STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345345	A. BUILDING ______ B. WING ______	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/MONROE	**204 OLD HIGHWAY 74 EAST** **MONROE, NC 28112**

(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 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		2/7/19

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/04/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to repair chipped paint on the hand rails and lower walls of 2 of 3 resident room hallways and the nurses' station; repair peeling plaster in 1 of 1 shower rooms on the 200 hallway; and repair 2 of 16 cabinet doors broken in the 200 hall resident rooms. Findings included: 1a. An observation on 1/8/19 at 8:50 am of Room 207, Resident #31's room, revealed the door to the sink cabinet was off the hinges and lying inside the sink cabinet. A review of Resident #31 Quarterly Minimum Data Set Assessment dated 12/26/18 revealed he was cognitively intact. During an interview with Resident #31 on 1/8/19 at 8:50 am he stated the door to his sink cabinet in his room had been off the hinges and lying in the sink cabinet for at least 6 months. He stated it looks bad but stated he had not reported it to anyone. He stated the staff use the sink when they are in the room and know the door is off the hinges. b. During a phone interview with Resident #3's Family Member on 1/7/19 at 11:47 am she stated the veneer was peeled off the door to the sink cabinet. An observation of Room 204, Resident #3's room, on 1/10/19 at 12:15 pm revealed the	F 584	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations the facility has taken and will take actions set forth in the Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that the deficiencies cited have been corrected by the date certain. F584 Safe/Clean/Comfortable/Homelike Environment Resident common area and resident rooms noted. " The cabinet door under the sink of room 207 was repaired/replaced on 1/18/2019. " The chipped veneer on the cabinet door under the sink of room 204 was repaired/replaced on 1/18/2019 " 200 Hall shower room walls will be repaired on 2/4/19. " Nursing Station chipped paint will be repaired and painted on 2/6/19 " 100 & 200 hallway walls will be repaired and painted on 2/6/2019	

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F 584 Continued From page 2

veneer was chipped off one of the sink cabinet doors.

c. An observation of the 200 hall shower room on 1/8/18 at 9:07 am revealed several areas of peeling plaster. There was a 2 inch by 5 inch area of peeling plaster above the sink mirror; another 12 inch by 4 inch area above the mirror; and 5 inch by 60 inch area in the corner of the wall.

d. An observation on 1/10/19 at 12:15 pm of 100 hallway revealed multiple black marks and chipped paint on the lower half of the walls and chipped paint on the handrails; multiple areas of chipped pain on the outside of the Nurses' Station; and multiple areas of black marks and chipped paint to the lower half of the walls and chipped paint on the handrails of the 200 hallway.

An interview with the Maintenance Director on 1/10/19 at 2:00 pm revealed he had sanded areas on the handrails on 100 and 200 hallways that were chipped to prepare them for painting. He stated the chipped paint and black marks on the lower walls and chipped paint on the handrails are from wheelchair wheels rubbing against the walls. He stated that no maintenance has been attempted on the chipped paint and black marks on the lower walls on 100 and 200 hallways.

During an interview on 1/10/19 at 2:15 pm with the Administrator he stated he had planned to paint the 100 and 200 hallways and the handrails. He stated he was not aware of the cabinet doors in rooms 204 and 207 being broken or the paint peeling in the 200 hallway shower room. The Administrator stated there was no excuse for the broken cabinet doors or the peeling sheetrock in

F 584

" 100 & 200 hallway hand rails were sanded and repainted on 1/12/2019.

Environmental rounds will be held with the Plant Operations Director and Administrator to generate an initial master task list.

Weekly environmental monitoring rounds will be completed by the Administrator/Designee for 3 months. 25% of the rooms will be audited weekly. Observations will include, but not limited to the general condition of the room; painting, cabinets and flooring. Audit tool will be utilized by Plant Operations Director and presented to Administrator weekly for review.

Results of audits will be reviewed in monthly QAPI meetings until substantial compliance is achieved for 3 months.

Facility Plant Operations Director and Administrator are responsible for monitoring compliance.

