STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345415	A. BUILDING _____ B. WING _____	C 01/16/2014

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PINEVILLE REHABILITATION AND LIVING CTR	1010 LAKEVIEW DRIVE PINEVILLE, NC 28134

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID MP0E11.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered	F 156		2/19/14

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

Electronically Signed | 02/06/2014

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F 156	Continued From page 1 under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility	F 156		

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F 156	Continued From page 2 written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide residents with the Denial of Payment of Medicare Coverage and their appeal rights for 3 of 3 residents. (Resident # 49, Resident # 123 and Resident # 150) The findings included: 1. A record review of the Liability Notices/Notice of Medicare Provider Non-Coverage forms revealed Resident # 49 was not provided with a Center for Medicare and Medicaid(CMS) form for notification which informed the resident/family of the resident ' s right to have a claim or demand bill submitted to Medicare as the resident no longer qualified for services on 09/06/13. During an interview on 01/16/14 at 4:40 PM the Social Worker reported she is responsible for completing the CMS form for notification which informed the resident/family of the resident 's right to have a claim or demand bill submitted to Medicare when the resident is no longer qualified for services. She further stated that these notifications had not been provided to resident/families since May of 2013 when the Business Office Manager left and she became responsible for completing them. She further	F 156	Residents, #49, #123, #150 have been identified and are no longer residents of Pineville Rehabilitation & Living Center. Facility Social Worker is responsible for ensuring that residents/family□s are informed of the Denial of Payment of Medicare coverage and their appeal rights. Facility Social Worker was in-serviced on this process by Regional Director of Reimbursement on January 13, 2014. The facility started issuing Denial of Payment of Medicare Coverage and their appeal rights on 1/13/14 Facility has implemented an audit tool to monitor and track that patients/family members are provided with Denial of Payment of Medicare Coverage and their appeal rights. Facility Social Worker will be responsible for completing and monitoring this audit tool. This process started on 2/5/14 Administrator/Assistant Administrator will	

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F 156	Continued From page 3 stated she had had no training on these forms until January 13, 2014. During an interview on 01/16/14 at 4:59 PM the Administrator revealed he was aware the facility had not been providing the CMS forms for notification which informed the resident/family of the resident ' s right to have a claim or demand bill submitted to Medicare since he arrived in June 2013. He further reported that his expectation and the Corporate expectation was to have the facility Social Worker complete the CMS forms. He revealed he had shared this with his Social Worker in June and again in October and incouraged her to receive training on these forms. He further revealed a plan was put in place in January of 2014 to provide the facility Social Worker with training on the notifications as they were not being done. 2. A record review of the Liability Notices/Notice of Medicare Provider Non-Coverage forms revealed Resident # 123 was not provided with one of the correct CMS forms for notification which informed the resident/family of the resident ' s right to have a claim or demand bill submitted to Medicare as the resident no longer qualified for services on11/22/13. During an interview on 01/16/14 at 4:40 PM the Social Worker reported she is responsible for completing the CMS form for notification which informed the resident/family of the resident ' s right to have a claim or demand bill submitted to Medicare when the resident is no longer qualified for services. She further stated that these notifications had not been provided to resident/families since May of 2013 when the Business Office Manager left and she became	F 156	conduct weekly audits of the audit tool for 1 Month, bi-weekly audits for 2 months, and then monthly audits for 3 months in addition the audit tool will be brought to and reviewed at the facility monthly QA meeting. Social Worker is responsible for compliance The facility will be in substantial compliance on 2/19/14	

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F 156	Continued From page 4	F 156		

responsible for completing them. She further stated she had had no training on these forms until January 13, 2014.

During an interview on 01/16/14 at 4:59 PM the Administrator revealed he was aware the facility had not been providing the CMS form for notification which informed the resident/family of the resident ' s right to have a claim or demand bill submitted to Medicare since June of 2013. He further reported that his expectation and the Corporate expectation was to have the facility Social Worker's to complete the CMS forms. He revealed he had shared this with his Social Worker in June and again in October and incouraged her to receive training on these forms. He further revealed a plan was put in place in January of 2014 to provide the facility Social Worker with training on the notifications as they were not being done.

