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	345305	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 253 SS=E	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 interview the facility failed to label and properly store personal hygiene products and resident care equipment on 4 of 5 resident halls. The findings included: 1. a. Observations of room 202 on 08/23/16 at 11:34 AM revealed an unlabeled and uncovered toothbrush on the shelf over the shared sink and an unlabeled wash basin on the floor under the shared sink. Observations of room 202 on 08/24/16 at 1:54 PM revealed 4 unlabeled and uncovered toothbrushes on the shelf over the shared sink and an unlabeled wash basin on the floor under the shared sink. Observations of room 202 on 08/25/16 at 8:35 AM revealed 4 unlabeled and uncovered toothbrushes on the shelf over the shared sink and an unlabeled wash basin on the floor under the shared sink. b. Observations of room 204 on 08/23/16 at 11:20 AM revealed an unlabeled wash basin on the floor under the shared sink. Observations of room 204 on 08/24/16 at 1:56	F 253	Personal items in rooms #202, #204, #207, #208, #210, #211, #302, #305, #307, #311, #312, #403, #405, #409, #504, and #506 were labeled and properly stored on 8/25 & 8/26/16. All residents have the potential to be affected. An audit of resident rooms was initiated on 8/25/16 and completed on 8/26/16 with labeling and storing of personal items as appropriate. Education was initiated by the Administrator and Staff Development Coordinator (SDC) on 9/5/16 and completed 9/15/16 related to ensuring personal items are labeled and stored appropriately, and correct if found unlabeled/ and not stored properly. Upon admission/readmission to the facility, personal items will be labeled by clinical staff and stored appropriately. Facility Department Managers will conduct room rounds five X weekly X 12 weeks to ensure personal items are labeled and stored appropriately. Results of these rounds will be taken to the QAPI Committee meeting monthly until substantial compliance is achieved.	9/22/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/15/2016

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PM revealed an unlabeled wash basin on the floor under the shared sink.

Observations of room 204 on 08/25/16 at 8:35 AM revealed an unlabeled wash basin on the floor under the shared sink.

c. Observations of room 207 on 08/23/16 at 11:47 AM revealed 3 unlabeled wash basins on the floor under the shared sink.

Observations of room 207 on 08/24/16 at 1:58 PM revealed 3 unlabeled wash basins on the floor under the shared sink.

Observations of room 207 on 08/25/16 at 8:35 AM revealed 3 unlabeled wash basins on the floor under the shared sink.

d. Observations of room 208 on 08/23/16 at 11:27 AM revealed 3 unlabeled wash basins on the floor under the shared sink.

Observations of room 208 on 08/24/16 at 3:08 PM revealed 3 unlabeled wash basins on the floor under the sink. In addition, there were two unlabeled emesis basins stacked inside of each other on the shelf over the shared sink that contained a tooth brush, tube of tooth paste, and a tube of denture adhesive which were all unlabeled.

Observations of room 208 on 08/25/16 at 8:36 AM revealed 3 unlabeled wash basins on the floor under the sink. In addition, there were two unlabeled emesis basins stacked inside of each other on the shelf over the shared sink that contained a tooth brush, tube of tooth paste, and a tube of denture adhesive which were all

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unlabeled.

e. Observations of room 210 on 08/23/16 at 11:21 AM revealed an unlabeled wash basin on the floor under the shared sink.

Observations of room 210 on 08/24/16 at 2:00 PM revealed 2 unlabeled wash basins on the floor under the sink. In addition, there were 3 unlabeled and uncovered toothbrushes and 2 unlabeled tubes of toothpaste on the shelf over the shared sink.

Observations of room 210 on 08/25/16 at 8:36 AM revealed 2 unlabeled wash basins on the floor under the sink. In addition, there were 3 unlabeled and uncovered toothbrushes and 2 unlabeled tubes of toothpaste on the shelf over the shared sink.

f. Observations of room 211 on 08/23/16 at 11:22 AM revealed an unlabeled wash basin on the floor under the sink.

Observations of room 211 on 08/24/16 at 2:03 PM revealed an unlabeled and uncovered toothbrush on the shelf over the shared sink.

Observations of room 211 on 08/25/16 at 8:36 AM revealed an unlabeled and uncovered toothbrush on the shelf over the shared sink.

g. Observations of the bathroom for room 302 on 08/22/16 at 2:26 PM revealed 2 unlabeled wet wash basins on the floor under the sink and an unlabeled toothbrush and hair brush on the top of the sink.

Observations of the bathroom for room 302 on

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08/23/16 at 9:30 AM revealed 2 unlabeled wash basins on the floor under the sink and an unlabeled toothbrush and hair brush on the top of the sink.

Observations of the bathroom for room 302 on 08/25/16 at 8:37 AM revealed 2 unlabeled wash basins on the floor under the sink and an unlabeled toothbrush and hair brush on the top of the sink.

h. Observations of the shared bathroom for room 305 on 08/22/16 at 2:28 PM revealed an unlabeled wash basin on the floor under the sink. In addition, there were 2 unlabeled toothbrushes, 2 unlabeled tubes of toothpaste, an unlabeled bottle of mouthwash, and an unlabeled denture cup on top of the sink.