Completion Date February 7, 2018

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F 584	Continued From page 3 the shower room. He stated his expectation was that needed repairs would be made timely and the chipped paint and peeling sheetrock would be fixed immediately.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, the facility's Abuse and Neglect Prohibition Policy and resident and staff interviews, the facility failed to follow policy and procedure for Abuse and Neglect to investigate and report the allegation to the State Agency for 1 of 2 residents reviewed (Resident #186) who reported alleged stolen personal property. The findings included: A review of a facility document titled Abuse and Neglect Prohibition with a revised date of August 2017, read in part, - "The facility will timely conduct an investigation of any alleged abuse/neglect, exploitation, mistreatment, injuries of unknown origin or	F 607	F-607 Develop/Implement Abuse/Neglect Policies Resident #186 has been discharged from facility prior to survey. All current residents were interviewed to ensure they have no allegations of abuse, neglect, exploitation or misappropriation of property. There were no allegations verbalized. Facility will report and investigate all allegations of abuse, neglect, exploitation or misappropriation of resident property or suspicion of crime to state agency Health Care Personnel Registry within 24 hours. If allegations involve bodily injury or harm, facility will report with 2 hours.	2/7/19

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F 607	Continued From page 4 misappropriate of resident property" - "The facility will report all allegation and substantiated occurrences of abuse, neglect, exploitation, mistreatment including injuries of unknown origin and misappropriation of property to the administrator, State Survey Agency and law enforcement officials" - "Timeline for reporting is as follows: If the events that cause the allegation do not involve abuse and do not result in serious bodily injury, a report is made no later than 24 hours" Resident #186 was admitted to the facility on 12/30/2017 with diagnoses that included major depressive disorder and diabetes mellitus. Review of a quarterly Minimum Data Set (MDS) dated 7/18/2018 revealed Resident #186 was cognitively intact and had no behaviors. A review of the State Agency Health Care Personnel Registry (HCPR) did not reveal a 24-hour facility initiated report. Further review of the HCPR revealed there was not a 5-day report. An interview on 1/10/2019 at 1:53 PM with Resident #186 revealed that his money, a gold watch, three hundred dollars and a gold necklace was reported stolen in April 2018, by him to several staff members and the Assistant Director of Nursing (ADON). Resident #186 further revealed that staff at the facility did not follow up with him regarding the allegedly stolen items before his discharge date in August 2018. An interview on 1/9/2019 at 2:46 PM with Nurse's Aide (NA) #1 revealed Resident # 186 had a thick, gold, herringbone patterned chain with a shark's tooth charm. NA #1 further revealed	F 607	Facility Management will conduct rounds on residents daily to discuss any concerns. Team members will report concerns during daily morning meeting. All concerns will be addressed according to policy. All Staff will be re-educated on the necessity of immediately reporting any allegations of abuse to Nursing Administration and the Administrator. Nursing Administration or the Administrator will initiate reports to the State Agency with the appropriate time frame and start investigation. Director of Nursing is responsible for monitoring compliance. Abuse training in-services for all staff will be completed by February 7, 2019	

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F 607	Continued From page 5 Resident #186 had a fifty-dollar bill in his hand upon admission and an unknown amount of money in his personal belonging's bag. NA #1 reported that she notified Nurse # 4 that Resident #186 had reported to her that his money and a necklace were allegedly stolen. An interview on 1/10/2019 at 1:25 PM with NA #4 revealed that Resident #186 admitted to the facility on the weekend and had a gold necklace with a cross like charm. NA #4 further revealed that she and NA #1 both reported the allegedly stolen necklace to Nurse #4. An interview on 1/10/2019 at 9:34 AM with Nurse #4 revealed she remembered hearing about Resident #186 allegedly stolen money and necklace but it was not directly reported to her. Nurse #4 further revealed that she did not report the allegation of stolen money or necklace to anyone. An interview with the Social Worker (SW) on 1/9/2019 at 4:37 PM revealed he was responsible for completing the concern forms for residents. The SW further revealed Resident #186 reported the allegedly stolen property in 4/2018 and he interviewed Resident 186 and his guardian regarding the allegation. He reported that the former Administrator was handling the investigation and he did not have any documentation of the report. An interview on 1/10/2019 at 3:14 PM with the Administrator revealed the alleged incident would have occurred before his tenure and he was unable to locate any documentation related to Resident #186's allegedly stolen property.	F 607		

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F 607	Continued From page 6 An interview on 1/9/2019 at 4:07 PM with the Assistant Director of Nursing (ADON) revealed she did not remember Resident #186 having any jewelry. She further revealed the SW would have handled the report of the allegedly stolen property. The ADON reported that she was never made aware that Resident #186 had an allegation of stolen items. An interview on 1/10/2019 on 8:38 AM with the Director of Nursing (DON) revealed she never saw Resident #186 with any of the reportedly stolen items. An interview on 1/10/2019 at 6:12 PM with the Administrator revealed he expected all staff to report all allegations of stolen items to their direct supervisors, the allegation should then be reported to the DON and then investigated. The Administrator further revealed that he would report the incident to Health Care Personnel Investigations within two hours when abuse is involved or 24 hours if no serious harm was caused to the resident.	F 607		
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:	F 695		2/7/19

