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	345522	A. BUILDING ______ B. WING ______	C 06/20/2014

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F 000	INITIAL COMMENTS No deficiencies were cited as result of the complaint investigation. Event ID# EKJO11.	F 000		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label bedpans with resident names for 2 of 2 bedpans stored in resident bathrooms. The findings included: During an observation on 06/17/14 at 4:17 PM in the resident bathroom of room 206 there were 2 bedpans that were each covered with a plastic bag and both plastic bags were tied to the hand rail in front of the toilet in the bathroom. There were no resident names visible on the plastic bags or on the bedpans. During an observation on 06/18/14 at 4:30 PM in the resident bathroom of room 206 there were 2 bedpans that were each covered with a plastic bag and both plastic bags were tied to the hand rail in front of the toilet in the bathroom. There were no resident names or resident identification written on the bags or on the bedpans. During an observation on 06/19/14 at 10:42 AM in the resident bathroom of room 206 there were 2	F 253	The corrective action for this alleged deficient practice was to correctly mark the bedpans in question with the names of the residents to whom they belonged. This was achieved on 6-20-14 by the Assistant Director of Nursing (ADON). This was accomplished for the occupants of room 206. Recognizing that all residents who use bedpans have the potential to be affected by this same alleged deficient practice, the housekeeping and nursing staff audited all resident bathrooms on 6-24-14 and no other unlabeled bed pans were found. Corrective action put into place to prevent this from recurring: 1) Nursing and housekeeping staff were inserviced by the ADON regarding this tag and the importance of labeling bedpans on 7-14-14, 2) Nursing staff to make sure bedpans are labeled with the resident's name before using.	7/18/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/17/2014

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 253	Continued From page 1 bedpans that were each covered with a plastic bag and both plastic bags were tied to the hand rail in front of the toilet in the bathroom. There were no resident names or resident identification written on the bags or on the bedpans. During an interview 06/19/14 at 1:49 PM with Nurse Aide (NA) #2 she stated all personal items for residents which included bedpans that were stored in resident bathrooms were supposed to be clearly marked with the resident's name. During an interview on 06/20/14 at 8:35 AM with NA #3 she confirmed there were no resident names on the plastic bags or on the bedpans in the resident bathroom in room 206. She further confirmed that 2 residents lived in room 206 and she could not determine which bedpan belonged to each of the residents. She explained the resident's name should have been placed on the bedpans so they did not get mixed up and used for the wrong resident. During an interview with on 06/20/14 at 10:45 AM with Nurse #3 she stated bedpans stored in resident bathrooms were to be visibly labeled with the resident's name. During an interview on 06/20/14 at 11:00 AM the Assistant Director of Nursing stated it was her expectation that bedpans stored in resident bathrooms would have the resident's name or their initials written on them with a marker. During an interview on 06/20/14 at 11:18 AM the Director of Nursing stated it was her expectation that bedpans were supposed to be labeled with the resident's name. She further stated the resident's name should be written with a	F 253	Measures put into place to monitor the performance of the corrective action to ensure sustainability include: 1) Nursing staff to check for proper ownership prior to using a bedpan and if they find a bedpan that is not labeled then they are to label it. If they find a bedpan that is labeled incorrectly then they are to dispose of it, replace with one that is appropriately marked and this is to be reported to the Director of Nursing (DON)or immediate supervisor. This incident is to be recorded on the 24 Hour Report and to be reviewed by the Inter Disciplinary Team (IDT) in the Daily Morning Meeting (M-F), 2) a monitor to be performed by the housekeeping staff checking bedpans for appropriate labeling. Five resident rooms a day will be checked by housekeepers for 3 months. 3) If bedpans are found to be unlabeled, the housekeepers will report this to both the Director of Housekeeping (DOH) and DON, 4) The DON will then ensure that the proper labeling occurs. These monitors will be maintained by the DOH and brought to the monthly Quality Assurance meeting for review for 3 months at which time the need for further audits or POC revisions will be made if necessary. Compliance will be achieved by 7-18-14 This Plan of Correction is the Centers credible allegation of compliance. Preparation and or/execution of this plan of correction does not constitute	

