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	345140	A. BUILDING _____ B. WING _____	08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTMOOR NURSING CENTER	610 WEST FISHER STREET SALISBURY, NC 28145

(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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessments for 1 of 1 resident reviewed for pressure ulcers. Resident #21 was coded inaccurately as to not having had a stage I or greater pressure ulcer over a bony prominence. Findings included: Resident #21 was originally admitted on 11/21/14. The resident's cumulative diagnoses included: Quadriplegia, generalized weakness, and unspecified open wound of the buttock. Review of Resident #21's most recent Minimum Data Set (MDS) assessment revealed a quarterly assessment with an Assessment Reference Date (ARD) of 5/18/18. The resident was coded as not having had a stage I or greater pressure ulcer over a bony prominence. Further review of the assessment revealed the resident was coded as having had one unhealed pressure ulcer which was coded as having been a stage IV, full thickness tissue loss with exposed bone, tendon or muscle. A review of Resident #4's wound assessment dated 7/3/18 revealed the resident had a stage IV area to his left buttock. A review of the physicians' orders for Resident	F 641	Brightmoor Nursing Center□s response to these cited deficiencies does not denote agreement with or admission of deficient practice. We are simply filing this response as we are required to do so by law. The deficient practice is the failure to accurately reflect the resident□s status in the assessment. This deficiency was cited due to the Minimum Data Set (MDS) Coordinator having not correctly coded section M 100 of the MDS. Resident # 21□'s MDS has been corrected to show coding for a stage 1 or greater pressure ulcer in section M 100. The MDS coordinator corrected this deficiency on 08/24/2018 and retransmitted the data to accurately define resident #21□'s pressure ulcer. Any resident has the potential to be affected by this deficient practice. The monitoring procedure that will be put into place to ensure the plan of correction is effective and that the specific deficiency cited remains corrected and / or in compliance with regulatory requirements will be for Cathy Perry, MDS Coordinator, to review residents with pressure ulcers in the weekly wound committee meeting. Also, at the wound committee meeting Cathy Perry, MDS Coordinator, will provide a schedule of all	8/24/18

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

Electronically Signed | 08/24/2018

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F 641	Continued From page 1 #21 revealed an order dated 7/31/18 for a treatment to the left gluteal wound-cleanse with normal saline then dress wound with silver alginate and cover with a hydrocolloid dressing every Monday, Wednesday, and Friday. A review of the Treatment Administration Record (TAR) for Resident #21 revealed a treatment for the left gluteal wound-cleanse with normal saline then dress wound with silver alginate and cover with a hydrocolloid dressing was signed off as completed on 7/30/18. Review of a wound note for Resident #21 dated 7/31/18 revealed the resident had a stage IV pressure ulcer to the left buttock, ischial area and the wound had been initially identified on 2/2/18. A review was completed of the care plan of Resident #21 which was most recently updated on 5/31/18. The resident had a problem/need titled, "Pressure Ulcers." Review of the problem need revealed documentation the resident had a stage IV wound on the left buttock, ischial. The goal was listed as the wound would heal and be free from infection through the next review period of 8/31/18. During an interview completed with Resident #21 on 7/30/18 the resident stated he had a pressure ulcer on his bottom. During an interview conducted with the wound/treatment aide on 8/1/18 she stated Resident #21 was receiving treatment for a stage IV pressure ulcer wound to his left buttock. An interview was conducted with the MDS Nurse	F 641	upcoming MDS assessments for pressure ulcers. Ms. Almon and Ms. DeLargy will ensure for 6 months that this process is being carried out and will record the results of this review on a QA form. The QA document will be discussed at the monthly Quality Assurance Performance Improvement(QAPI)/Quality Assurance (QA) meeting for review by the Medical Director to ensure the solution is achieved and sustained. Christine DeLargy, Administrator, will be responsible for implementing the plan of correction.	