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F 695	Continued From page 7 Based on observations, record review and staff and nurse practitioner interviews, the facility administered oxygen without a physician's order for 1 of 1 residents reviewed for oxygen (Resident #28). The findings included: Resident #28 was admitted to the facility on 12/1/2018 with diagnoses that included heart failure, chronic obstructive pulmonary disease and chronic pain. Review of an admission Minimum Data Set (MDS) dated 12/8/2018 revealed Resident #28 was cognitively intact and Section O was coded for oxygen. Review of the physician's (MD) orders on 1/7/2019 did not reveal an order for oxygen. An observation on 1/7/2019 at 10:19 AM revealed Resident #28 had an oxygen concentrator operating at 3 liters per minute with humidified water attached. An observation on 1/9/2019 at 1:48 PM revealed Resident #28 resting in bed with oxygen applied via nasal cannula at 3 liters per minute. An observation on 1/10/2019 at 9:19 AM revealed Resident #28 resting in bed with oxygen applied via nasal cannula at 3 liters per minute. An interview on 1/9/2019 at 9:47 AM with Nurse #1 revealed Resident #28 received 2 liters per minute of oxygen. Nurse #1 observed Resident #28's electronic medical record and further revealed she could not locate an order for oxygen within the MD orders.	F 695	F-695 Respiratory/Tracheostomy Care and Suctioning Physician order obtained for oxygen for resident #28 on 1/10/19. Medical records for all residents receiving oxygen were audited on 1/11/19 by Director of Nursing and Assistant Director of Nursing to ensure Physician orders for oxygen were present. All residents had oxygen orders in place. No deficient practice noted. Licensed nursing staff will be educated to obtain Physician orders for oxygen prior to administrating oxygen. Oxygen Physician orders in-service were completed on 1/31/19 Nursing Administration will audit medical records of all residents receiving oxygen weekly times 4 weeks then randomly thereafter. Results of audit will be discussed in monthly QAPI meeting. Nurses will be re-educated as needed. Director of Nursing is responsible for monitoring compliance.	

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F 695	Continued From page 8 An interview on 1/9/2019 with the Nurse Practitioner (NP) revealed Resident #28 was on oxygen when she came to the Assisted Living in August 2018. The NP further revealed she was unaware Resident #28 did not have an order to administer oxygen. Additionally, she reported that she expected staff to follow orders for the administration of oxygen. An interview on 1/10/2019 at 6:18 PM with the Director of Nursing (DON) revealed she expected nursing staff to provide treatments and medications as ordered, question orders for clarity and perform double checks with MD orders. An interview on 1/10/2019 at 6:20 PM with the Administrator revealed he expected nursing to follow MD orders as prescribed.	F 695		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732		2/7/19

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F 732	Continued From page 9 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on review of the daily nurse staffing forms and nursing schedules and staff interviews, the facility failed to accurately report care hours provided by licensed and unlicensed personnel for 8 out of 13 daily posted nurse staffing forms reviewed. Findings included: 1. Review of the facility ' s daily nursing staffing forms and daily nursing schedules for 8/1/2018, 8/4/2018, 9/21/2018, 9/30/2018, 10/19/2018, 11/9/2018, 1/6/2019, and 1/7/2019 revealed the daily nursing staffing forms were not accurate on the following 8 of 13 days: a. The nursing schedule for the facility dated	F 732	F-732 Posted Nurse Staffing Information Care hours were corrected for the 8 inaccurate staffing forms by scheduler on 1/11/19. Scheduler was educated on 1/11/19 by Director of Nursing regarding accurate posting of care hours. Director of Nursing, Assistant Director of Nursing, Charge Nurse or Scheduler will review daily nurse staffing forms for accuracy during each shift for three months. Forms will be updated and corrected as needed.	