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F 253	Continued From page 2 permanent marker so it was visible to staff to use for the correct resident.	F 253	admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to provide nail care for 1 of 3 residents reviewed for activities of daily living (Resident #60). The findings included: Resident #60 was re-admitted to the facility on 05/05/14 with diagnoses which included general muscle weakness, macular degeneration (an eye condition that usually affects older adults with a loss of vision), anxiety, depression and dementia. A review of the most recent 30 day Minimum Data Set (MDS) dated 06/02/14 revealed Resident #60 had no short term or long term memory problems and was moderately impaired in cognition for daily decision making. The MDS further revealed Resident #60 required extensive assistance with	F 312	The corrective action for this alleged deficient practice was to clean and trim the fingernails of resident #60. This was achieved on6-20-14 by the certified nursing assistant. All residents have the potential to be affected by this same alleged deficient practice. A fingernail check was done for all residents in the facility by the Director of Nursing (DON) and Assistant Director of Nursing (ADON). this was completed on 6-24-14. All fingernails that were unclean or needed trimming were attended to by the DON and ADON. Measures put into place to prevent this alleged deficient practice from recurring include: 1) an inservice for all nursing	7/18/14

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activities of daily living which included personal hygiene and Resident #60 had not rejected care.

A review of a care plan with an onset date of 04/20/14 revealed Resident #60 required assistance with ADLs related to progressing dementia. The goals indicated Resident #60 would have her daily needs met with staff support and the interventions were to assist Resident #60 as needed.

A review of an ADL sheet which was the daily care guide for Nurse Aides (NAs) to provide resident care indicated Resident #60 required assistance with grooming. A section for notes on the back of the ADL sheet indicated there were no handwritten notes that Resident #60 had refused nail care.

During an observation on 06/16/14 at 11:16 AM Resident #60 was sitting in a chair next to her bed and all ten fingernails on her hands were long and extended approximately ¼ inch at the end of each finger. The fingernails had whitish/brown debris under the nails on both hands.

During an observation on 06/18/14 at 8:46 AM Resident #60 was lying on top of her bed and was rubbing her right knee with her right hand and her left hand was lying on top of the bed. All ten fingers on her hands were long and extended approximately ¼ inch at the end of each finger and had whitish/brown debris underneath the nails.

During an observation on 06/18/14 at 4:30 PM Resident #60 was sitting in her room in a chair next to her bed holding a book. All ten fingernails on her hands were long and extended

F 312

staff was provided by the ADON regarding this tag and the importance of it. This was achieved on 7-14-14, 2) a check off line has been placed on the shower forms indicating that the resident's fingernails were looked at and proper attention given to them. This line is to be initialed by the charge nurse after the resident's shower and after the nurse has visually checked the resident's fingernails. This started 7-14-14. This will be ongoing daily according to the shower schedule for 12 months.

To ensure that these measures are successful, a monitor is in place in which 5 residents are selected at random and their fingernails are checked for cleanliness and need for trimming. This is done 3 times a week by the DON and ADON starting 7-16-14. Nails that are found to be in need of attention are to be addressed immediately as directed by the DON, ADON, and/or immediate supervisor. These monitors are to be maintained by the DON and will be reviewed at the monthly Quality Assurance (QA) meeting. These monitors will continue for 3 months. It will be determined by the QA committee if the plan needs to be adjusted or changed to ensure compliance.

This plan of correction is the centers credible allegation of compliance.
Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or

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F 312	Continued From page 4 approximately ¼ inch at the end of each finger and had whitish/brown debris underneath the nails. There were 2 middle fingernails that were broken and jagged on her left hand. During an observation on 06/19/14 at 10:42 AM Resident #60 was sitting in a chair next to her bed. All ten fingernails on both hands were long with whitish/brown debris under the nails. The nails on her left hand were uneven with two nails that were broken off and jagged on her left hand. During an interview with the observation revealed Resident #60 stated she had a shower yesterday but her nails were not trimmed. During an interview on 06/19/14 at 1:49 PM with Nurse Aide (NA) #2 she stated NAs were expected to check residents' nails and clean and trim them when they gave residents a shower. She further stated she had not trimmed Resident #60's nails because she was not the NA who was usually assigned to provide care to her. During an interview on 06/20/14 at 8:35 AM with NA #3 she confirmed she was the NA who was usually assigned to provide care to Resident #60 and gave her a shower on 06/18/14 but did not trim her nails during her shower. She stated sometimes Resident #60 did not like to have her nails trimmed but if they caught her in a good mood she allowed her nails to be cleaned and trimmed and confirmed Resident #60 was cooperative with care while in the shower on 06/18/14 but just didn't get her nails trimmed. During an interview on 06/20/14 at 10:45 AM with Nurse #3 she confirmed Resident #60 had a shower on the 7:00 AM to 3:00 PM shift on Wednesday and Saturday of each week. She	F 312	conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law.	