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F 641	Continued From page 2 on 8/2/18 at 12:32 PM. During the interview the MDS Coordinator stated she had not coded Resident #21 for having had a stage I or greater pressure ulcer over a bony prominence and the resident did have a stage IV pressure ulcer. The MDS Nurse stated the resident should have been coded as having had a stage I or greater pressure ulcer over a bony prominence. During an interview with the Administrator on 8/2/18 at 6:06 PM she stated it was his expectation for the MDS assessments to be coded accurately.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a	F 655		8/24/18

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F 655	Continued From page 3 comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to initiate a plan of care for 1 of 2 residents, Resident #43, reviewed for development of baseline care plans or facility discharges. Findings included: Review of the medical record for Resident #43 revealed he was admitted 5/23/18 with diagnoses of a delirium, kidney failure, and had a urinary tract infection. He was admitted Hospice services on 6/1/18 and expired on 6/2/18. Further review of the medical record revealed no plan of care was found in the chart. An interview with the Minimum Data Set (MDS)	F 655	The deficient practice is the failure to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. This deficiency was cited due to the nursing staff failing to initiate a baseline care plan for resident #43. Since resident #43 is no longer in the facility, a baseline care plan cannot be completed for this resident. However, any resident has the potential to be affected by this practice and the facility will implement corrective action to ensure that there is not a repeat occurrence. Beginning August 24, 2018, Alisha Sturgill, director	

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F 655	Continued From page 4 Coordinator on 8/2/18 at 8:37 am revealed there was not a baseline care plan done for Resident #43. She stated the staff nurses were responsible for completing an interim care plan when a resident was admitted. She stated she did not know who had admitted the resident. The MDS Coordinator stated she was aware there was an issue with interim care plans not being completed and she was reviewing the charts after each admission now to make sure they were completed, but did not have a monitoring system in place for reviewing the interim care plans after each admission. An interview on 8/2/18 at 3:04 pm with the Administrator revealed the Director of Nursing had completed the admission paperwork for Resident #43 and she failed to complete the interim care plan at the time of admission. She stated Resident #43 had expired before a comprehensive assessment would be completed.	F 655	of nursing (DON), will confirm all baseline care plans are complete within 48 hours of admission to the facility. This Quality Assurance (QA) will be conducted by Ms. Sturgill for every admission for the next 6 months and the results of this QA will be recorded on a QA form and will be presented to the weekly QA Committee Meetings for review by the Committee. The results will also be reviewed at the Monthly Quality Assurance Performance Improvement (QAPI)/QA Meeting with the Medical Director to ensure that the solution is effective and maintained. Christine DeLargy, Administrator, will be responsible for implementing the Plan of Correction.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and	F 693		8/27/18

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F 693	Continued From page 5 §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to store the piston and the syringe, separated, for one of one residents reviewed for tube feeding (Resident #4). Findings included: Resident #4 was admitted to the facility on 7/30/10 and most recently admitted on 4/29/16. The resident's diagnoses included: Dysphagia (difficulty swallowing), aphasia (difficulty speaking), hemiplegia (weakness of one side of the body), and stroke. Review of Resident #4's Minimum Data Set (MDS) revealed the most recent assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 7/9/18. The resident was coded as having had severe cognitive impairment. The resident was coded as having been totally dependent for assistance for Activities of Daily Living (ADLs) including: Bed mobility, transfer (such as from the bed to a wheelchair), moving about the facility, eating, toileting, and bathing. The resident was coded as having had a feeding tube and received 51% or more of his total calories through tube feeding. In addition the resident was coded as having received 501 cubic centimeters (ccs) or more of	F 693	The deficient practice is the of the nurse providing the tube feeding to resident #4 failing to separate the piston and syringe for storage purposes after using the syringe to flush the resident□s tube. Since any resident receiving tube feedings has the potential to be affected by this practice, an in-service education for all nursing staff (Registered Nurse (RN)/Licensed Practical Nurse (LPN)) will be provided by Alisha Sturgill, Director of Nursing (DON) and Christine DeLargy, Administrator, to ensure proper storage of piston and syringe for all tube feed residents on 08/27/2018. Cathy Almon, Vice President/Administrator, Christine DeLargy, Administrator, Alisha Sturgill, DON, and Ann Elliot, Weekend Supervisor will conduct Quality Assurance (QA) checks of all tube feeding residents to ensure that the syringe is being properly stored in the bag attached to the Intravenous (IV) pole. This QA check will be conducted daily for 6 months, twice weekly for 3 months, weekly for 3 months, and monthly for 3 months. The results of these QA checks will be recorded on a QA form and will be brought to the Weekly QA Committee Meeting for review by the	