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F 732	Continued From page 10	F 732		

8/1/2018 was reviewed and 1 Licensed Practical Nurse (LPN) was scheduled to work day shift (7:00 AM to 3:00 PM), 5 nursing assistants (NA) were scheduled to work day shift and no Medication Technician (MT) was scheduled to work day shift. The daily posted nurse staffing sheet form for day shift on 8/1/2018 did not document an LPN on day shift, documented 6 NAs provided 45 hours of care and one MT provided 4 hours of care on 8/1/2018. The nursing schedule for afternoon shift (3:00 PM to 11:00 PM) revealed 4 Registered Nurses (RN) on the schedule for 8/1/2018, and the daily posted nurse staffing form indicated that 3 RNs had provided 12 hours of care.

b. The nursing schedule for 8/4/20018 was reviewed and it was noted 4 NAs were scheduled to work the afternoon shift on that date. The daily posted staffing form indicated 5 NA had provided 37.5 hours of care on 8/4/2018.

c. The nursing schedule for 9/21/2018 was reviewed and 4 NAs were scheduled to work the afternoon shift. The daily nurse staffing form indicated 5 NAs had provided 37.5 hours of care on the afternoon shift that date. The schedule further noted a MT worked for 2 hours on afternoon shift for that date. The daily nurse staffing form indicated a MT had worked 4 hours on day shift and recorded no hours for the afternoon shift on 9/21/2018. The nursing schedule further disclosed no RN had been scheduled to work night shift (11:00 PM to 7:00 AM), no LPN had been scheduled to work night shift, 1 NA and 2 MTs were scheduled to work the night shift. The daily nurse staffing sheet indicated that 1 LPN had provided 8 hours of care and 3 NA had provided 22.5 hours of care and 1

Director of Nursing, Assistant Director of Nursing or Charge Nurse will audit and initial staffing forms. Findings will be discussed in monthly QAPI meetings until substantial compliance is achieved for 3 months

Director of Nursing is responsible for monitoring compliance.

Completion date February 7, 2019

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F 732	Continued From page 11	F 732		

MT had provided 8 hours of care on 9/21/2018.

d. The nursing schedule for 9/30/2018 was reviewed and 4 NAs were scheduled to work the afternoon shift. The daily nurse staffing form indicated 5 NAs had provided 37.5 hours of care on that date. The nursing schedule for night shift on 9/30/2018 revealed two RNs scheduled to work. The daily nurse staffing form indicated 3 RN had provided 24 hours of care on 9/30/2018.

e. The nursing schedule dated 10/19/2018 was reviewed and it was noted no LPN was scheduled to work the night shift on that date. The daily nurse staffing form indicated 1 LPN had provided 8 hours of care on 10/19/2018.

f. The nursing schedule for 11/9/2018 was reviewed and it was noted 1 RN was scheduled to work day shift on that date. The daily nurse staffing form indicated 2 RNs had provided 16 hours of care on day shift for 11/9/2018.

g. The nursing schedule for 1/6/2019 was reviewed and it was noted 1 NA would be late "20 minutes" on day shift. The daily nurse staffing form indicated 4 NA had provided 30 hours of care on day shift that date and the total hours of care provided were not adjusted to reflect the late employee.

h. The nursing schedule for 1/7/2019 was reviewed and it was noted 3 RN were scheduled to work the afternoon shift. The daily nurse staffing form indicated 2 RN had provided 8 hours of care during the afternoon shift on that date.

The scheduling coordinator was interviewed on 1/10/2019 at 2:30 PM. The scheduling

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	345345	A. BUILDING ______ B. WING ______	C 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/MONROE	**204 OLD HIGHWAY 74 EAST MONROE, NC 28112**

(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 732	Continued From page 12 coordinator reported that she made corrections to the daily posted nurse staffing when she was in the building working and when she came in first thing in the morning. She further reported she had not been adjusting the daily posted nurse staffing when the scheduled staff called out sick, or when employees were late until the next day. She reported she filled out the daily nurse staffing form for the entire day with the schedule and adjusted for call-outs during her working hours. The scheduling coordinator reported night shift did not adjust the hours during their shift and the form was not corrected until she amended it the next day. The Director of Nursing (DON) was interviewed on 1/10/2019 at 4:07 PM. The DON reported it was her expectation the daily posted nurse staffing sheet were completed in such a manner to accurately reflect the staffing of nurses and NA on the halls for each shift. The Administrator was interviewed on 1/10/2019 at 5:56 PM. He reported it was his expectation that the daily posted nurse staffing sheet were updated accurately and reflected all schedule changes.	F 732		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing	F 804		2/7/19