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F 312	Continued From page 5 stated NAs were expected to provide nail care which included cleaning under the nails, trimming and filing them during their showers. She explained the NAs usually soaked the resident's hands to soften their nails and then they cleaned and trimmed them and she was not aware that Resident #60's nails had not been trimmed. During an interview on 06/20/14 at 11:00 AM the Assistant Director of Nursing stated it was her expectation that nail care was usually done during the resident's shower. She explained if a resident refused to have nail care the NAs were expected to document the refusal on the back of the ADL sheets and report the refusal to the nurse. She further explained the nurse was then expected to document the resident refused in the nurse's notes. During an interview on 06/20/14 at 11:18 AM the Director of Nursing stated it was her expectation for nail care to be provided during the resident's shower. She stated Resident #60 did not like to have her nails cut short but they should be clean, trimmed and filed.	F 312		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323		7/18/14

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F 323	Continued From page 6 by: Based on resident interview, staff interviews and record review the facility failed to provide adequate supervision to prevent a fall, which resulted in a fracture, for 1 of 1 sampled resident reviewed for accidents (Resident #14). The findings included: Resident #14 was readmitted to the facility on 04/17/08 with diagnoses including; hemiplegia, muscle weakness, shoulder joint pain and osteoporosis. Resident #14's quarterly "Fall Risk Review" assessment completed on 08/27/13 assessed the resident as being at high risk for falls. Further record review revealed Resident #14 did not have any quarterly "Fall Risk Review" assessments completed from 08/28/13 to 01/19/14. Resident #14's Quarterly Minimum Data Set (MDS) dated 10/21/13 revealed the resident was cognitively intact with no memory problems and required extensive assistance with dressing. The MDS assessed the resident as requiring extensive assistance for transfers with staff providing weight bearing support with one person physical assistance. The MDS also assessed the resident as having unsteady balance during transitions and walking and only able to stabilize with staff assistance. Review of Resident #14's care plan, which was reviewed by facility staff on 11/12/13, contained a "Problem/Need" which identified the resident as being at risk for falls related to mobility impairment and medication regime. The goal specified for the resident not to experience any	F 323	Licensed nurse obtained order from P.A. on 1-1-14 and resident #14 received an xray of left knee on 1-1-14. P.A. was notified on 1-1-14 of results and stated that the physician would be at facility to see resident #14 on 1-2-14. Resident #14 was sent to the Emergency Room for evaluation on 1-2-14. Resident #14 returned to the facility on that same day. She had and order for an immobilizer on her left leg and an appointment to see an orthopaedic physician on 1-23-14. All residents who require the extensive assist of one for transfer (sit to stand) activity have the potential to be affected by this same alleged deficient practice. All residents who require this same type of assistance were screened by therapy for the possible need for increased assistance on 7-14-14. No changes for assistance with transfers (sit to stand) for these residents were identified. Measures put into place to prevent this alleged deficient practice from recurring include: 1) nursing and therapy staff were inserviced on accident prevention as it relates to tag 323 by 7-17-14 by the Assistant Director of Nursing (ADON)to include making sure that the nursing dept. provides appropriate support and assistance to residents, 2) a comprehensive list of current residents requiring extensive assist of one for transfers (sit to stand) activity was developed by the Administrator and Regional Clinical Nurse on 7-15-14, 3)	

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injuries related to falls through the next assessment period.

Review of Resident #14's Nursing notes revealed she experienced the following falls on 12/21/13 and 01/01/14 while being assisted by a nursing assistant in a shower room:

Nursing note of 12/22/13 at 4:13 PM: "on 12/21/13 @ 4:30 PM, Res. (resident) was in shower room with CNA, attempted to stand at rail, res. states her knee gave out and she slid to floor, MAEW (moves all extremities well) for res. denies pain or discomfort, assisted res. back into w/c, no acute distress noted, will con't to moniter (sic)."

