STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345109	A. BUILDING _____ B. WING _____	C 07/13/2017

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey. Event ID #R53211.	F 000		
F 282 SS=G	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to implement the plan of care interventions to prevent injury for a resident at high risk for falls. Resident #31 sustained a fall that resulted in a left femur (hip) fracture for 1 of 4 residents reviewed for accidents. The findings included: Resident #31 was admitted to the facility on 9/11/16 with diagnoses that included a right femur fracture, hypertension, heart disease, and dementia. The admission Minimum Data Set (MDS) assessment dated 9/18/16 indicated Resident #31 had moderate cognitive impairment. He required extensive assistance of 2 or more staff with bed mobility, transfers, dressing, toileting, and personal hygiene. Resident #31 was not steady on his feet and was only able to stabilize	F 282	Resident affected: Resident number 31 care plan was updated with fall interventions by Minimum Data System nurse on or before 8/6/17. Interventions of low bed, floor matt, increased lighting, Urinal, gripper socks or shoes when out of bed and gripper socks when in bed, call light in reach, place patient in highly visible area when out of bed, anti roll backs to wheelchair, noodle to bed, and restorative nursing for ambulation interventions were added to the nursing assistant assignment sheet on 8/6/17 by the Director of Nursing, Staff Development Coordinator,MDS nurse, Nursing Supervisor or Charge Nurse. Inservices were provided to licensed staff, medication aides and nursing assistants full time, part time and PRN nursing staff on patient interventions starting 8/1/17 and complete on 8/6/17.	8/6/17

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

Electronically Signed | 07/31/2017

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F 282	Continued From page 1 with staff assistance. He utilized a wheelchair and a walker. He was indicated to be frequently incontinent of bladder and always incontinent of bowel. Resident #31 had 1 fall since his admission to the facility. This fall resulted in no injury. Resident #31 had 1 fall prior to his admission to the facility and within the past month that resulted in a related fracture. The Care Area Assessment (CAA) related to falls for the 9/18/16 MDS admission assessment indicated Resident #31 had one fall since his admission to facility. The fall occurred on 9/18/16 at 12:45 AM when Resident #31 fell out of bed. This fall was indicated to result in no injury. Resident #31 was assessed with difficulty maintaining standing position, impaired balance during transitions, gait problem even with mobility aid or personal assistance. He was noted with a decline in functional status, muscle weakness, impulsivity or poor safety awareness, cognitive impairment, dementia, fatigue, and incontinence. Resident #31 was admitted to the facility following a recent hospitalization stay due to a right femur fracture that had been repaired. The plan of care for Resident #31 initiated on 9/29/16 indicated he was at risk for falls. The interventions initiated on 9/29/16 included, in part, call bell within reach and provide proper footwear. Interventions initiated on 9/30/16 indicated antiroll-backs to wheelchair as ordered and floor mat. An intervention initiated on 10/27/16 indicated a pool noodle (used to create a raised boundary at the outer edge of the bed) was to be placed under the cover when Resident #31 was in bed. The goal of this fall risk plan of care, initiated 9/29/16 and reviewed 6/2/17, read "I don ' t want to be seriously injured if I fall."	F 282	Interventions are in place as evidenced by a Visual audit that was started on 8/3/17 and completed by 8/6/17 by the DON, SDC, MDS nurse, Supervisor or Charge Nurse. Residents potentially affected: A falls assessment was conducted for 100% of residents started on 7/10/17 and completed on 8/3/17 by the DON, SDC, MDS nurse, Supervisor, and/or charge nurse. Residents with falls were reviewed on 8/3/17 to assure all interventions were on the care plan. Review was conducted by the interdisciplinary team. Interventions are on the care plans. Inservices were completed for full time, part time and PRN. licensed nurses, medication aides and nursing assistants starting on 7/25/17 and completed on 8/6/17 by the DON, SDC, MDS nurse, Nursing Supervisor and/or Charge nurse on patient interventions to be in place for residents at risk for falls, care plans were updated as indicated by the MDS Nurse, DON, SDC, Nursing Supervisor or charge nurse. A visual audit to assure all interventions are in place for residents with falls was conducted on 8/4/17 by the DON, SDC, MDS nurse, Nursing Supervisor and/or charge nurse. All interventions are in place. Systemic changes: Facility adopted a new nursing assistant assignment sheet with a space for fall care plan interventions. Assignment sheets will be updated in morning clinical meetings, other shifts and weekends by the DON, SDC, MDS nurse, Nursing Supervisor charge nurse, unit nurse or	

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F 282	Continued From page 2 An acute condition note indicated Resident #31 had an unobserved fall in his bathroom on 4/21/17 at 7:30 PM. No injuries were noted. The fall risk assessment dated 4/22/17 indicated Resident #31 was at high risk for falls. An acute condition note indicated Resident #31 had an unobserved fall in his bedroom on 5/23/17 at 4:30 AM. No injuries were noted. The fall risk assessment dated 5/23/17 indicated Resident #31 was at high risk for falls. The 5/24/17 quarterly MDS assessment indicated Resident #31 had moderate cognitive impairment. He required limited assistance of 1 staff with bed mobility, transfers, walking in corridor, dressing, toileting, and personal hygiene. Resident #31 had limitations with range of motion on one side of his lower extremities, he was not steady on his feet, and was only able to stabilize with staff assistance. Resident #31 had 2 or more falls with no injury since his previous MDS assessment (quarterly dated 2/22/17). An acute condition note indicated Resident #31 was observed on the floor by Nursing Assistant (NA #2) on 6/19/17 at 5:30 AM. NA #2 heard Resident #31 fall, she went to his room, observed him lying on his back, and she then alerted the nurse. Resident #31 was noted to have regular socks on both feet (not non-skid socks). The nurse assessed Resident #31. He was noted with blood around the left side of his head behind his ear and a small raised hematoma (solid swelling of clotted blood) about the size of a dime. Resident #31 was unable to move his left	F 282	nursing secretary. If changes are made to the interventions the assignment sheet will be printed and given to the nursing assistants, medication aides and licensed nursing staff. Licensed nurse, medication aides and nursing assistant were inserviced by the DON, SDC, Supervisor, MDS nurse or charge nurse on the new nursing assignment sheets on or before 8/6/17. Visual checks were completed on 8/4/17 for all residents with falls by the DON, SDC, MDS nurse, Nursing Supervisor and/or Charge Nurse. Interventions are in place. QA and monitoring: DON, SDC, MDS nurse, Supervisor or charge nurse will audit nursing assistant assignment sheets for fall interventions and conduct visual checks that interventions are in place daily, to include weekends and all shifts, times one week, weekly times 4 weeks, monthly times 4 months, and quarterly times one year. Results of audits will be reviewed in monthly QA meetings with DON, SDC, Nursing Supervisor or Charge nurse bringing the data to the monthly QA meeting.	