3. A record review of the Liability Notices/Notice of Medicare Provider Non-Coverage forms revealed Resident # 150 was not provided with one of the correct CMS forms for notification which informed the resident/family of the resident ' s right to have a claim or demand bill submitted to Medicare as the resident no longer qualified for services on 10/13/13.

During an interview on 01/16/14 at 4:40 PM the Social Worker reported she is responsible for completing the CMS form for notification which informed the resident/family of the resident ' s right to have a claim or demand bill submitted to Medicare when the resident is no longer qualified for services. She further stated that these notifications had not been provided to resident/families since May of 2013 when the

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F 156	Continued From page 5 Business Office Manager left and she became responsible for completing them. She further stated she had had no training on these forms until January 13, 2014. During an interview on 01/16/14 at 4:59 PM the Administrator revealed he was aware the facility had not been providing the CMS form for notification which informed the resident/family of the resident ' s right to have a claim or demand bill submitted to Medicare since June of 2013. He further reported that his expectation and the Corporate expectation was to have the facility Social Worker's to complete the CMS forms. He revealed he had shared this with his Social Worker in June and again in October and incouraged her to receive training on these forms. He further revealed a plan was put in place in January of 2014 to provide the facility Social Worker with training on the notifications as they were not being done.	F 156		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews, and physician interviews the facility staff failed to assess and obtain orders for an eye	F 309	Resident #1 no longer resides in the facility. He was discharged home on 1/20/14	2/19/14

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F 309	Continued From page 6 infection for 1 of 3 sampled residents reviewed for conjunctivitis. (Resident #1). The findings included: Resident #1 was admitted to the facility on 11/17/13 with diagnoses which included muscle weakness, abnormality of gait, conjunctivitis (eye infection), depression, and stroke. A physician order dated 11/17/13 revealed Resident #1 was ordered Tobramycin-Dexamethasone 0.3%-0.1% ointment (eye ointment medication for bacterial infection) to both eyes 1 drop every 12 hours for 5 days for bacterial eye infection. A review of the current care plan dated 11/29/13 identified conjunctivitis which included interventions to monitor for watery eyes, and notify physician of changes and signs and symptoms of infection. The care plan also identified self care deficit, which included assess functional level, administer medications, monitor for changes in condition and notify the physician as needed. A review of the admission Minimum Data Set (MDS) dated 12/14/13 coded Resident #1 as severely impaired cognitively for daily decision making skills. Resident #1 required extensive assistance with staff for his activities of daily living skills (ADL) s which included bed mobility, transfers, bathing, personal hygiene, and toileting. A review of the nurses notes December 2013 through January 15, 2014 for Resident #1 revealed no assessments reflecting the assessment of Resident #1's eyes for signs and symptom of infection and no documentation reflecting communication with the physician to report the Resident #1's red and watery eyes.	F 309	To determine that all resident are free from eye infection, an assessment of all residents will be completed by 2/7/14 The results to be presented to the Medical Director Four in-services have been conducted. Licensed staff where in serviced on 1/23 and 1/24/14. C.N.A.□s where in serviced on 1/28 and 1/29/14. These in-services stressed the importance of observation and the need to report anything new to the appropriate staff. The nurses were also instructed on the proper use of the SBAR when reporting any change in condition. A review of completed SBAR forms will be conducted, weekly, by the DON. This review will ensure that any/all changes in conditions have been acted upon. 2/3/14 Results of the eye assessments and SBAR reviews will be presented at the monthly QA Director of Nursing is responsible for compliance The facility will be in substantial compliance on 2/19/14	

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A review of Resident #1's Medication Administration Records (MAR) dated December 2013 and January 2014, indicated no medication ointment was given to the eyes in December 2013 through January 15,2014.

During an observation of the tour of facility on 01/13/14 at 10:30 AM Resident #1 was observed with reddened watery eyes.