Nursing note of 01/02/14 at 1:18 AM: "Res. fell (lowered to ground) while in shower room @ 4PM. CNA states residents legs gave out while standing at the shower bar and had to lower res. to the floor. Res. c/o (complained of) L) knee pain, no other inj. noted. (Name of Physician's Assistant), PA here and evaluated res. and ordered a L) knee x-ray... Will cont. to monitor. VSS (vital signs stable), afebrile."

Review of Resident #14's 01/02/14 hospital discharge information revealed she experienced a fractured left knee joint.

Review of Resident #14's Quarterly MDS assessment dated 04/01/14 revealed she was cognitively intact with no memory problems. The MDS assessed the resident as requiring extensive assistance with two person physical assist with transfers.

On 06/18/14 at 2:40 PM an interview was

F 323

The residents on this list were screened by the Physical and Occupational Therapists (PT and OT) for possible need for increased assistance with transfer (sit to stand) activity on 7-15-14, 4) the care plans and Care Cards of residents identified as needing additional or increased assistance with transfers (sit to stand) activity were updated by the ADON on or before 7-17-14 and as appropriate, added to the Restorative Care program or Part B therapy services, 5) PT and OT will screen all residents quarterly assessing function and needs effective 7-15-14 and will be ongoing and residents identified as having needs will be evaluated for Part B therapy services or Restorative Care Program, 6) a monitor was done by the Administrator, ADON, and Regional Clinical nurse on 7-15-14 to ensure that all Fall Risk Reviews for current residents identified in#2 of this paragraph were completed. This monitor revealed that all Fall Risk Reviews were present and up to date for the quarter for these residents, 7) all staff were inserviced on 7-14-14 by the ADON to notify charge nurse, DON, or ADON of identified changes in residents for need of increased assistance with transfers (sit to stand) which will then be referred to therapy for screening 8) The MDS nurse will complete a monitor weekly for the residents on the weekly care plan schedule ensuring that the quarterly Fall Risk Review is complete for the current quarter. This begins 7-16-14 and will be ongoing for the next 12 months. If a medical record is identified by the MDS

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F 323	Continued From page 8 conducted with Resident #14. During the interview Resident #14 voiced a concern regarding her fall on 01/01/14 when Nursing Assistant (NA) #4 was attempting to dress her in a facility shower room. Resident #14 stated prior to this fall she was attempting to hold on to a support bar in the shower room as the NA was placing a brief on her. The resident stated she told the NA to stop placing the brief on her until she could get a better hold of the support bar in the shower room, but the NA then told her to wait a minute and continued applying the brief without supporting her. The resident stated that she tried to hold onto the bar, but her knees gave out and she fell to the floor. The resident explained that she hit her knee against a wall in shower room and it hurt "really bad". The X-ray at the hospital revealed she had a fractured knee. The resident stated that she believed her fall on 01/01/14 could have been avoided if the NA would have supported her as she was losing her grip on the shower room bar instead of continuing to place a brief on her at the time of the fall. The resident also explained that a week prior to her 01/01/14 fall she experienced another fall in the shower room, which did not result in injury, when only one NA was assisting her with care. On 06/18/14 at 4:00 PM an interview was conducted with the facility's Assistant Director of Nurses (ADON). The ADON stated that Resident #14 was identified as a high risk for falls on her quarterly 08/27/13 "Fall Risk Review". The ADON explained the "Fall Risk Review" assessment is a tool which assesses numerous possible risk factors and evaluates a resident's overall risk for falls. The ADON stated this assessment should be conducted every three months, but staff failed to conduct a quarterly "Falls Risk Review" for	F 323	nurse to be lacking in a quarterly Fall Risk Review, the DON and ADON will be notified and the Fall Risk Review will then be completed. 9) when a fall occurs during a transfer, an incident report will be completed by the charge nurse and then reviewed at the following morning meeting. The interdisciplinary team will also review the fall and the resident involved will be referred to the rehab director for a therapy screening. Part B services or restorative care services may be necessary and ordered for the resident by the MD. The resident's care plan and care card will be updated to reflect changes involving the level of support needed with transfers. The DON/ADON will review each of these incident reports ensuring that the appropriate level of staff support was provided. The Rehab Director will maintain the list of residents receiving Part B services and this will be shared with the administrator weekly. The names of resident who have been added to Part B services due to the need for increased assistance with transfers (sit to stand) activity will be brought to the monthly Quality Assurance meeting for 12 months. The ADON will maintain the list of residents receiving Restorative Care services and this will be shared with the administrator weekly. The names of the residents who have been added to the Restorative Care program due to the need for increased assistance will transfers (sit to stand) activity will be brought to the Quality Assurance meeting monthly for 12 months.	