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F 804	Continued From page 13 temperature. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, and observation the facility failed to provide food at an appetizing temperature for 5 of 23 resident, Resident #14, Resident #32, Resident #18, Resident #28, and Resident #26. Findings included: A review of the Minimum Data Set Quarterly Assessment dated 12/17/18 for Resident #14 revealed he was coded as moderately cognitively impaired. During an interview on 1/7/19 at 9:48 am with Resident #14 she stated the food is delivered cold for all meals. A review of the Quarterly Minimum Data Set Assessment dated 12/27/18 for Resident #32 revealed he was cognitively intact. An interview on 1/7/19 at 10:09 am with Resident #32 revealed the food is cold when it is served. A review of Resident #18's Quarterly Minimum Data Set Assessment dated 11/8/18 revealed he was coded as cognitively intact. An interview on 1/7/19 at 11:26 am revealed Resident #18 revealed the food is served cold. A review of Resident #28's Admission Minimum Data Set Assessment dated 12/8/18 revealed she was cognitively intact. During an interview with Resident #28 she stated the meals are usually cold and breakfast is always cold.	F 804	F804 - Palatable Food / Temp Resident #14, Resident #32, Resident #18, Resident #28 and Resident #26 will have the food preferences re-evaluated. Plate warmer was inspected by Facility Plant Operations Director on 1/10/19 and was observed not to be turned on. Facility Plant Operations Director determined both sides of the plate warmer to be functioning properly. An electrical contractor inspected the plate warmer, outlet and circuit breaker on 1/15/19 indicating all areas were functioning properly. All Residents have the potential to be affected. Dietary staff will be re-educated to ensure plate warmer always remains on, food is not served to residents unless it is at correct temperatures and to contact Facility Plant Operations Director if any equipment is not working property. Certified Dietary Manager will interview 4 residents weekly to ensure satisfaction with food temperature and taste. Results of audits will be reviewed in monthly QAPI meetings until substantial compliance is achieved for 3 months. Certified Dietary Manager and Administrator are responsible for	

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F 804	Continued From page 14 A review of the Quarterly Minimum Data Set Assessment dated 12/17/18 for Resident #26 revealed he was cognitively intact. An interview on 1/8/18 at 9:58 am with Resident #26 revealed his food was always cold. An interview on 1/9/19 at 12:00 pm with the Dietary Manager revealed the facility did not have the metal warmers in the plate covers that keep the food warm. She stated all the carts they used to transport the food have open sides, so it is difficult to keep the food warm until it is served to the residents. On 1/9/19 at 12:05 pm an observation delivered to the residents revealed parts of the meal not palatable. The Succotash beans were cool and had a firm texture and the corn was cool and firm when tasted; the Pork Tenderloin was lukewarm and dried out when tasted; and the french fries were rubbery and cold when tasted. On 1/10/19 at 7:55 am an observation of the breakfast food tray delivered to the residents revealed parts of the meal were not warm. The test tray plate was cool to the touch. The ham was cool and dry to taste; and the eggs were watery and cool to taste. The Dietary Manager and District Manager were present and agreed the reason the temperature of the food was low was because the plate warmer was broken and there were no plate warmer disks to keep the food warm, and the facility had open carts that did not hold the temperature of the food after it left the kitchen. An interview on 1/10/19 at 8:18 am with the Dietary District Manager revealed the plate warmer was not working and there were not plate	F 804	monitoring compliance. Date of Completion February 7, 2019	

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F 804	Continued From page 15 warmers to use with the plate covers to keep the food warm. He also stated the open carts do not help to hold the temperatures after the food leaves the kitchen. An interview with the Dietary District Manager and the Dietary Manager on 1/10/19 at 11:30 am revealed the Dietary Manager had reported the broken plate warmer to the Maintenance Director and he had tried to fix it last week. The Dietary Manager stated the Maintenance Director told her he could not fix the plate warmer. An interview with the Administrator on 1/10/19 at 3:40 pm revealed he was not aware the plate warmer unit was not working. He stated his expectation was the food would be at appropriate temperatures and the equipment in the kitchen would be in good working order. He stated if equipment could not be fixed it should be replaced. During an interview with the Maintenance Director on 1/10/19 at 4:50 pm he stated he did maintenance on the plate warmer unit last week but stated he did not have a maintenance request for the repair. He stated he thought one side of the warmer was working. He stated he had called an electrician to work on the plate warmer unit, but they would not be available until 1/15/19.	F 804		