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F 282	Continued From page 3	F 282		

leg and he complained of pain in the left hip area. The physician was notified and Resident #31 sent to the ER for evaluation.

The medical record revealed Resident #31 was admitted to the hospital on 6/19/17 for a left femur fracture. Resident #31 was readmitted to the facility on 6/23/17.

The plan of care for Resident #31 related to his risk for falls was updated on 7/11/17 with the same interventions that were in place prior to the 6/19/17 fall that resulted in a left femur fracture. The interventions included, in part, provide proper footwear and a pool noodle under the cover when Resident #31 was in bed.

On 7/12/17 the NA Care Guide was reviewed. Resident #31 was indicated to require staff assistance of 1+ for transfers, he was on a toileting program, and used a low bed. It was noted that all residents were to be wearing shoes or gripper socks when out of bed unless care planned otherwise. There were no other fall risk interventions indicated on Resident #31 ' s NA Care Guide.

Resident #31 was observed sleeping in bed in his room on 7/13/17 at 7:15 AM. There was no pool noodle under the covers on Resident #31 ' s bed.

An interview was conducted with NA #2 on 7/13/17 at 7:20 AM. She indicated she was familiar with Resident #31 and she had worked with him regularly on the third shift (11:00 PM to 7:00 AM). She reported he was at high risk for falls. She stated she was informed of fall risk interventions by reviewing the NA Care Guide and by talking to staff. NA #2 indicated if a new

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intervention was put into place she was informed by the nurse verbally. She reported she had not reviewed Resident #31 ' s plan of care. She stated the fall risk interventions that were in place for Resident #31 were to check on him every 2 hours, fall mat on the floor when in bed, and non-skid footwear. The plan of care for Resident #31 that indicated a noodle was to be placed under the cover when he was in bed was reviewed with NA #2. She stated she had not known this was an intervention for Resident #31. She revealed she had not utilized a pool noodle as an intervention for Resident #31 when she worked with him.

The interview with NA #2 continued on 7/13/17 at 7:25 AM. The documentation from Resident #31 ' s 6/19/17 fall in which he sustained a femur fracture was reviewed with NA #2. She verified she was the NA assigned to Resident #31 at the time of the fall. She confirmed the information provided in the documentation that Resident #31 had regular socks on at the time of the 6/19/17 fall. NA #2 stated Resident #31 sometimes took his non-skid socks off during the night if he was hot. She indicated she had not regularly checked to see if he was wearing his non-skid socks throughout the night. NA #2 was asked if Resident #31 was capable of removing his non-skid socks and replacing them with regular socks. She stated she was unsure because sometimes he needed assistance getting dressed and other times he didn ' t. NA #2 revealed the intervention of a pool noodle under the covers when Resident #31 was in bed was not implemented at the time of the 6/19/17 fall.

An interview was conducted with the Director of Nursing (DON) on 7/12/17 at 10:10 am. The

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documentation from Resident #31 ' s 6/19/17 fall in which he sustained a femur fracture was reviewed with the DON. She reported proper footwear meant non-skid socks when the resident was in bed and non-skid shoes when the resident was out of bed. The DON stated the NA assigned to the resident was responsible for checking his footwear. The 7/13/17 observation of Resident #31 in bed with no pool noodle under the covers at 7:25 AM was reviewed with the DON. The interview with NA #2 that revealed the pool noodle was not in use at the time of 6/19/17 fall was reviewed with the DON. She stated her expectation was for the fall risk interventions to be in place at all times.

An interview was conducted with MDS Nurse #1 on 7/13/17 at 10:50 AM. She indicated she was responsible for creating and revising the plans of care with fall risk interventions. She stated the fall risk interventions on the care plan were supposed to be on the NA Care Guide. The care plan interventions for Resident #31 ' s risk for falls were reviewed with MDS Nurse #1. The NA Care Guide for Resident #31 that had not matched the fall risk interventions in his care plan were reviewed with MDS Nurse #1. The NA Care Guide had not included the interventions of a floor mat or a pool noodle under the cover when Resident #31 was in bed. MDS Nurse #1 reported she thought when a fall risk intervention was added to the care plan that the electronic medical records system automatically added the intervention to the NA Care Guide. She indicated that based on the discrepancies with Resident #31 ' s care plan and NA Care Guide, that she was incorrect. MDS Nurse #1 revealed there had not been monitoring in place to ensure the fall risk interventions in the care plan were on the

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F 282	Continued From page 6 NA Care Guide. She additionally revealed there had not been any monitoring in place to ensure the fall risk interventions in the care plan were implemented.	F 282		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, and record review, the facility failed to implement the fall risk interventions for 1 of 4 residents (Resident #31) at high risk for falls	F 323	Resident affected: Falls were reviewed for patient number 31 and 64 by the interdisciplinary team and interventions for resident number 31 of	8/6/17

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resulting in the resident sustaining a left femur (hip) fracture. The facility also failed to provide adequate supervision to prevent repeated falls for a resident with a history of falls for 1 of 4 residents (Resident #64) reviewed for accidents.

The findings included:

1. Resident #31 was admitted to the facility on 9/11/16 with diagnoses that included a right femur fracture, hypertension, heart disease, and dementia.

The admission Minimum Data Set (MDS) assessment dated 9/18/16 indicated Resident #31 had moderate cognitive impairment. He required extensive assistance of 2 or more staff with bed mobility, transfers, dressing, toileting, and personal hygiene. Resident #31 was not steady on his feet and was only able to stabilize with staff assistance. He utilized a wheelchair and a walker. He was indicated to be frequently incontinent of bladder and always incontinent of bowel. Resident #31 had 1 fall since his admission to the facility. This fall resulted in no injury. Resident #31 had 1 fall prior to his admission to the facility and within the past month that resulted in a related fracture. He was indicated to be receiving Physical Therapy (PT) and Occupational Therapy (OT) with a start date of 9/12/16.