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F 693	Continued From page 6 fluid intake through tube feeding. Review Resident #4's physician's orders for July 2018 included an order for 1.5 calories per 1 milliliter (ml) tube feeding formula to be delivered via the percutaneous endoscopic gastrostomy (PEG) tube at 40 mls continuously for 24 hours with an automatic water flush of 275 mls of water every 4 hours. There was also an order to check the PEG tube for residual, if the residual was greater than 60 mls, hold the feeding, recheck the residual in hour, resume the tube feeding when the residual was less than 60 mls. An observation was conducted of the tube feeding equipment of Resident #4 on 7/30/18 at 4:27 PM. The observation revealed a 2 ounce syringe stored with the plunger inside the barrel in a clear plastic bag hanging on an intravenous (IV) pole. The syringe had visible liquid inside the tip of the syringe. An observation was conducted of the tube feeding equipment of Resident #4 on 8/1/18 at 2:38 PM. The observation revealed a 2 ounce syringe stored with the plunger inside the barrel in a clear plastic bag hanging on an intravenous (IV) pole. The syringe had visible liquid inside the tip of the syringe. An observation was conducted of the tube feeding equipment of Resident #4 on 8/1/18 at 2:44 PM. The observation revealed a 2 ounce syringe stored with the plunger inside the barrel in a clear plastic bag hanging on an intravenous (IV) pole. The syringe had visible liquid inside the tip of the syringe. An interview with Nurse #1 was conducted in	F 693	Committee and to the Monthly Quality Assurance Performance Improvement (QAPI) /QA Meeting for review by the Medical Director to ensure that the solution is achieved and maintained. Christine DeLargy, Administrator will be responsible for implementing the plan of correction.	

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F 693	Continued From page 7 conjunction with an observation of Resident #4 on 8/2/18 at 8:29 AM. The observation revealed a 2 ounce syringe stored with the plunger inside the barrel in a clear plastic bag hanging on an intravenous (IV) pole. The syringe had visible liquid inside the tip of the syringe. The nurse removed plunger and the barrel which had been stored in a plastic bag. Upon completion of checking for residual the nurse rinsed and flushed the syringe and placed the syringe back into the bag. The syringe had visible liquid inside the tip of the syringe. The nurse stated she usually placed the syringe inside the bag for storage with the plunger inside the barrel of the syringe. An interview was conducted with the Administrator on 8/2/18 at 6:11 PM. The Administrator stated it was her expectation that the pieces of the syringe, the plunger and the barrel, be stored separately within the bag, so the plunger and barrel could dry.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to clean respiratory	F 695	The deficient practice is the failure of nursing staff to clean the respiratory	8/27/18

