the nourishment refrigerators. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Any resident has the potential to be affected by the alleged cited deficient practice. All opened but not properly labeled, dated or stored food in the kitchen was disposed off on day of survey. The container of sour cream was disposed of on 02-01-2017. A mandatory in-service was conducted on January 29, 2017 for all dietary staff on	

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	345541	A. BUILDING _____ B. WING _____	C 02/01/2017

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F 371	Continued From page 10 manager checked the kitchen's walk-in refrigerator throughout the day. A review of the facility's food storage policy revealed all food items were to be opened, dated, and labeled appropriately by the cook in charge. The cook was responsible for monitoring any and all items opened, dated, and labeled. The cook was unavailable for an interview. 3. Observations in the facility's kitchen on 01/29/17 at 11:31 AM to 1:01 PM revealed the following problems: a. An ice scoop was stored in a container of water. b. 20 of 24 dinner plate bases were stacked together wet on rolling carts ready for use. c. 17 of 19 trays were stacked together wet ready for use. d. 28 of 28 domes for dinner plates were stacked together wet ready for use. e. 9 of 9 nosey cups were stacked together wet ready for use. f. 5 of 7 dessert cups were stacked together wet ready for use. g. 2 of 10 dinner plates were stacked together wet ready for use. h. 8 of 9 tea and water swirl cups were stacked together wet ready for use. An observation on 01/31/17 at 10:39 AM revealed 12 of 12 dinner plate bases were stacked together wet and ready for use. An interview on 01/29/17 at 10:58 AM with the cook/supervisor revealed the ice scoop should not have been stored in water and all dishware	F 371	proper storage (labeling, dating and proper sealed containers) of all food especially foods that have been opened and not totally used as well as proper washing, sanitizing, air drying and storage of plates, domes, trays and glasses and proper storage of ice scoop. Charge Nurses and Nurse Supervisors will be in-serviced on February 22, 2017 on properly storing of food in the nourishment refrigerators. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: A quality audit using a specifically designed audit tool will be completed by the Dietary Manager and/or her designee three (3) times a day to audit that dishes are properly air dried before stacking, the ice scoop is properly stored and food is properly dated, labeled and stored in air tight containers (properly sealed) for four (4) weeks, then four (4) times a week for four (4) weeks, then twice weekly thereafter. The regional dietary consultant will conduct at least one (1) audit with each visit to Olde Knox Commons. The charge nurses and nurse supervisors will be responsible for auditing the nourishment room refrigerators for properly stored food on a per shift bases	

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F 371	Continued From page 11 should have been air dried and not stacked together wet. An interview on 01/29/17 at 1:01 PM with the dietary manager revealed the ice scoop should not have been stored in water and all dishware should have been air dried and not stacked together wet. An interview on 01/29/17 at 1:41 PM with the regional dietary director revealed the ice scoop should not have been stored in water and all dishware should have been air dried and not stacked together wet. An interview on 01/29/17 at 5:07 PM with the regional dietary director revealed staff did not allow ample time for the dishware to dry. After the dishware was rinsed, staff should have allowed the dishware to dry before stacking together. When the dishes came out of the dishwasher the dishes did not dry before they were stacked together. An interview on 01/31/17 at 10:41 AM with dietary aide #1 revealed he stacked the dinner plate bases together. He stated he usually doesn't stack them together wet and he was trained not to stack them together wet. He usually let the dishware dry and then stack them together. An interview on 02/01/17 at 8:30 AM with the regional dietary director revealed that on 01/29/17 the reason dishes were stacked together wet was because the kitchen staff were running late trying to get dishes washed for lunch. An interview on 02/01/17 at 8:33 AM with the	F 371	for the first four (4) weeks, then the 7-3 Nurse Managers will be responsible for auditing the nourishment refrigerators for properly stored foods daily thereafter. They will use a specifically designed audit tool. The completed audits will be turned end daily (after completion) to the facility administrator who will review the audit tools for completeness and identified issues. Employees not adhering to the policies and procedures for proper storage of food and proper sanitation and drying of dishes and service ware will be disciplined up to and including termination. INDICATE HOW THE FACILITY PLANS TO MONITOR IT□S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. The QA Committee will review the Quality Audit Tools presented to the QA Committee by the Facility Administrator monthly to evaluate the facility□s progress toward implementation of corrective action(s) and the facility□s performance	

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F 371	Continued From page 12 dietary manager revealed the kitchen staff monitored for wet dishes every meal. Wet dishes had not been a problem before. She stated the lead cook was responsible for labeling, dating and sealing food packages. A review of the facility's equipment and utensil cleaning and sanitization policy revealed food preparation equipment was to be dried using appropriate racks. The cook was unavailable for an interview. 4. Observations of 1 of 2 nourishment room refrigerators revealed the following problems (500/600/700 hall nourishment refrigerator): An observation on 01/29/17 at 2:45 PM revealed a container of sour cream with the factory date of 01/21/17. An observation on 01/30/17 at 1:38 PM revealed a container of sour cream with the factory date of 01/21/17. An observation on 01/31/17 at 8:42 AM revealed a container of sour cream with the factory date of 01/21/17. An interview on 02/01/17 at 7:54 AM with housekeeper #1 revealed she checked for residents' expired foods in the nourishment room refrigerator twice a week and discarded expired food. An observation on 02/01/17 at 8:01 AM of the nourishment room with housekeeper #1 revealed a container of sour cream with the factory date of 01/21/17. Housekeeper #1 took the container of sour cream to the kitchen.	F 371	to ensure that corrective performance is achieved and sustained. The QA Committee will review the facility□s progress monthly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions.	

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F 371	Continued From page 13 An interview on 02/01/17 at 8:07 AM with the dietary manager confirmed the sour cream was expired and should be discarded.	F 371		