The Care Area Assessment (CAA) related to falls for the 9/18/16 MDS admission assessment indicated Resident #31 had one fall since his admission to facility. The fall occurred on 9/18/16 at 12:45 AM when Resident #31 fell out of bed. This fall was indicated to result in no injury. Resident #31 was assessed with difficulty

low bed, floor matt, increased lighting, Urinal, gripper socks or shoes when out of bed and gripper socks when in bed, Call light in reach, place patient in highly visible area when not in bed, anti rollbacks to wheelchair, noodle when in bed, restorative ambulation. Resident number 64 interventions of rearranged room, increase lighting, personal alarm, bed alarm, toileting program, toilet at 9 pm, toilet throughout the night as needed, urinal, place in highly visible area, gripper socks or shoes when out of bed and gripper socks when in bed, are in place and added to the nursing assistant assignment sheet by the DON, SDC, MDS Nurse, Nursing Supervisor, Charge Nurse, unit nurse or the nursing secretary. Nursing staff licensed, medication aides and nursing assistants, full time, part time and PRN were inserviced by the DON, SDC, Nursing Supervisor or charge nurse on the interventions for resident number 31 and resident number 64 started on 8/1/17 and completed by 8/6/17. A visual audit of resident 31 and resident 64 to assure interventions were in place was conducted on 8/4/17 by the DON, SDC, MDS Nurse, Nursing Supervisor and/or Charge Nurse and are in place.
Resident potentially affected:
A falls assessment was completed beginning 7/10/17 and completed by 8/3/17 for 100% of residents by the DON, SDC, MDS Nurse, Nurse Supervisor or charge nurse. Interventions were put in place for anyone with fall risk. A visual audit of all patient with falls interventions was completed by the DON, SDC, MDS

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F 323	Continued From page 8 maintaining standing position, impaired balance during transitions, gait problem even with mobility aid or personal assistance. He was noted with a decline in functional status, muscle weakness, impulsivity or poor safety awareness, cognitive impairment, dementia, fatigue, and incontinence. He was admitted to the facility following a recent hospitalization stay due to a right hip fracture that had been repaired. The plan of care for Resident #31 initiated on 9/29/16 indicated he was at risk for falls. The interventions initiated on 9/29/16 included, in part, call bell within reach and provide proper footwear. Interventions initiated on 9/30/16 indicated antiroll-backs to wheelchair as ordered and floor mat. An intervention initiated on 10/27/16 indicated a pool noodle (used to create a raised boundary at the outer edge of the bed) was to be placed under the cover when Resident #31 was in bed. An acute condition note indicated Resident #31 was observed on the floor in his bathroom on 4/21/17 at 7:30 PM. The call light in Resident #31 ' s bathroom was on. He was assessed with no injuries. Resident #31 indicated he was standing in front of the toilet and his feet started sliding. Resident #31 was assisted to bed, his bed was then placed in the lowest position, and his call light was put within his reach. Resident #31 was asked by staff not to get up on his own and to use the call light for assistance. He was noted to be wearing non-slip shoes, his room and bathroom were uncluttered, and the bathroom light was on. The fall report related to Resident #31 ' s 4/21/17 fall indicated the bathroom call light had been utilized, but the call light in his bedroom was in	F 323	nurse, Nursing Supervisor or Charge Nurse on 8/4/17 and are in place. Systemic changes: Facility adopted a new nursing assistant assignment sheet with a space for fall interventions. Assignment sheets will be updated with new interventions by the DON, SDC, MDS Nurse, Nursing Supervisor, Charge Nurse, unit nurse, or unit secretary in daily clinical meeting, on all shifts and on weekends. Any changes to assignment sheets will be copied and given to the licensed nurse, Medication Aide and nursing assistants by the DON, SDC, MDS Nurse, Nursing Supervisor, Charge Nurse, unit nurse or nursing secretary. Inservices on the new process was provided on 7/28/17 by the DON, SDC, MDS nurse, RN Supervisor, and/or Charge Nurse to all full time, part time and PRN nursing staff. Visual checks were provided to assure interventions were in place for all patients with falls on 8/4/17 by the DON, SDC, MDS nurse, Nursing Supervisor and/or Charge Nurse. Any resident who sustains a fall will be reviewed by the interdisciplinary team to assure interventions are in place as indicated. DON, SDC, MDS nurse, Nursing Supervisor and/or charge nurses will conduct visual audits to assure fall interventions are in place for all residents with falls to include all shifts and weekends. Audits will be completed daily times 1 week, weekly times 4 weeks, monthly times 4 months and quarterly times one year. QA and Monitoring: DON, SDC, MDS nurse, Nursing	

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F 323	Continued From page 9 reach of the bed and had not been utilized. Resident #31 was indicated to have been wearing proper footwear. The floor in Resident #31 ' s bathroom was noted to be slick (no urine or water was noted on the floor). Resident #31 ' s known behaviors were a history of falls and getting up without assistance. Interventions in place/added for Resident #31 were "low bed, noodle on his bed, clean/dry floor ...the floor was noted slick when the [staff] entered the room, they started to slide on the floor, the floor was mopped after [Resident #31] was assisted to bed". The fall risk assessment dated 4/22/17 indicated Resident #31 was at high risk for falls. Resident #31 was taught how to use the call light. The facility indicated the fall risk intervention added was a clean/dry floor, as Resident #31 ' s bathroom floor where he had fallen was noted slick when staff found the resident. He was indicated to have had 1 or more falls in the past 6 months. Resident #31 required assistance with toileting. He was assessed with intermittent confusion. An acute condition note indicated Resident #31 was observed on the floor of his bedroom with his back against the bed on 5/23/17 at 4:30 AM. The floor was noted to be clean and clear, bed in the lowest position, and the wheelchair was close to the bed. Resident #31 was wearing white cotton socks and bedroom slippers. He was assessed with no injuries. Resident #31 indicated he had tried to get up to put his shoes on and he slid down to the floor. Neurological checks were initiated and no concerns were identified. Resident #31 was instructed on the use of his call light.	F 323	Supervisor or Charge Nurse will audit nursing assignment sheets and complete visual checks that interventions are in place on all shifts and weekends daily times 1 week, weekly times 4 weeks, monthly times 4 months and quarterly times a year. Results will be brought by the DON, SDC, MDS nurse,Nursing Supervisor and/or Charge Nurse of audits and they will be reviewed in monthly QA meetings.	

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The fall report related to Resident #31 ' s 5/23/17 fall indicated he had not utilized his call light. Resident #31 had fallen in his room, he was indicated to be attempting to put his shoes on and he slid to the floor. His call light was noted to be in reach and he was wearing proper footwear. His known behavior was getting up without assistance. Interventions in place/added for Resident #31 were "low bed".

The fall risk assessment dated 5/23/17 indicated Resident #31 was at high risk for falls. Resident #31 was instructed on use of the call light. The intervention added was increased lighting (leaving night light on). He was indicated to have had 1 or more falls in the past 6 months. Resident #31 was assessed with intermittent confusion

The 5/24/17 quarterly MDS assessment indicated Resident #31 had moderate cognitive impairment. He had no behaviors and no rejection of care. He required limited assistance of 1 staff with bed mobility, transfers, walking in corridor, dressing, toileting, and personal hygiene. Resident #31 had limitations with range of motion on one side of his lower extremities, he was not steady on his feet and was only able to stabilize with staff assistance. He utilized a wheelchair and a walker. He was indicated to always be continent of bladder and occasionally incontinent of bowel. Resident #31 had 2 or more falls with no injury since his previous MDS assessment (quarterly dated 2/22/17). He was indicated to be receiving PT with a start date of 5/9/17. He was also indicated to have received restorative nursing services for active range of motion and walking.