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F 695	Continued From page 8 equipment and administer oxygen for one of one resident reviewed for oxygen use (resident #4). The findings included: Resident #4 was admitted to the facility on 7/30/10 and most recently admitted on 4/29/16. The resident's diagnoses included: Dysphagia (difficulty swallowing), aphasia (difficulty speaking), hemiplegia (weakness of one side of the body), and stroke. Review of Resident #4's Minimum Data Set (MDS) revealed the most recent assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 7/9/18. The resident was coded as having had severe cognitive impairment. The resident was coded as having been totally dependent for assistance for Activities of Daily Living (ADLs) including: Bed mobility, transfer (such as from the bed to a wheelchair), moving about the facility, eating, toileting, and bathing. Review Resident #4's physician's orders for July 2018 included an order for ipratropium bromide/albuterol sulfate 0.5-3(2.5) milligram (mg)/3 milliliter (ml), one ampule to be administered via nebulizer by inhalation four times a day as needed for wheezing with a start date of 7/17/18. An order for oxygen to be administered at 2 liters per minute (lpm) via a nasal canula (NC) continuously dated 7/12/18. An order to administer oxygen via facemask to keep oxygen saturation percentages greater than 93% dated 7/17/18. A review was completed of Resident #4's July 1, 2018 Through August 2, 2018 Medication	F 695	equipment and administer oxygen for resident #4. An in-service for proper respiratory equipment care will be conducted on 08/27/2018 to all Registered Nursing (RN) and Licensed Practical Nursing (LPN) staff. Resident #4□s need for oxygen has now been added to the resident□s Medication Administration Record (MAR) so that the Nurses must check to ensure that his oxygen is in place and must sign that the check has been completed. Since any resident receiving oxygen may have the potential to be affected by this practice, all residents that receive continuous oxygen will also have that need added to their MAR for the Nurses to check to ensure that their oxygen is in place and must sign that the check has been completed. Alsiha Sturgill, Director of Nursing (DON), Cathy Almon, Vice President/Administrator, Christine DeLargy, Administrator, and Ann Elliot, weekend supervisor will conduct twice daily Quality Assurance (QA) checks to ensure that all residents receiving continuous oxygen therapy have their oxygen in place as ordered. The results of these QA checks will be recorded on a QA form and will be brought to the Weekly QA Committee Meeting for review and to the Monthly Quality Assurance Performance Improvement (QAPI)/QA Meeting for review with the Medical Director to ensure the solution is achieved and sustained. Christine DeLargy, Administrator will be responsible for implementing the plan of correction.	

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F 695	Continued From page 9	F 695		

Administration Record (MAR) conducted on 8/2/18 at 4:01 PM. The last recorded administration of medication via a nebulizer mask was on 7/17/18.

An observation conducted on 7/30/18 at 4:38 PM of Resident #4's oxygen concentrator revealed the concentrator to have dust and debris on it. The air filter on the concentrator was observed to have dust and debris build up. The resident's oxygen mask was on the resident's face while he was resting in bed.

An observation conducted on 8/1/18 at 2:38 PM of Resident #4's oxygen concentrator revealed the concentrator to have dust and debris on it. The air filter on the concentrator was observed to have dust and debris build up. The resident was observed to be wearing the nebulizer mask which was connected via tubing the nebulizer machine, which was observed to be off. There were no or only traces of a liquid in the medication chamber of the nebulizer mask. The resident did not appear to be in any distress. The oxygen mask connected to the oxygen concentrator via tubing was observed to be sitting on the mattress. The oxygen concentrator was observed to have been running.

An observation conducted in conjunction with an interview with Nurse #1 was conducted on 8/1/18 at 2:40 PM. The nurse stated Resident #4 should have had the oxygen mask on and not the nebulizer mask. The nurse stated the Nursing Assistant (NA) must have taken the oxygen mask off and placed the nebulizer mask on the resident by mistake. The nurse was observed to have removed the nebulizer mask from the resident and placed the oxygen mask on the resident.

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The nurse stated the NA had completed her last incontinent round at 2:00 PM. The nurse removed the nebulizer mask from the resident and placed it on top of the nebulizer machine on the nightstand at the foot of the bed. The nurse placed the oxygen mask on the resident which was connected to the oxygen concentrator. The nurse further stated the nebulizer mask should have been stored in a plastic bag when the mask was not in use and the nebulizer mask had not been placed in a plastic bag for storage.

An interview with NA#2 and an observation of Resident #4 was conducted on 8/1/18 at 2:44 PM. The NA stated she was Resident #4's NA. The NA stated she did not remove the mask during her last round for incontinent care. The NA stated the mask which was on the mask which was on the resident when she provided incontinent care, referring to the oxygen mask. An observation of the resident as she made the statement was the oxygen mask. The NA stated the nebulizer mask was not on the resident when she had provided care. The NA stated the only time she would remove an oxygen mask and put it back on was when she was changing a resident's gown and she had not changed the resident gown during the last round.