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Resident #14 from 08/28/13 to 01/19/14. The ADON further explained that Resident #14 had many risk factors which made her a high risk for falls. The ADON stated that Resident #14 required a minimum of extensive assistance with one person physical assistance with transferring and dressing when she fell in the shower room on 01/01/14 while being assisted by NA #4.

On 06/19/14 at 2:20 PM MDS Coordinator #1 was interviewed. MDS Coordinator #1 stated that prior to Resident #14's injurious fall on 01/01/14 it was verbally communicated to nursing staff that the resident may need additional assistance and support during the provision of care to prevent further falls because the resident had experienced two prior falls during the month of December 2013. MDS Coordinator #1 confirmed the facility failed to meet Resident #14's care plan goal to not experience any injuries related to falls when she fell in the shower room, while being assisted by NA #4, which resulted in a knee fracture on 01/01/14. MDS Coordinator #1 stated that NA #4 was no longer employed at the facility and was unavailable for interview.

On 06/19/14 at 3:00 PM the facility's ADON was interviewed regarding the facility's investigation of Resident #14's fall on 01/01/14. The ADON stated during the facility's investigation NA #4 said the resident's legs gave out and she was lowered to the shower room's floor during the fall on 01/01/14. The ADON further explained that Resident #14, who is interviewable, was not interviewed as part of the facility's investigation to obtain her version of how the fall occurred and how it could have possibly been prevented. The ADON stated NA #4 should have provided the necessary assistance and support when

The weekly Fall Risk Review monitors will be maintained by the MDS nurse and presented at the monthly Quality Assurance committee meeting for 3 months. Changes will be made as deemed necessary by the QA committee to ensure compliance.

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F 323	Continued From page 10 requested by the resident to prevent the fall on 01/01/14.	F 323		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, record review and tasting of foods served on a requested test tray the facility failed to serve hot breakfast foods at proper temperatures to 3 of 3 sampled residents reviewed for food quality (Residents #59, #60 and #68). The findings included: 1. Resident #59 was readmitted to the facility on 10/07/10 with diagnoses including diabetes and joint pain. Resident #59's Quarterly Minimum Data Set dated 05/08/14 specified she did not have any cognition or memory problems and required set up assistance only with meals. On 06/17/14 at 9:18 AM an interview was conducted with Resident #59. During the interview Resident #59 voiced a concern that her breakfast foods, especially eggs, were not always hot when served.	F 364	Corrective action for residents #59,60,and 68 will be to ask them upon delivery of their breakfast meal if the temperature is suitable for them and if not, then it is to be heated up or cooled down depending on the issue. This action is the responsibility of the nursing staff delivering the affected meal tray. All resident have the potential to be affected by the same alleged deficient practice. Nursing staff delivering meal trays have been instructed to ask each resident if the temp of their meal is suitable for them. If not, then appropriate action is to take place either reheating or replacing foods that are tool cool or too warm. This is to be accomplished by nursing staff delivering meal trays. This inservice was given to nursing staff on 7-14-14 by the Director of nursing (DON) and Assistant Director of Nursing (ADON. Measures put into place to prevent this	7/18/14