An acute condition note indicated Resident #31

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was observed on the floor by Nursing Assistant (NA #2) on 6/19/17 at 5:30 AM. NA #2 heard Resident #31 fall, she went to his room, observed him lying on his back, and she then alerted the nurse. Resident #31 was noted to have regular socks on both feet (not non-skid socks). The nurse assessed Resident #31. He was noted with blood around the left side of his head behind his ear and a small raised hematoma (solid swelling of clotted blood) about the size of a dime. Resident #31 was unable to move left leg and he complained of pain in the left hip area. Resident #31 ' s room was clean, uncluttered, the floor was dry, and the call light was clipped to the side of the bed (within reach of Resident #31 when he was in bed). The physician was notified and Resident #31 sent to the ER for evaluation.

The fall report related to Resident #31 ' s 6/19/17 fall indicated he had not utilized his call light and he was not wearing proper footwear. Resident #31 was instructed on use of the call light, but he was noted to be unable to retain knowledge at that time due to pain. His known behaviors were a history of falls and getting up without assistance. Interventions in place/added for Resident #31 were "low bed, encourage to wear proper footwear".

The fall risk assessment dated 6/19/17 indicated Resident #31 was at high risk for falls. The interventions added were noted to be low bed and proper footwear. He was indicated to have had 1 or more falls in the past 6 months. Resident #31 required assistance with toileting. He was assessed with intermittent confusion.

The medical record revealed Resident #31 was admitted to the hospital on 6/19/17 for a left

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femur fracture. Resident #31 was readmitted to the facility on 6/23/17.

The plan of care for Resident #31 related to his risk for falls was updated on 7/11/17 with the same interventions that were in place prior to the 6/19/17 fall that resulted in a femur fracture. The interventions included, in part, call bell within reach, provide proper footwear, antiroll-backs to wheelchair as ordered, floor mat, and a pool noodle under the cover when Resident #31 was in bed.

On 7/12/17 the NA Care Guide was reviewed. Resident #31 was indicated to require staff assistance of 1+ for transfers, he was on a toileting program, and used a low bed. It was noted that all residents were to be wearing shoes or gripper socks when out of bed unless care planned otherwise. There were no other fall risk interventions indicated on Resident #31 ' s care guide.

Resident #31 was observed sleeping in bed in his room on 7/13/17 at 7:15 AM. There was no pool noodle under the covers on Resident #31 ' s bed.

An interview was conducted with NA #2 on 7/13/17 at 7:20 AM. She indicated she was familiar with Resident #31 and she had worked with him regularly on the third shift (11:00 PM to 7:00 AM). She reported he was a high risk for falls. She stated she was informed of fall risk interventions by reviewing the NA Care Guide and by talking to staff. NA #2 indicated if a new intervention was put into place she was informed by the nurse verbally. She reported she had not reviewed Resident #31 ' s plan of care. She stated the fall risk interventions that were in place

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for Resident #31 were to check on him every 2 hours, fall mat on the floor when in bed, and non-skid footwear. The plan of care for Resident #31 that indicated a noodle was to be placed under the cover when he was in bed was reviewed with NA #2. She stated she had not known this was an intervention for Resident #31. She revealed she had not utilized a pool noodle as an intervention for Resident #31 when she worked with him.

The interview with NA #2 continued on 7/13/17 at 7:25 AM. The documentation from Resident #31 ' s 6/19/17 fall in which he sustained a femur fracture was reviewed with NA #2. She verified she was the NA assigned to Resident #31 at the time of the fall. She confirmed the information provided in the documentation that Resident #31 had regular socks on at the time of the 6/19/17 fall. NA #2 stated Resident #31 sometimes took his non-skid socks off during the night if he was hot. She explained that Resident #31 had a history of attempting to get out of bed without calling for assistance. She reported she checked on him about every 2 hours to ensure he was still in bed, but she had not regularly checked to see if he was wearing his non-skid socks throughout the night. NA #2 was asked if Resident #31 was capable of removing his non-skid socks and replacing them with regular socks. She stated she was unsure because sometimes he needed assistance getting dressed and other times he didn ' t. NA #2 revealed the intervention of a pool noodle under the covers when Resident #31 was in bed was not implemented at the time of the 6/19/17 fall.

An interview was conducted with the Director of

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Nursing (DON) on 7/12/17 at 10:10 am. The documentation from Resident #31 ' s 6/19/17 fall in which he sustained a femur fracture was reviewed with the DON. She reported proper footwear meant non-skid socks when the resident was in bed and non-skid shoes when the resident was out of bed. The DON stated the NA assigned to the resident was responsible for checking his footwear. The 7/13/17 observation of Resident #31 in bed with no pool noodle under the covers at 7:25 AM was reviewed with the DON. The interview with NA #2 that revealed the pool noodle was not in use at the time of 6/19/17 fall was reviewed with the DON. She stated her expectation was for the fall risk interventions to be in place at all times.
2. Resident #64 was admitted to the facility on 5/25/17 with multiple diagnoses including Dementia and Right femur fracture.

The admission Minimum Data Set (MDS) assessment dated 6/2/17 indicated that Resident #64 had severe cognitive impairment and he needed extensive assistance with transfer. The assessment also indicated that he had a fall with injury in the last 6 months prior to admission to facility. The assessment further indicated that Resident #64 was frequently incontinent of bowel and bladder and he was unsteady when moving on and off toilet, moving from seated to standing and when transferring between bed, chair or wheelchair.

Resident #64's care plan dated 6/8/17 was reviewed. One of the care plan problems was "at risk for falls due to unsteady gait and recent falls". The goal was "resident will not be seriously injured if he falls". The approaches included " encourage to ask for assistance, bed alarm as

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needed, scheduled toileting, toilet upon awakening, after meals, at bedtime and as needed".

The incident reports for Resident #64 were reviewed. The reports indicated that he had 6 falls since admission (5/25/17) to facility.

On 6/1/17 at 8:03 PM, Resident #64 was found sitting on the floor in the bathroom. The interventions added were the room was rearranged, wheelchair and bedside table were placed at friendlier angle and lighting was increased on hallway.

On 6/6/17 at 10:28 AM, Resident #64 was found sitting on the floor in front of the recliner. His clothes were wet with urine and he stated that he was going to the bathroom. The intervention added was personal alarm.

On 6/15/17 at 9:05 AM, Resident #64 was observed on the floor in the doorway of the bathroom door. The interventions added were low bed, fall mat and bed alarm.