During an observation on 01/14/14 at 10:48 AM Resident #1 was observed in the dining room with both his eyes noted to be red and watery with the right eye to be more reddened than the left.

During an observation on 01/15/14 at 9:39 AM Resident #1 was observed in his wheelchair in the hallway next to the nurse's station with reddened watery eyes and was rubbing his eyes with his left hand.

During an interview on 01/15/2014 at 10:12 AM Nurse #1 stated Resident #1 had red and watery eyes, and had been like that since his admission. Nurse #1 further stated the resident had received eyes drops when he was first admitted to treat an eye infection. Nurse #1 revealed she had communicated with the doctor regarding the continuation of Resident #1's red and watery eyes. Nurse #1 further revealed that she had not written a nurses note regarding Resident #1's red watery eyes and had not followed up with the doctor since her last communication regarding Resident #1's condition.

During an interview on 01/15/2014 at 10:18 AM the Director of Nursing (DON) confirmed that she had observed Resident #1's eyes were red and

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F 309	Continued From page 8 watery. The DON verified there was no communication with the doctor regarding the signs and symptoms of infection of Resident #1's eyes November 2013 through January 15, 2014. The DON further verified there were no new or additional orders for any medications for bacterial eye infection for Resident #1 since his original admission date in November. The DON stated that it was her expectation that nurses who observed the Resident #1's eyes to be reddened and watery should have reported the symptoms to the doctor and followed up to be sure that interventions were done. During and interview on 01/15/2014 at 11:54 AM the physician stated that the nurses had brought Resident #1's red and watery eyes to his attention this morning to assess. He further stated Resident #1 had a history of chronic conjunctivitis and he had requested medical records from the ophthalmologist regarding this history. The physician confirmed Resident #1 had swelling, redness and watery eyes	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents	F 329		2/19/14

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F 329	Continued From page 9 who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic 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 observations, medical records, staff interviews and physician interviews the facility failed to obtain physician orders for over the counter medications for 3 of 8 residents. (Residents #140, #8, #178). The findings included: 1. Resident #140 was originally admitted on 03/17/13 and was readmitted on 12/30/14 with diagnoses which included urinary tract infections, lumbar degenerative joint disease, spinal stenosis, chronic knee pain, insomnia, anxiety, depression, and hypertonicity of bladder. A review of the quarterly Minimum Data Set (MDS) dated 01/06/14 coded Resident #140 as cognitive intact for daily decision making skills but had difficulty with memory recall. Resident #8 required extensive assistance with staff for her activities of daily living skills (ADL) ' s which included bed mobility, transfers, dressing, bathing, and toileting. Resident was also coded	F 329	Resident #s 140, 8, and 178, still reside in the facility. A facility sweep was conducted on 1/17/14, in order to remove all unauthorized medications. Medications were placed in the DON□s office to be returned to the family or to secure an order for the needed medications. A Resident Council Meeting was held on 1/21/14 in order to inform the resident□s about keeping unauthorized medications at the bedside. The staff advised the residents to refrain from buying OTCs while on a shopping excursions. The Activity staff has been alerted, and will deter residents from purchasing OTCs. A letter has been drafted, and will be sent to all family members. The letter advises families to refrain from bringing medications from home, without the	

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F 329	Continued From page 10 as being compliant with care. A review of hospital physician discharge orders for 12/30/13 for Resident #140 revealed no physician order for melatonin, Vitamin C or antibacterial cream. A review of facility physician orders for January 2014 for Resident # 140 revealed no physician orders for the administration of melatonin, Vitamin C or antibacterial cream. A review of Resident #140 ' s Medication Administration Record (MAR) for January 2014 revealed no current record of administration for melatonin, vitamin C or antibacterial cream. During an observation on 01/14/14 at 9:00 AM 3 white round tablets laying on Resident #140 ' s night stand. During an observation on 01/14/14 at 12:01 PM 3 white round tablets laying on Resident #140 ' s night stand. During an observation on 01/14/14 at 5:59 PM 3 white round tablets laying on Resident #140 ' s night stand. During an interview on 01/15/14 at 5:11 PM Resident #140 stated the three white pills were ginseng and that she took them for energy. She further stated the three white pills had fallen on the floor earlier this afternoon and she had thrown them away. Resident declined to say where she had obtained the pills but did state the nurse had not given them to her.	F 329	approval of the DON 2/3/14 Continuous monitoring will be conducted by the licensed staff. Each week, a room search will be conducted by the assigned staff member. These completed audits will be returned to the DON. Any removed medications will be given to the DON. Family will then be notified. 2/8/14 □ ongoing Completed audits will be brought to the monthly QA meeting for further review. Director of Nursing is responsible for compliance The facility will be in substantial compliance on 2/19/14	