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F 364	Continued From page 11 On 06/18/14 at 8:17 AM Resident #59 was observed eating breakfast in her room. Observations of the resident's meal tray revealed she was served foods including; scrambled eggs, bacon and toast. The resident stated the scrambled eggs, bacon and toast served on her meal tray were cold. The resident further stated that she would prefer to receive hot foods, but at breakfast she usually received eggs, bacon and toast on her meal tray that were cold. On 06/19/14 at 8:15 AM the hot foods served on a requested breakfast test tray were tasted with the facility's Dietary Manager (DM). Tasting of the test tray's scrambled eggs, bacon, sausage and toast revealed these foods were cold and the oatmeal served on the test tray was barely warm. Also, when butter was spread on the toast served on the test tray it did not melt. Interview with the facility's DM, during the tasting of foods served on the test tray, revealed the DM agreed the scrambled eggs, toast, bacon, sausage and oatmeal served on the test tray were not hot. 2. Resident #60 was readmitted to the facility on 06/05/10 with a diagnosis of Cerebral Vascular Accident with left side hemiplegia. Resident #60's Annual Minimum Data Set dated 04/09/14 indicated she was cognitively intact with no memory problems and required set up assistance only with meals. Observations on 06/18/14 at 8:04 AM revealed Resident #60 was in bed when staff placed the resident's breakfast meal in her room, but did not serve the meal. On 06/18/14 at 8:28 AM staff was observed to assist Resident #60 to sit up on the	F 364	alleged deficient practice from recurring include: 1) Inservice provided to all nursing and dietary staff by the DON, ADON, and/or Dietary Manager. This was achieved on 7-14-14. This inservice addressed tag 364 (Nutritive Value/Appear, Palatable/Pre Temp)and what to do in the event that the food temps are not acceptable to the resident. 2) the dietary cook will place hot foods directly onto the steam table when coming out of the oven or steamer, utilizing steam table food covers as determined necessary by the cook and 3) toast will be delivered to the resident placed on the plate and under the insulated dome. To ensure compliance, the facility has implemented: 1) a monitor in which 3 randomly selected residents (that eat breakfast in their rooms) will be asked to complete a Dietary Satisfaction Survey following breakfast starting 7-15-14. This will be conducted daily Monday through Friday by the Dietary Manager or Activity Staff for 3 months. As satisfaction surveys are received, any dissatisfaction will be followed up by the dietary manager or other dietary staff by monitoring a test tray for acceptable temperatures and following up with the resident voicing dissatisfaction. 2) any other food temperature concerns voiced outside of the Dietary Satisfaction Surveys will be addressed by the Dietary Manager and followed up on for resolution for satisfaction 3) Food temps will be addressed in the monthly Food Committee meeting which is facilitated by	

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F 364	Continued From page 12	F 364		

side of her bed and provided set up assistance with her breakfast meal. Observations on 06/18/14 at 8:30 AM revealed the resident was served foods including; toast and grits as part of her breakfast meal. Interview with Resident #60 on 06/18/14 at 8:30 AM revealed the toast served on her meal tray was cold and that she would not eat the grits served at this meal because she was not feeling well. The resident further stated that she would prefer for her foods to be hot when served, but her toast was usually cold when served at breakfast.

On 06/19/14 at 8:15 AM the hot foods served on a requested breakfast test tray were tasted with the facility's Dietary Manager (DM). Tasting of the test tray's scrambled eggs, bacon, sausage and toast revealed these foods were cold and the oatmeal served on the test tray was barely warm. Also, when butter was spread on the toast served on the test tray it did not melt. Interview with the facility's DM, during the tasting of foods served on the test tray, revealed the DM agreed the scrambled eggs, toast, bacon, sausage and oatmeal served on the test tray were not hot. The DM further stated nursing staff should deliver meal trays and provide residents with needed set up meal assistance as soon as possible to ensure the resident's foods were hot when served.

3. Resident #68 was admitted to the facility on 11/18/10 with diagnosis which included Alzheimer's disease and muscle weakness. The quarterly Minimum Data Set (MDS) dated 05/06/14 indicated Resident #68's cognition was moderately impaired and she was capable of making her needs known. She required extensive assistance with most of her activities of daily

the administrator effective 7-1-14. Concerns will be addressed by the dietary manager with follow up with residents voicing the concerns

The monitors will be maintained by the Dietary Manager and presented at the monthly Quality Assurance meeting at which time, the measures implemented will be adjusted/changed so as to achieve compliance with this tag as necessary. These monitors will be ongoing for 3 months.