On 6/24/17 at 7:20 PM, Resident #64 was found sitting on the bathroom floor. The intervention added was to toilet after meals.

On 6/28/17 at 10:28 AM, Resident #64 was found lying on his left side in the bathroom. Skin tear to his left wrist was noted. The interventions added were "spoke with therapy and explained that we do not leave the resident in room during the day and to keep him with others at activities and toilet him very often".

On 7/10/17 at 10:20 AM, Resident #64 was found

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on the floor. He sat down on floor on the way back from the toilet. Interventions added were increased lighting and foot wear provided".

Resident #64 was observed on 7/12/17 at 3:46 PM. He was up in wheelchair in his room. A family member was in the room with the resident. NA #1 came in the room and was interviewed. NA #1 stated that he was assigned to Resident #64. He indicated that the resident was on toileting program and he toileted him every 2 hours.

A family member was interviewed on 7/12/17 at 3:47 PM. The family member stated that she/he came to visit Resident #64 every day from 2 PM until 6-6:30 PM. She/he stated that she/he had not observed the staff taking Resident #64 to the bathroom during her/his visits.

An interview was conducted with the Director of Nursing (DON) on 7/12/17 at 4:05 PM. The DON stated that she was aware that Resident #64's falls happened in the bathroom. She expected his care plan to be individualized and to toilet him more often than after every meal and at bedtime and not to leave resident in his room during the day and to provide more supervision. She also expected the staff to ensure a urinal was kept at bedside when he was in bed.

Resident #64 was observed in bed on 7/13/17 at 7:10 AM. There was no urinal observed at the resident's bedside.

NA #2, assigned to Resident #64 on 3rd shift was interviewed on 7/13/17 at 7:30 AM. She stated that the resident was incontinent of bowel and bladder and he was wearing a disposable brief. NA #2 further indicated that the resident was

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F 323	Continued From page 17 unsteady and he tried to get up and to walk to the bathroom. She indicated that the resident was not on any toileting schedule at night. She further stated that she checked the resident every 2 hours for incontinence and he was wet most of the time. She further stated that she offered the resident a urinal but didn't keep the urinal at bedside.	F 323		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic	F 329		8/6/17

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F 329	Continued From page 18 drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and Psychiatric Nurse Practitioner interview, the facility failed to discontinue antipsychotic medication as ordered (Resident #42) and failed to attempt non-pharmacological interventions prior to administering PRN (as needed) antipsychotic medication (Resident #73) for 2 of 5 residents reviewed for unnecessary medications. The findings included: 1. Resident #42 was admitted to the facility on 12/13/10 with diagnoses that included psychosis. The quarterly Minimum Data Set (MDS) assessment dated 5/24/17 indicated Resident #42 ' s cognition was significantly impaired. She had other behavioral symptoms and rejection of care on 1-3 days during the MDS review period. Resident #42 was administered antipsychotic medication on 7 of 7 days during the MDS review period. A Psychiatric Nurse Practitioner (PNP) note dated 5/25/17 indicated Resident #42 had no agitation, behavioral outbursts, or new problems. Staff	F 329	Resident affected: Resident number 42's Risperdal was discontinued by psychiatric Adult Nurse Practitioner-Board Certified on 7/11/17. Resident number 73's Haldol prn order was discontinued on 7/26/17 by the psychiatric ANP-BC. Residents potentially affected: DON audited 100% of residents on antipsychotic medications on 7/14/17 and no other patients were on prn antipsychotic medications. 100% of Family Nurse Practitioner and Medical Doctor orders were checked to assure medications have stop dates by the DON, SDC, MDS Nurse, Nursing Supervisor or Charge Nurse starting on 8/1/17 and completed on 8/6/17 and are in compliance. Systemic changes: Patients with prn antipsychotic medications will be reviewed within 48 to 72 hours of order received by the ANP-BC, FNP or MD to determine if medication is indicated. If not indicated the ANP-BC, FNP or MD will discontinue the prn antipsychotic medication. If the	

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F 329	Continued From page 19 reported Resident #42 was at her baseline. The PNP indicated her plan included a Gradual Dose Reduction (GDR) for Risperdal (antipsychotic medication). A physician ' s order dated 5/25/17 indicated Risperdal 0.25 milligrams (mg) every other day at 5:00 PM times 10 days and then discontinue (last date 6/3/17). A review of the June 2017 and July 2017 Medication Administration Records (MARs) revealed Resident #31 continued to receive Risperdal 0.25mg every other day through 7/10/17. The Risperdal was not discontinued on 6/3/17 as ordered by the physician. Resident #31 was administered 19 doses of Risperdal after the date it was ordered to be discontinued: 6/4, 6/6, 6/8, 6/10, 6/12, 6/14, 6/16, 6/18, 6/20, 6/22, 6/24, 6/26, 6/28, 6/30, 7/2, 7/4, 7/6, 7/8, and 7/10. A review of Resident #42 ' s plan of care, reviewed on 7/11/17, indicated the potential for side effects due to antianxiety, antipsychotic, antidepressant use. An observation was conducted of Resident #42 in her room in her wheelchair on7/11/17 at 3:45 PM. There were no behavioral issues observed. An interview was conducted with Nurse #2 on 7/11/17 at 3:53 PM. She indicated she was familiar with Resident #42 and she worked with her regularly on the second shift (3:00 PM to 11:00 PM). She reported Resident #42 had behaviors in the past, but she was presently at her baseline. Nurse #2 stated she thought Resident #42 received Risperdal every other day, but she needed to review the MAR for	F 329	prn antipsychotic medication is indicated nonpharmacological interventions will be implemented prior to the antipsychotic medication being administered. These nonpharmacological interventions will be documented in the nurses notes by the DON, SDC, MDS Nurse, Nursing Supervisor charge Nurse, unit nurse or Medication Aide. Nurses and Medication Aides, Full time, part time, and PRN will be inserviced on nonpharmacological interventions by the DON, SDC, MDS Nurse, Nursing Supervisor, MDS nurse, Charge Nurse starting 7/25/17 and completed by 8/6/17. The nonpharmacological interventions list was developed by the DON, SDC, MDS nurse, Nursing Supervisor or the charge nurse on 7/13/17. This list of nonpharmacological interventions will be placed on each medication cart. Computer software has been upgraded to include stop dates on all meds requiring stop dates when the order is entered. Update was complete on 8/2/17. FNP or MD orders will be reviewed within 48 to 72 hours of admission by the DON, SDC, MDS Nurse, Nursing Supervisor or Charge Nurse to assure medication stop dates are in the medical record. Inservices will be provided on use of stop dates by the DON, SDC, MDS Nurse, Nursing Supervisor or Charge Nurse for the nurses and medication aides to include full time, part time and prn starting on 7/12/17 and completed by 8/6/17. QA and Monitoring: DON, SDC, MDS Nurse, Nursing Supervisor, or Charge Nurse will audit	