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F 329	Continued From page 11 During an interview on 1/16/14 at 2:51 PM with Nurse #3 revealed Resident #140 should not have any medication on her night stand and she always places resident ' s medications in a cup and pours them into her mouth as Resident #140 hands shake. Entered Resident #140 ' s room and observed Nurse #3 open nightstand top drawer. Nurse #3 pulled out bottle of melatonin with no lid, bottle of Vitamin C and a tube of antifungal cream. During a phone interview on 01/16/14 at 3:50 PM with the physician he stated he should have been notified of any medication that comes into the facility. He further stated he needed to be aware of any medications that a resident was taking to have a better clinical judgment in determining treatment. During an interview on 01/16/14 at 4:14 PM with Director of Nursing (DON) and Administrator and Regional Director of Clinical Services the DON stated her expectation was for all medications to come through the facility pharmacy and have a physicians order. 2. Resident #8 was originally admitted on 06/16/05 and readmitted to the facility on 12/20/13 with diagnoses which included muscle weakness, depression, diabetes, peripheral edema, recurrent urinary tract infections, and neurogenic bladder. A review of the quarterly Minimum Data Set (MDS) dated 12/21/13 coded Resident #8 as cognitively intact for daily decision making skills. Resident #8 required extensive	F 329		

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assistance with staff for her activities of daily living skills (ADL) which included bed mobility, transfers, dressing, bathing, and toileting.

A review of Resident #8 's Medication administration record (MAR) for December 2013 and January 2014 revealed no current record of administration for zinc oxide dimethicone spray (a topical skin product that is used as a protective coating for mild skin irritations).

A review of physician orders for December 2013 and January 2014 for Resident #8 revealed no physician orders for the administration of zinc oxide dimethicone spray.

A review of Resident #8 's most recent care plan for potential for impaired skin integrity dated 11/04/10 revealed interventions to ensure adequate hydration, weekly skin audits, treat as ordered for zinc oxide to be kept at bedside.

During an observation on 01/13/14 at 10:30 AM a tube of zinc oxide dimethicone spray was observed on Resident #8's bedside table.

During an observation on 01/14/14 at 6:05 PM the same tube of zinc oxide dimethicone spray was observed on Resident #8's bedside table.

During an observation on 01/15/14 at 09:25 AM the zinc oxide dimethicone spray was observed again on the bedside table.

During an interview on 01/15/14 at 9:25 AM Resident #8 stated the zinc oxide spray was bought at chain department store on one of her shopping trips. She further stated that she buys many different over the counter creams to treat

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her dry skin.

During an interview on 01/16/14 at 9:35 AM The Director of Nursing (DON) confirmed the zinc oxide spray was on Resident #8's bedside table along with other lotions. The DON further confirmed there were no physician orders for the zinc oxide spray and no self administrations of medication assessments completed for Resident #8. The DON stated her expectations for nurses providing care for residents were to remove any over the counter medications, notify the physician and obtain orders for the administration of these medications.

During an interview on 01/16/14 at 3:05 PM Nurse #2 who was familiar with the medications of Resident #8 stated any over the counter or prescription medications should have had a doctor's order and were kept in the medication cart or the treatment cart.

During a phone interview on 01/16/14 at 3:50 PM with the physician he stated he should have been notified of any medication that comes into the facility. He further stated he needed to be aware of any medications that a resident was taking to have a better clinical judgment in determining treatment.