An interview was conducted with Nurse #1 on 8/1/18 at 3:37 PM. The nurse stated Resident #4 had not received a nebulizer treatment on 8/1/18. The nurse stated the treatment was scheduled but had been dropped down to as needed. The nurse further stated the resident had the oxygen mask on prior to when she had gone to lunch at 11:00 AM. The nurse stated she had checked the resident's oxygen saturation not long before she and I had entered the room and the resident's

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F 695	Continued From page 11	F 695		

oxygen saturation rate was 96% and he was not in respiratory distress. The nurse stated she did not remember which mask he had on at the time when she had checked his oxygen saturation but only that he had a mask on. The nurse stated she did not who had put the nebulizer mask on the resident.

An interview with Nurse #1 and observation of Resident #4 was conducted on 8/2/18 at 8:29 AM. Resident #4's oxygen concentrator was observed to have dust and debris on it. The nurse stated the machine needed to have been wiped off. The nurse stated whoever changed the oxygen tubing and mask had the responsibility of wiping down the machine. The nurse stated the oxygen mask and tubing were changed once weekly and she was not the nurse who had changed Resident #4's oxygen mask and tubing last. The air filter on the oxygen concentrator was observed to have dust and debris on it. The nurse stated the filter on the oxygen concentrator needed to be cleaned due to having had dust and debris on it. The nurse stated the filter was to be checked daily by the nurse and she had not checked the filter yet that day. The nurse further stated she had worked on 8/1/18 and had not checked the filter on 8/1/18. The nurse stated she was going to clean the filter right away and removed the filter. The nurse stated she was going to clean the filter because it needed to be cleaned.

An interview was conducted with the Administrator on 8/2/18 at 6:10 PM. The Administrator stated it was her expectation that the oxygen concentrator be clean, the oxygen concentrator filter be clean, nebulizer masks should be stored properly in a bag, and if a

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F 695	Continued From page 12 resident was ordered oxygen, then the resident should be receiving oxygen.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(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. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to assess for the need and remove unnecessary side rails from a bed for 1 of 3 residents reviewed for bed side rail usage (Resident #24). Findings included: Resident #24 was originally admitted to the facility	F 700	The deficient practice is the failure to assess for the need and to remove unnecessary side rails from a bed for resident #24. When resident # 24□s bed was switched out for a longer bed, facility maintenance staff failed to remove a set of bed rails that were located on lower half of the bed. On 08/02/2018 these side rails were removed from resident #24□s bed.	8/30/18

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F 700	Continued From page 13 on 10/20/17 and was most recently readmitted on 7/25/18. The resident's diagnoses included: Gastrointestinal (GI) bleed, dementia, psychosis, diabetes, generalized weakness, impaired communication, personality and behavioral disorders, depression, and stroke. Review of Resident #24's most recent Minimum Data Set (MDS) Assessment revealed a significant change assessment with an Assessment Reference Date (ARD) of 5/17/18. Review of the assessment revealed the resident was coded as having been moderately cognitively impaired. The resident was coded as having been totally dependent on one person or more for all Activities of Daily Living (ADLs) including: bed mobility, transfer (such as from the bed to a wheelchair), moving about the facility once in a wheelchair, dressing, eating, toilet use, personal hygiene, and bathing. The bed rails were not coded as a restraint. Review of Resident #24's siderails assessment dated 7/25/18 revealed the resident was to have side rails up times two as a support to facilitate turning and repositioning in bed. The person who completed the siderail assessment did not sign the siderail assessment. Review of Resident #24's care plan, which was last reviewed on 6/7/18, revealed no mention of the use of siderails. An observation of Resident #24's bed conducted on 7/30/18 at 4:48 PM revealed two siderails up on the left side of the bed, the same side as the wall. The siderail at the head of the bed on the left side was measured to be approximately 20.5 inches long. The siderail at the foot of the bed on	F 700	Since any resident has the potential to be affected by this practice, all beds in the facility have been inspected for side rails and any resident with side rails will be assessed for necessity of side rails and then properly documented in the care plan or removed if they are deemed unnecessary by 08/30/2018. Upon admission for all new residents, an assessment of necessity of side rails will be performed and documented appropriately. The Maintenance Supervisor, Sidney McGuire, will be in-serviced on the need to alert Alisha Sturgill, Director of Nursing (DON), anytime he has to change out a bed so that Ms. Sturgill can ensure that any bed rails that are present are necessary, otherwise the Maintenance Supervisor, Sidney McGuire, will be instructed to remove unnecessary bed rails. A weekly side rail report will be discussed at the Weekly Quality Assurance (QA) Committee meeting and monthly at the Monthly Quality Assurance Performance Improvement (QAPI)/QA Meeting with the Medical Director to ensure that the solution is achieved and maintained. The Director of Nursing, Alisha Sturgill, will be responsible for implementing the acceptable plan of correction.	