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F 329	Continued From page 20 verification. The July MAR for Resident #42 was reviewed with Nurse #2. She reported the physician ' s order for Risperdal was no longer showing up on Resident #42 ' s MAR. Nurse #2 stated she was unsure why this was happening and she referred the surveyor to Unit Manager (UM) #1. An interview was conducted with UM #1 on 7/11/17 at 4:00 PM. UM #1 reviewed the 5/25/17 physician ' s order for Risperdal for Resident #42. She stated she had entered the physician ' s order dated 5/25/17 for Risperdal 0.25mg every other day times 10 days for Resident #42. She indicated she thought the electronic medical records system would automatically discontinue the medication after the 10th day, but she revealed that had not occurred. UM #1 reported the 10th day was 6/3/17 and the Risperdal should not have been administered to Resident #42 after that date as per the 5/25/17 physician ' s order. The 19 additional administrations of Risperdal 0.25mg were reviewed with UM #1. UM #1 stated her expectation was for the nurses who had administered the Risperdal to Resident #42 to read the order and to have noticed it should have been discontinued. UM #1 stated that UM #2 had discontinued the Risperdal order for Resident #42 in the electronic medical record on the morning of 7/11/17. A second interview was conducted with Nurse #2 on 7/11/17 at 4:05 PM. She indicated she had not noticed that the 5/25/17 physician ' s order for Risperdal 0.25mg every other day specified a 10 day timeframe. An interview was conducted with the Director of Nursing (DON) on 7/11/17 at 4:20 PM. She stated it was her expectation for medications to	F 329	50% of ANP-BC, FNP and/or MD orders for PRN antipsychotic medications and meds with stop dates. Audits will be completed daily times 2 weeks, weekly times 4 weeks, monthly times 4 months, quarterly times one year. Results of audits will be brought by the DON, SDC, MDS Nurse, Nursing Supervisor or charge nurse and reviewed in monthly QA meetings.	

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be administered as ordered by the physician. The 5/25/17 physician ' s order for Risperdal for Resident #42 that indicated 0.25mg every other day at 5:00 PM times 10 days was reviewed with the DON. The June 2017 and July 2017 MARs that revealed Resident #42 had received 19 additional administrations of Risperdal were reviewed with the DON. She stated she thought the electronic medical records system automatically discontinued the medication when the order specified a timeframe. She indicated this was a failure of the nurse to read the complete physician ' s order and to notice the medication should have been discontinued.

An observation was conducted of Resident #42 in her room in her wheelchair on 7/12/17 at 8:28 AM. There were no behavioral issues observed.

An interview was conducted with UM #2 on 7/12/17 at 8:30 AM. He reported he was reviewing all psychotropic medication orders on 7/11/17 as the PNP was scheduled to visit. He revealed it was during that review he noticed the Risperdal for Resident #42 should have been previously discontinued. UM #2 stated he discontinued the Risperdal in the electronic medical records system for Resident #42 on 7/11/17. He indicated the nurses who administered the Risperdal after the specified 10 day timeframe should have noticed the medication was to be discontinued.

An interview was conducted with the PNP on 7/12/17 at 2:45 PM. She reported she had decided to discontinue the Risperdal as Resident #42 was at her baseline with no behavioral concerns. The PNP revealed she was notified on 7/11/17 by facility staff that Resident #42 ' s

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F 329	Continued From page 22 Risperdal was not discontinued as ordered. She stated it was her expectation for medications to be administered as ordered. 2. Resident #73 was admitted to the facility on 3/17/14 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 6/2/17 indicated that Resident #73 had memory and decision making problems and he had received antipsychotic medication during the 7 day assessment period. The care plan dated/last updated on 6/2/17 for Resident #73 was reviewed. One of the care plan problems was "I have potential for adverse medication side effects related to antipsychotic, antianxiety and antidepressant use". The goal was "I will not cause harm to myself or others should I have an episodes of combative behavior and I will not have side effects due to the medication regimen". The approaches included "to monitor for side effects every shift, may offer resident music and memory, my nurse aide will attempt to prevent behavior, take resident to chapel area or green room, offer resident a choice of movies to watch, allow resident to listen to music, offer resident drink or food". Resident #73 ' s physician ' s orders included Buspar (drug used to treat anxiety) 15 milligrams (mgs) 3 times a day for Anxiety, Ativan (anti-anxiety drug) 1 mgs every 8 hours for Anxiety, Cymbalta (anti-depressant drug) 60 mgs daily for Depression, Seroquel (anti-psychotic drug) 40 mgs twice a day for dementia with behavioral disturbances. In addition, there was also an order for Haldol (anti-psychotic drug) 5	F 329		

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mgs three times a day as needed (PRN) for agitation/increase shouting dated 7/26/16.

The Medication Administration Records (MARs) and the nurse's notes for the last 5 months (April - July 2017) were reviewed.

The April 2017 MAR revealed that Resident #73 had received the PRN Haldol on 4/12/17 at 1:07 AM for agitation, restlessness, screaming and cursing, on 4/12/17 at 9:45 PM for agitation, yelling out and cursing, on 4/17/17 at 4:09 AM for agitation and shouting out, on 4/22/17 at 4:31 PM for agitation and yelling out, on 4/26/17 at 2:49 AM for agitation, yelling and cursing, on 4/27/17 at 4:07 AM for agitation, yelling, cursing and screaming, and on 4/27/17 at 4:56 PM for agitation, increased yelling and cursing.

The May 2017 MAR revealed that Resident #73 had received the PRN Haldol on 5/10/17 at 3:29 AM for agitation, restlessness, yelling and cursing, on 5/16/17 at 7:52 PM for agitation, yelling out and cursing, on 5/27/17 at 10:15 PM for agitation and yelling, and on 5/30/17 at 8:59 PM for agitation and yelling out.

The June 2017 MAR revealed that Resident #73 had received PRN Haldol on 6/3/17 at 10:36 PM for agitation and yelling out, on 6/14/17 at 2:03 AM for agitation, yelling and screaming, on 6/26/17 at 4:22 AM for agitation, yelling, cursing and grabbing, and on 6/27/17 at 7:39 PM for agitation and yelling.

The July 2017 MAR revealed that Resident #73 had received PRN Haldol on 7/5/17 at 1:38 AM for agitation, yelling and cursing, on 7/5/17 at 10:40 PM for agitation, yelling out and cursing

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and on 7/8/17 at 12:55 AM for agitation, yelling out, cursing and grabbing.

The April, May, June and July 2017 MARs and nurse's notes did not indicate that non pharmacological interventions were tried prior to administering the PRN Haldol.