3. Resident #178 was admitted to the facility on 10/11/13 with diagnoses which included muscle weakness, abnormality of gait disturbance, Alzheimer's, depression, stroke, and chronic kidney disease. A review of the quarterly Minimum Data Set (MDS) dated 12/31/13 coded Resident #178 as severely impaired cognitively for daily decision making skills. Resident #178

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required extensive assistance with one staff for her activities of daily living skills (ADL) which included bed mobility, transfers, dressing, bathing, personal hygiene, and toileting.

A review of Resident #178's Medication Administration Record (MAR) for December 2013 and January 2014 revealed no current record of administration of nystatin 30 g 100,000 usp units & 1 mg triamcinolone ointment (an antibiotic cream that kills yeast infections on skin).

A review of physician orders for December and January 2014 for Resident #178 revealed no physician orders for the administration of nystatin triamcinolone ointment.

A review of Resident #178's most recent care plan for at risk for skin impairment dated 10/23/13 revealed interventions to ensure adequate hydration, assess skin condition daily, and assist with hygiene and general skin care.

During an observation on 01/13/14 at 10:30 AM a tube of nystatin 30 g 100,000 usp units & 1 mg triamcinolone ointment was observed in the bathroom on resident #178's shelf.

During an observation on 01/14/14 at 6:05 PM the tube of nystatin triamcinolone ointment was observed on Resident #178's bathroom shelf.

During an observation on 01/15/14 at 09:25 AM the tube of nystatin triamcinolone ointment was again observed on Resident #178's bathroom shelf.

During an interview on 01/16/14 at 9:35 AM The Director of Nursing (DON) stated the nystatin

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F 329	Continued From page 15 triamcinolone ointment should not be in Resident #178's bathroom. The DON confirmed the tube of nystatin triamcinolone ointment was in Resident #178's bathroom along with other lotions. The DON further confirmed there were no physician orders for the tube of nystatin triamcinolone ointment and no self administrations of medication assessments were completed for Resident #178. The DON stated her expectations for nurses providing care for residents were to remove any over the counter medications, notify the physician and obtain orders for the administration of these medications. During a phone interview on 01/16/14 at 3:50 PM with the physician he stated he should have been notified of any medication that comes into the facility. He further stated he needed to be aware of any medications that a resident was taking to have a better clinical judgment in determining treatment.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		2/19/14

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F 371	Continued From page 16 Based on observations, staff interviews, and a facility cleaning schedule, the facility failed to 1) complete hand hygiene using warm water and soap, 2) use clean utensils to serve rolls and a grilled cheese sandwich to 18 residents (Residents #12, 3, 104, 85, 42, 35, 8, 178, 136, 93, 7, 44, 70, 78, 111, 57, 196 and 17) for 1 of 2 tray line observations, and 3) maintain 3 of 3 storage racks clean. The findings are: 1. An observation of the lunch meal tray line occurred on 01/13/14 from 12:47 PM until 1:03 PM. During the observation dietary staff #1 was observed to push the steam table into the main dining room (MDR) from the kitchen with ungloved hands and plugged the cord of the steam table into a wall outlet. Dietary staff #1 then walked to a dispenser of an alcohol-based hand sanitizer and applied one pump to both hands, donned gloves and then began the lunch meal tray line. On 01/13/14 at 12:48 PM dietary staff #1 walked to the kitchen door, placed her right gloved hand on the door handle while attempting to open it, then knocked on the glass window of the kitchen door with her right hand and rested the palm of her right hand on the glass window. The kitchen door handle and glass window of the door were both observed soiled with dried food debris, greasy residue and white and red food splatters. On 01/13/14 at 12:49 PM dietary staff #1 was observed to resume the lunch tray line by picking up a grilled cheese sandwich with her right gloved hand, plated this for Resident #93 and served the sandwich to the Resident. Hand hygiene was not performed, neither were gloves changed prior to	F 371	Dietary manager and staff have been made aware of the deficient practice regarding improper hand washing techniques, failure to use clean utensils to serve food to residents, as well as failing to ensure that storage racks in dietary are in clean condition. The utensils and storage racks were cleaned by Dietary staff. Dietary staff will be in serviced on proper hand washing techniques, proper cleaning methods for dietary utensils, as well as ensuring storage racks are kept clean. A cleaning log and audit tool has been created and implemented to ensure proper cleaning methods for dietary utensils are in place, as well as ensuring storage racks are kept clean. The audit tool will also ensure proper hand washing techniques are used by dietary staff. Dietary manager will conduct weekly audits of audit tool for 1 month, bi-weekly audits for 2 months, and then monthly audits for 3 months. In addition, the audit tool will be brought to and reviewed at the facility□s monthly QA meetings. Dietary Manager is responsible for compliance. The facility will be in substantial compliance on 2/19/14	