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the left side was measured to be approximately 28.75 inches long. On the right side of the bed there was one siderail up at the head of the bed and one siderail down at the foot of the bed. The siderail which was up at the head of the bed on the right side was measured to be approximately 20.5 inches long. The resident was in the bed at the time of the observation.

An observation of Resident #24's bed conducted on 7/30/18 at 11:29 AM revealed two siderails up on the left side of the bed, the same side as the wall. On the right side of the bed there was one siderail up at the head of the bed and one siderail down at the foot of the bed. The resident was not in the bed at the time of the observation.

An interview and observation was conducted with Nurse #1 on 8/2/18 at 11:35 AM. Nurse #1 stated Resident #24 was on her assignment. The nurse stated the resident used the top rails for bed mobility. An observation of Resident #24's bed conducted with the nurse revealed two siderails up on the left side of the bed, the same side as the wall. On the right side of the bed there was one siderail up at the head of the bed and one siderail down at the foot of the bed. The resident was not in the bed at the time of the observation. The nurse stated when the resident was out of bed he was in a geri-chair. The nurse stated she was going to have the two siderails at the foot of the bed removed.

An interview and observation was conducted with Nursing Assistant (NA) #1 on 8/2/18 at 11:49 AM. The NA stated she had Resident #24 on her assignment. An observation of Resident #24's bed conducted with the NA revealed two siderails up on the left side of the bed, the same side as

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the wall. On the right side of the bed there was one siderail up at the head of the bed and one siderail down at the foot of the bed. The NA stated she had not remembered the siderails on the left side of the bed having been up. The NA further stated the resident had received a different bed a little over a week ago. The NA stated information about the resident's siderails should have been on his care card. The NA went to the nurses' station to find the resident's care card. The MDS nurse arrived at the nurses' station and she stated the information was no longer printed but was available on the computer. The NA logged into the computer but was unable to discover information regarding the resident's siderails in the care guide on the computer.

An observation conducted on 8/2/18 at 12:00 PM revealed the Maintenance Director (MD) exiting Resident #24's room with the two siderails which had been located on the bottom of Resident #24's bed.

An interview was conducted with the MDS Nurse, in the presence of Nurse #1, on 8/2/18 at 12:09 PM. The MDS Nurse stated she was unable to identify who had completed the siderail assessment on Resident #24 on 7/25/18 due to the person who completed the assessment had not only not signed the siderail assessment but had not signed other assessments completed on the same day. The MDS Nurse stated she did not put information in the care plans or the care guides regarding siderails unless the siderails were considered a restraint. The MDS Nurse stated there were no residents in the facility where siderails were being utilized as a restraint. The MDS Nurse stated typically everybody had siderails to help turn and reposition and their use