On 7/11/17 at 9:20 AM and 5:12 PM and on 7/12/17 at 10:05 AM and 12:25 PM, Resident #73 was observed in bed with eyes closed.

The psychiatric Nurse Practitioner (NP) who had been following Resident #73 for behavior and medication management was interviewed on 7/12/17 at 2:40 PM. The NP stated that she was aware that Resident #73 was on PRN Haldol and she expected the nurses to try non pharmacological interventions prior to administering the PRN Haldol. The NP added that Haldol was ordered PRN and should only be given in cases of severe aggression/psychosis.

Nurse #1, assigned to Resident #73 on 3rd shift, and was interviewed on 7/13/17 at 7:00 AM. Nurse #1 stated that Resident #73 had been combative and aggressive in the past and these behaviors had improved. Most of his behaviors lately were yelling and screaming and she administered the PRN Haldol when he started to yell and scream. Nurse #1 added that she tried to change the channel on the television when he started to yell and scream but that didn't work. Nurse #1 didn't say that she tried to get resident up nor offer movies, music or snacks prior to administering the PRN Haldol.

NA #2, assigned to Resident #73 on 3rd shift was interviewed on 7/13/17 at 7:30 AM. She stated

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F 329	Continued From page 25 that the resident had yelled and screamed at night. She didn't get him up nor offer him movies or music at night. The Director of Nursing was interviewed on 7/13/17 at 9:58 AM. She stated that she expected the nurses to try non pharmacological interventions such as getting him up if he would allow, offering snacks or turning the television on when he started yelling/screaming and before administering the PRN Haldol and to document the interventions tried in the nurses notes.	F 329		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage,	F 371		8/6/17

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F 371	Continued From page 26 handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to clean food service equipment, cookware, meal delivery carts and kitchen fans. The facility allowed lettuce to contact an unsanitized towel and counter surface that had not been properly sanitized exposing food to possible contaminants for 21 of 21 residents who received specialized diets. The facility failed to maintain a thoroughly clean floor under five of nine appliances. Findings Included: 1. Observations were conducted of the kitchen on 7/10/17 at 10:44 AM, on 7/12/17 at 9:17 AM, and on 7/12/17 at 11:44 AM that revealed the following: a. Two of two handles on the two door reach in freezer had a buildup of grease, dirt, and debris. b. Two of two fans suspended from walls were observed to have visible dust build up. c. Underside of the shelf over the flat top grill was observed to have visible dust. d. The knobs on two of two of the flat top griddle, two of two on the steamer, two of two on the stove, one of one on the deep fat fryer, and one of one on the convection oven had a buildup of grease, dirt and debris. e. Six of thirty-three pot lids stored under the steamer were observed to have visible dust. f. The underside of the shelf, under the steamer, over the pot lids, was observed to have visible dust. g. The floor under five of nine appliances, six door reach in freezer, two door reach in freezer, two door reach in cooler, four door reach in	F 371	Resident affected: All residents have the potential to be affected. For the residents potentially exposed to possible contaminates, the following items were cleaned by the kitchen staff beginning 7/14/17 and complete 8/6/17: food service equipment, cookware, meal delivery carts, floors and kitchen fans. Dietary staff was inserviced on sanitation, including proper cleaning of equipment, cookware, meal delivery carts, floors, and kitchen fans by the Dietary Manager or Assistant Dietary Manager by 8/6/17 Residents potentially affected: All residents have the potential to be affected. For residents potentially exposed to possible contaminates the following items were cleaned by the kitchen staff: Food Service Equipment, cookware, meal delivery carts, floors and kitchen fans beginning 7/14/17 to 8/6/17. Systemic effects: The dietary manager implemented a daily cleaning schedule, a weekly cleaning schedule and a monthly cleaning schedule. Fans are on a every two week cleaning cycle, floors are on an every week cleaning cycle. Sanitation audits will be conducted on a weekly schedule times 4 weeks then monthly by the Dietary Manager, Assistant Dietary Manager and/or the Registered Dietician. The Dietary Manager or Assistant Dietary Manager inserviced staff on the new	

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F 371	Continued From page 27 cooler, and single door reach in cooler was observed to not be thoroughly cleaned. h. Dust, debris, and food build up were observed on the front, sides, top and/or rear on four of four appliances on the cook line including: The convection oven, the deep fat fryer, the stove, and the steamer. An interview conducted with the Dietary Manager on 7/12/17 at 9:54 AM revealed the Dietary Manager's expectation was for the appliance knobs to be clean, appliance handles to be clean, appliances to be clean, the underside of shelving that was over food contact surfaces to be clean, kitchen utensils to be clean, and kitchen equipment such as the fans to be clean. 2. An observation on 7/12/17 at 9:36 AM revealed Dietary Employee #2 was observed wiping down the first of six meal delivery carts, she returned the wiping cloth to the water, the cart was then pushed into the area where food trays would be placed into the carts. Dietary Employee #2 was then observed removing the wiping cloth from the water and proceed wiping down a second cart. Upon completing wiping down the cart, Dietary Employee #2 returned the wiping cloth to the water and pushed the second tray cart next to the first into the area where food trays would be placed into the carts. An interview that was conducted with the Dietary Manager on 7/12/17 at 9:45 AM revealed meal delivery carts one and two were ready and in position to be loaded with trays for lunch and there would be no further cleaning required for tray carts positioned there. The Dietary Manager stated Dietary Employee #2 should have sprayed the tray with the disinfectant spray and then wiped	F 371	cleaning processes to include food service equipment, cookware, meal delivery carts, floors and kitchen fans, on the new cleaning schedules, and importance of sanitation beginning 7/14/17 and complete on 8/6/17. QA and Monitoring: Dietary Manager, Assistant Dietary Manager or Cook will audit daily cleaning schedules on all shifts and weekends daily times 2 weeks, weekly times one month, monthly times 4 months and quarterly times one year. Dietary Manager, Assistant Dietary Manager or Cook will audit weekly cleaning schedules weekly times 4 weeks, monthly times 4 months, and quarterly times 1 year. Sanitation audits will be conducted weekly times 4 weeks them monthly times one year by the Dietary Manager, Assistant Dietary Manager or Registered Dietician. The results of the audits will be brought by the Dietary Manager or Assistant Dietary Manager and will be reviewed in monthly QA meetings.	

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down the tray cart.

An interview conducted with Dietary Employee #2 on 7/12/17 at 9:47 AM revealed she did not use the disinfectant spray on the tray carts because the tray carts had a hard surface.

An interview conducted with the Dietary Manager on 7/12/17 at 9:54 AM revealed the Dietary Manager's expectation was for the tray carts to be properly sanitized prior to being placed into position ready for resident trays. The Dietary Manager added she expected appliance knobs to be clean, appliance handles to be clean, appliances to be clean, the underside of shelving that was over food contact surfaces to be clean, kitchen utensils to be clean, and kitchen equipment such as the fans to be clean.