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plating the grilled cheese sandwich.

On 01/13/14 from 12:50 PM until 1:03 PM, dietary staff #1 was observed to plate rolls with her right gloved hand for Residents #12, 3, 104, 85, 42, 35, 8, 178, 136, 7, 44, 70, 78, 111, 57, 196 and 17. Hand hygiene was not performed, neither were gloves changed prior to plating the rolls.

On 01/13/14 dietary staff #1 was interviewed at 1:13 PM. During the interview, dietary staff #1 stated she served lunch from the MDR for the past 2-3 years and routinely washed her hands in the kitchen with soap in warm water for 20-25 seconds prior to starting the tray line. Dietary staff #1 further stated that if her gloves became soiled during the tray line, she would remove the soiled gloves and use the alcohol-based sanitizer and don new gloves. Dietary staff #1 stated that since she pushed the steam table into the MDR and plugged the cord into the wall socket, she used the alcohol-based hand sanitizer prior to donning gloves. Dietary staff #1 further stated that she was trained and knew to use utensils to plate food for residents, but had never considered using utensils when plating rolls or sandwiches. Dietary staff #1 stated "I usually do not use utensils to plate rolls and I did not use utensils to plate the grilled cheese (sandwich)." Dietary staff #1 observed the glass window and door handle of the kitchen door and confirmed that both the handle and window were soiled.

An interview on 01/13/14 at 3:48 PM with the certified dietary manager (CDM) revealed he started as the CDM at the facility in October 2013. The CDM stated that staff should use utensils to plate food during the meal service and hand hygiene should be performed by dietary

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staff using soap and warm water. The CDM further stated that he monitored the tray line for the use of utensils by spot checking, but on 01/13/14 he was running and did not notice it.

2. On 01/13/14 at 11:02 AM the kitchen was observed with three storage racks. One rack contained insulated bottom plate covers, a second rack contained insulated dome plate lids and a third storage rack was a four-shelved wire storage unit that contained items stored directly on the shelving to include 20 stainless steel pans stacked and inverted, 20 stainless steel sheet pans stacked and inverted, and 2 stainless steel bowls stacked and inverted. Each storage rack/cart was observed with a build-up of a greasy residue, dried food particles and dust. Follow-up observations of the storage racks/carts occurred on 01/15/14 at 07:20 AM and 01/16/14 at 5:00 PM in which the storage racks were observed in the same condition.

An interview with the CDM occurred on 01/16/14 at 5:00 PM and revealed that he maintained a weekly cleaning schedule which included weekly cleaning of the storage racks/carts. Review of cleaning schedule revealed that cleaning of the storage racks/carts was not documented as completed for the current week (week of January 12th) or the two weeks prior (weeks of January 5th and December 29th). The CDM stated that he checked the weekly cleaning schedule each Monday to make sure all items were completed, but he had not checked the schedule for the past few weeks. The CDM stated he had not noticed the buildup of debris on the storage racks/carts, but he expected staff to follow the weekly

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F 371	Continued From page 19 cleaning schedule. He offered no explanation as to why he had not monitored the cleaning schedule to ensure tasks were completed.	F 371		