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F 364	Continued From page 13 living (ADLs) but was independent with eating. On 06/17/14 at 9:38 AM Resident #68 was interviewed. She stated her breakfast meal was always served cold, especially the eggs, and the grits were cold and thick like paste. On 06/18/14 at 8:28 AM Resident #68 was observed eating breakfast in her room. Her breakfast meal was observed and revealed she was served scrambled eggs, bacon, and toast. She stated the scrambled eggs and the toast on her tray were cold. Resident #68 further stated she would prefer to have hot foods served to her but the eggs and toast were always served cold. On 06/19/14 at 8:15 AM the hot foods served on a requested breakfast test tray were tasted with the facility's Dietary Manager (DM). Tasting of the test tray's scrambled eggs, bacon, sausage and toast revealed these foods were cold and the oatmeal served on the test tray was barely warm. Also, when butter was spread on the toast served on the test tray it did not melt. Interview with the facility's DM, during the tasting of foods served on the test tray, revealed the DM agreed the scrambled eggs, toast, bacon, sausage and oatmeal served on the test tray were not hot.	F 364		
F 371 SS=F	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	F 371		7/18/14

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F 371	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove a food product with an expired expiration date from refrigeration storage, ensure stored food preparation and service equipment was clean and/or dry and properly store foods in 1 of 2 facility nourishment rooms. The findings included: 1. Observations on 06/16/14 at 9:00 AM of foods stored in the kitchen's walk-in refrigerator revealed a five pound container of cottage cheese with an expired expiration date of 06/13/14. On 06/16/14 at 9:25 AM an Interview was conducted with the facility's Dietary Manager (DM). The DM stated that the dietary staff should check the expiration dates of refrigerated foods everyday and the cottage cheese with the expired expiration date should have been discarded by staff on 06/13/14. 2. On 06/16/14 at 9:10 AM observations were made of the kitchen's ice machine and ice scoop holder. Observations of the ice machine revealed it was filled with ice, but a piece of metal inside of the machine was unclean with a black mold like substance. The black substance was easily removed by wiping the substance away with a paper towel. A log posted on the side of the ice machine specified the machine was last cleaned on 03/03/14. Observations of the kitchen's ice	F 371	The corrective action for this alleged deficient practice was: 1) To discard the outdated cottage cheese. This was done on 6-16-14 by the Dietary Manager 2) Clean the ice machine and ice scoop holder. The ice machine was cleaned on 6-17-14 by the maintenance director. The ice scoop holder was ran through the dishwasher and cleaned on 6-16-14 by the Dietary Manager. 3) a) The food prep sheet pan in question was discarded by the dietary manager on 6-16-14. b) The 4 food serving scoops identified as being soiled were removed from the drawer and run through the dishwasher and air dried. This was done on 6-17-14 by the dietary manager. c) Five of the ten identified food preparation pans that were soiled were ran back through the dishwasher and allowed to air dry. This was done on 6-17-14 by the dietary manager. 4) a) The 7.5 ounce package of pizza rolls were discarded on 6-17-14 by the dietary manager, b) The two brownies that were not labeled and dated were discarded on 6-17-14 by the dietary manager An inventory to include both resident nourishments rooms as well as the walk-in refrigerator in the dietary dept. was completed by the dietary manager on 6-17-14. No other outdated, unlabeled or inappropriately closed foods were	