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of siderails was determined through the siderail assessment. The MDS Nurse reviewed Resident #24's siderail assessment and stated his siderail assessment revealed the resident was to have two siderails up as a support mechanism for the resident to turn and position himself while he was in bed. The MDS Nurse stated two siderails up meant the two siderails at the head of the bed. The MDS Nurse stated the facility did not use lower siderails at the foot of the bed. Nurse #1 stated Resident #24 had had lower siderails on his bed. The MDS Nurse told Nurse #1 the two lower siderails needed to be removed from the bed because the facility did not use any siderails on the foot of the bed, or lower siderails. The MDS Nurse stated Resident #24 should not have had lower siderails at the foot of his bed and she was going to ask the MD if Resident #24's bed had recently been changed. The MD arrived to the MDS Nurses' office on 8/2/18 at 12:21 PM. The MD stated Resident #24's bed had been switched to a longer bed due to the height of the resident on 7/18/18. The MD stated he had removed the lower siderails from the foot of the bed. The MDS Nurse stated the resident had not had a fall since 3/12/18 when the resident had thrown his legs out of the bed and slipped to the floor. The MDS Nurse stated the resident was care planned for a fall mat at the side of the bed when he was in bed and that information was available for NAs as part of the care guide.

During an interview conducted with the Administrator on 8/2/18 at 6:07 PM revealed her expectation was there should not have been four siderails on the resident's bed and the only siderails up on residents' bed should be the two siderails at the head of the bed.

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F 812	Continued From page 17	F 812		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure the kitchen's ice machine was kept clean and sanitary. Findings included: Observations of the kitchen's ice machine on 7/30/18 at 3:50 PM revealed the machine's lid, which covered the ice stored inside the machine, was not clean. The interior lip of the ice machine's lid was unclean with a dried dark gray substance. Additionally, the exterior of the ice machine's lid was unclean with a clustered black linear substance approximately 11 inches wide and 3/4th inches in length.	F 812	The deficient practice is the failure of the dietary staff to ensure the kitchen □ ice machine was kept clean and sanitary. Because this ice machine is used to service all residents in the facility,any resident has the potential to be affected by this practice. The ice machine was thoroughly cleaned with the appropriate sanitizing/cleaning solution on 08/02/2018 by Robin Jones, Dietary Manager with special attention being paid to the area of the interior lip of the ice machine's lid. Additionally the Dietary Manager, Robin Jones, provided an in-service to all dietary staff on how to properly clean and sanitize	8/6/18

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F 812	Continued From page 18 A follow up observation of the kitchen's ice machine on 8/1/18 at 8:58 AM revealed the ice machine's lid remained in the same unclean condition as observed on 7/30/18 at 3:50 PM, but during this observation small white crumblike loose particles were also observed on the exterior of ice machine's lid. An interview with the Dietary Manager (DM) on 8/1/2018 at 8:58 AM revealed the ice machine should be cleaned daily, but was not an assigned as a scheduled cleaning task. The DM further revealed the dietary aide/dishwasher was responsible for cleaning the ice machine daily. An interview with Dietary Aide (DA) # 1 on 8/1/2018 at 9:01 AM revealed he wiped the ice machine down often but did not scrub the ice machine clean. During a follow-up interview on 8/1/2018 at 9:12 AM the DM reported the matter and loose particles on the ice machine could fall into the ice and contaminate the ice served to the residents. On 8/2/2018 11:26 AM the DM revealed she expected dietary staff to clean the ice machine daily with cleaner and sanitizer. On 8/2/2018 5:38 PM an interview with the Administrator revealed she expected all equipment in the kitchen to be cleaned with the proper cleaner and degreaser if needed and sanitized, especially the ice machine.	F 812	the ice machine on 08/02/2018 and 08/03/2018. Dietary staff were instructed during this in-service to clean/sanitize the ice machine daily. A Quality Assurance (QA) form for the cleaning of the ice machine has been developed and was implemented on 08/03/2018 and a designated staff member from first and second shift is responsible for performing cleaning and sanitizing of the ice machine and signing off on the log. Robin Jones, Dietary Manager will conduct daily QA checks of the ice machine and the cleaning QA form to ensure that daily cleaning is being performed. This QA will be daily for six (6) months, twice weekly for 3 months, and then weekly for 3 months. Ms. Jones will record the results of her QA checks on a separate QA form and will present those results to the Weekly QA Committee Meeting for review and at the Monthly QAPI/QA Committee Meeting with the Medical Director to ensure that the solution is achieved and sustained. The Dietary Manager, Robin Jones, will be responsible for implementing the acceptable plan of correction.	