3. An observation was conducted of the kitchen on 7/12/17 that began at 11:19 AM revealed Dietary Employee #3 was observed to have wiped down the steam table service line with a wiping cloth then place the wiping cloth on the food preparation table across from the stove. There were six wiping cloths sitting on the food preparation table. There was not a sanitizer bucket on top of or under the food preparation table. Dietary Employee #3 was observed to have wiped down the food preparation table across from the stove with one of the non-sanitized wiping cloths that were on the table. The wiping cloth was placed back on the table. Dietary Employee #4 was observed to have wiped down a commercial grade food processor, light duty food processor, and blender with a wiping cloth she had removed from a preparation table. Dietary Employee #3 was observed to be chopping lettuce. The lettuce was observed to be

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in contact with the table surface that had been wiped down with the non-sanitized wiping cloth and came in contact with the non-sanitized wiping cloth. The lettuce that had been chopped was placed into small bowls and was brought to the service line and placed on resident trays who were receiving mechanical soft diets. Dietary Employee #3 was observed to wipe down the food preparation table with one of the non-sanitized wiping cloths from the six wiping cloths sitting on the food preparation table.

An interview with Dietary Employee #3 on 7/12/17 at 11:56 AM revealed she had been chopping lettuce for the 21 residents on mechanical soft diets.

During an interview with Dietary Employee #3 on 7/12/17 at 12:07 PM she stated when she finished preparation food for the meal she would place the wiping cloths in a sanitizer bucket that was located on the food preparation sink.

An interview conducted with the Dietary Manager on 7/12/17 at 12:09 PM revealed her expectation was for employees to wash, rinse, sanitize and wipe food preparation surfaces, areas, and equipment.

An interview conducted on 7/13/17 at 11:14 AM with the Administrator revealed her expectations were for appliance to be cleaned, including knobs and handles. In addition to the appliances food utensils and areas that would expose utensils or food should be kept clean as well as equipment in the kitchen such as the fans. She further clarified she expected the floors under appliances to be clean. Her expectations also included for the proper sanitizing procedure to be used.

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F 520 SS=G	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality	F 520		8/6/17

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F 520	Continued From page 31 deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility ' s Quality Assurance and Assessment (QAA) committee failed to maintain implemented procedures and to monitor these interventions that the committee put into place in July 2016. This was for recited deficiencies that were originally cited in July 2016 recertification and complaint investigation survey and subsequently recited on the facility's recertification and complaint investigation survey on July 13, 2017. The deficiencies were in the areas of accidents F323 and kitchen sanitation F371. The continued failure of the facility during the two federal surveys of record shows a pattern of the facility's inability to sustain an effective QA program. Findings included: This tag is cross referred to: F323 (Accidents) -Based on observation, family interview, staff interview, and record review, the facility failed to implement the fall risk interventions for 1 of 4 residents (Resident #31) at high risk for falls resulting in the resident sustaining a left femur (hip) fracture. The facility also failed to provide adequate supervision to prevent repeated falls for a resident with a history of falls for 1 of 4 residents (Resident #64) reviewed for accidents. During the recertification and complaint investigation survey of July 2016, the facility was cited accidents for failure to safeguard a resident	F 520	Residents affected: resident number 31 and resident number 64 had fall incidents reviewed on by the DON, SDC, MDS nurse, nursing supervisor, or charge nurse to assure there were interventions in place and that they were care planned. Interventions in place for resident number 31 are low bed, floor matt, increased lighting, gripper socks or shoes when out of bed, gripper socks when in bed, call light in reach, patient in a highly visible area when out of bed, anti roll backs to the wheelchair, noodle when in bed and restorative ambulation and interventions for resident number 64 are rearranged room, night light on in hallway to increase lighting, personal alarm, bed alarm, toileting program,, toilet after 9 pm and toilet throughout the night , urinal, place in highly visible area when out of bed, gripper socks or shoes when out of bed and gripper socks when in bed. Kitchen equipment, cookware, delivery carts, floors and fans were cleaned by dietary staff by 8/6/17 and dietary staff were inserviced on cleaning schedules, cleaning lists and sanitation by 8/6/17. Residents potentially affected: 100% of residents were assessed for fall risk on 8/4/17 by the DON, SDC, MDS nurse, nursing supervisor, or charge nurse. Residents will fall interventions were identified and visually checked that interventions were in place on 8/4/17 by	

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F 520	Continued From page 32 from entrapment between the side rail and the air mattress. F371 (Kitchen Sanitation) - Based on observation and staff interviews the facility failed to clean food service equipment, cookware, meal delivery carts and kitchen fans. The facility allowed lettuce to contact an unsanitized towel and counter surface that had not been properly sanitized exposing food to possible contaminants for 21 of 21 residents who received specialized diets. The facility failed to maintain a thoroughly clean floor under five of nine appliances. During the recertification and complaint investigation survey of July 2016, the facility was cited kitchen sanitation for failure to consistently monitor and maintain a refrigerator temperature of 41 degrees Fahrenheit (F) or below. The QA Nurse was interviewed on 7/13/17 at 10:15 AM. The QA Nurse stated that she was aware that accidents and kitchen sanitation were cited during the recertification survey of July 2016. She indicated that the facility had been monitoring the use of side rails on admission. She also indicated that she had been monitoring the temperature of the nourishment refrigerators. The QA Nurse stated that the areas that were recited were different from last year. She added that the committee would create a new system to address falls. The Administrator was interviewed on 7/13/17 at 10:35 AM. She stated that she started working at the facility as administrator 2 weeks ago. She was aware that accidents and kitchen sanitation were cited during the recertification survey of July 2016. She also indicated that she would take	F 520	the DON, SDC, MDS nurse, nursing supervisor or charge nurse.Kitchen equipment, cookware, delivery carts, floors and fans were cleaned by dietary staff by 8/6/17 and dietary staff were inserviced on cleaning schedules, cleaning lists and sanitation by 8/6/17. Systemic changes: Audits mentioned under each citation will be given to the Administrator who will audit that they are complete per the stated time lines. Inservices were provided by the Administrator, to the department heads, on Quality Assurance and Performance Improvement on 8/2/17. QA and Monitoring: Administrator will complete a review of all audits submitted per the stated time line to assure they are complete and are in compliance. Results of audits will be brought by DON, SDC, MDS nurse, nursing supervisor, charge nurse, dietary manager, assistant dietary manager, and/or Administrator and will be reviewed in the monthly QA meetings.	

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F 520	Continued From page 33 over as head of the QA committee.	F 520		