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F 371	Continued From page 15 scoop holder revealed, an ice scoop was stored inside, and the inner bottom of the holder was unclean with a dried brown substance. On 06/16/14 at 9:25 AM an interview was conducted with the facility's Dietary Manager (DM). The DM stated the kitchen's ice machine was scheduled to be cleaned every three months, but confirmed the machine had not been cleaned since 03/03/14 which was over three months ago. The DM confirmed the kitchen's ice scoop holder was not clean and stated the dietary staff were responsible for cleaning the ice scoop holder as needed to ensure it was kept clean. 3. Observations on 06/17/14 of stored food preparation and service equipment in the kitchen revealed the following: a. On 06/17/14 at 4:22 PM a food preparation sheet pan, stored on a shelving unit as clean and ready for use, was observed with a heavy grease residue on both sides of the pan. Interview with the Dietary Manager (DM) on 06/17/14 at 4:22 PM confirmed the sheet pan was unclean with a greasy residue. The DM stated the dietary staff should make sure food preparation equipment is grease free and completely clean prior to storing for use. b. Observations on 6/17/14 at 4:25 PM revealed four of ten food serving scoops, stored in a drawer and ready for use, were not dry. The four food scoops were observed to have water on their inner serving surfaces. Interview with the Dietary Manager on 06/17/14 at 4:29 PM revealed dietary staff should make sure	F 371	identified. All other pans were found to be grease free, clean and dry. No other stored scoops were found to be wet or to have food particles on them. the Maintenance Director checked the ice machine and ice scoop holder on the 100 hall and these were found to be clean on 6-17-14. Measures to ensure compliance with this tag include: 1) The maintenance Director will clean ice machines on a monthly basis unless on weekly inspection, an additional cleaning is noted to be needed at which time the Maintenance Director will clean it. Weekly audits are to be done by the maintenance director for 3 months. This monitor will also include checking the ice scoop holder and making sure it is ran through the dish machine at least weekly, 2) Upon daily stocking of resident nourishment room refrigerators, the dietary manager or dietary aide, a check will be completed to ensure all contents are sealed appropriately, dated, and labeled. If any are found out of compliance, the food will be discarded. Housekeeping staff will check cabinets in the resident nourishment rooms daily during cleaning assignments for any inappropriately stored food items to include dating and opened packages of foods. If any are found not stored appropriately, the food will be discarded. Dietary manager or dietary cook will check (at random times) the utencils and pans to make sure that they are clean and stored appropriately. This monitor is to be performed 3 times per week for the next 3	

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F 371	Continued From page 16 all scoops are clean and dry when they are stored for use. c. Observations on 6/17/14 at 4:27 PM revealed five of ten food preparation pans, stored as clean and ready for use, were not dry. These five pans were observed to be stacked on top of other pans and contained moisture on their inner and outer surfaces. Interview with the Dietary Manager on 06/17/14 at 4:29 PM revealed all food preparation pans should be clean and dry when stored by staff. 4. Observations on 06/17/14 of the facility's Nourishment room for halls 100, 200 and 300 revealed the following problems with food storage: a. Observations on 06/17/14 at 4:34 PM revealed an opened and undated 7.5 ounce package of pizza rolls was stored in the nourishment room's freezer. This undated package of pizza rolls was not closed and the package's contents was unprotected from possible contamination. Interview with the facility's Dietary Manager, on 06/17/14 at 4:34 PM revealed all foods stored in the nourishment room's freezer should be dated when opened and completely closed when stored by staff. b. Observations on 6/17/14 at 4:40 PM revealed two brownies wrapped in a piece of unlabeled and undated aluminum foil were stored in a nourishment room cabinet. Both brownies were observed to be very hard and had a very dried out appearance.	F 371	months. If any of these are found to be wet or soiled then they will be run back through the dishwasher by the dietary manager or cook and air-dried. Findings will be reported to the dietary manager. 3) the dietary manager, cooks and/or aides will do a daily monitor ensuring that refrigerated items are dated, labeled, and appropriately sealed, and disposed of by expiration date in the dietary department 4) Inservicing provided to dietary staff and maintenance director regarding tag 371 Food Procure, Store/Prepare, Serve-Sanitary and how it relates to this alleged deficient practice on 7-14-14 by the ADON. Monitors regarding the ice machine will be kept by the maintenance director, the monitor on the nourishment room cabinets will be kept by the Director of Housekeeping, and the others noted in this POC will be kept by the dietary manager. Monitors will be brought to Quality Assurance (QA) monthly for review for 3 months. This committee will also determine if changes are necessary to this plan in order to achieve compliance. The plan of correction is the centers credible allegation of compliance. Preparation and or/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. the plan of correction is prepared and /or executed solely because it is required by the provisions of federal	

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F 371	Continued From page 17 Interview with the Dietary Manager (DM) on 06/17/14 at 4:40 PM revealed all stored leftover foods should be labeled and dated by staff and staff should check the nourishment room's storage cabinets each day to identify any food storage concerns. The DM stated she was unable to recall the last time brownies were served to residents because it had been awhile since they were on the facility menu.	F 371	and state law.	