Observations of the shared bathroom for room 305 on 08/24/16 at 2:06 PM revealed an unlabeled wash basin on the floor under the sink. In addition, there were 2 unlabeled toothbrushes, 2 unlabeled tubes of toothpaste, an unlabeled bottle of mouthwash, and an unlabeled denture cup on the top of the sink.

Observations of the shared bathroom for room 305 on 08/25/16 at 8:37 AM revealed an unlabeled wash basin on the floor under the sink. In addition, there were 2 unlabeled toothbrushes, 2 unlabeled tubes of toothpaste, an unlabeled bottle of mouthwash, and an unlabeled denture cup on the top of the sink.

i. Observations of the shared bathroom for room 307 on 08/23/16 at 11:14 AM revealed an unlabeled wash basin on the floor under the sink.

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F 253	Continued From page 4 Observations of the shared bathroom for room 307 on 08/24/16 at 2:15 PM revealed an unlabeled wash basin on the floor under the sink. Observations of the shared bathroom for room 307 on 08/25/16 at 8:38 AM revealed an unlabeled wash basin on the floor under the sink. j. Observations of the shared bathroom for room 311 on 08/22/16 at 4:13 PM revealed an unlabeled wash basin on the floor under the sink. Observations of the shared bathroom for room 311 on 08/24/16 at 2:18 PM revealed an unlabeled wash basin on the floor under the sink with a white plastic spoon inside. Observations of the shared bathroom for room 311 on 08/25/16 at 8:38 AM revealed an unlabeled wash basin on the floor under the sink with a white plastic spoon inside. k. Observations of the bathroom for room 312 on 08/22/16 at 3:23 PM revealed 2 unlabeled wash basins on the floor under the sink. Observations of the bathroom for room 312 on 08/23/16 at 11:12 AM revealed 2 unlabeled wash basins on the floor under the sink. Observations of the bathroom for room 312 on 08/25/16 at 8:38 AM revealed 2 unlabeled wash basins on the floor under the sink. l. Observations of the shared bathroom for room 403 on 08/22/16 at 2:18 PM revealed an unlabeled toothbrush and an unlabeled tube of toothpaste on the top of the sink and an unlabeled emesis basin on the floor under the	F 253		

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sink.

Observations of the shared bathroom for room 403 on 08/24/16 at 2:46 PM revealed an unlabeled toothbrush and an unlabeled tube of toothpaste on table next to the sink and an unlabeled emesis basin on the floor under the sink.

Observations of the shared bathroom for room 403 on 08/25/16 at 8:39 AM revealed an unlabeled toothbrush and an unlabeled tube of toothpaste on table next to the sink and an unlabeled emesis basin on the floor under the sink.

m. Observations for the bathroom for room 405 on 08/22/16 at 2:24 PM revealed an unlabeled wash basin on the floor under the sink and 2 labeled bedpans on the seat cushion of a wheelchair.

Observations for the bathroom for room 405 on 08/24/16 at 2:34 PM revealed 2 labeled bedpans on the seat cushion of a wheelchair.

Observations for the bathroom for room 405 on 08/25/16 at 8:39 AM revealed 2 labeled bedpans on the seat cushion of a wheelchair.

n. Observations of the bathroom for room 409 on 08/22/16 at 2:41 PM revealed an unlabeled wash basin on the back of the commode.

Observations of the bathroom for room 409 on 08/24/16 at 2:37 PM revealed an unlabeled wash basin on the floor under the sink.

Observations of the bathroom for room 409 on

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F 253	Continued From page 6 08/25/16 at 8:39 AM revealed an unlabeled wash basin on the floor under the sink. o. Observations of the shared bathroom for room 504 on 08/23/16 at 9:28 AM revealed an unlabeled toothbrush, an unlabeled tube of toothpaste, and 2 unlabeled hairbrushes on top of the sink. Observations of the shared bathroom for room 504 on 08/24/16 at 3:00 PM revealed an unlabeled toothbrush, an unlabeled tube of toothpaste, an unlabeled comb, and 2 unlabeled hairbrushes on top of the sink. Observations of the shared bathroom for room 504 on 08/25/16 at 8:40 AM revealed an unlabeled toothbrush, an unlabeled tube of toothpaste, an unlabeled comb, and 2 unlabeled hairbrushes on top of the sink. p. Observations of the shared bathroom for room 506 on 08/23/16 at 9:22 AM revealed an unlabeled toothbrush, an unlabeled tube of toothpaste, and an unlabeled comb on top of the sink. Observations of the shared bathroom for room 506 on 08/24/16 at 3:03 PM revealed an unlabeled toothbrush, 2 unlabeled tube of toothpaste, and an unlabeled comb on top of the sink. Observations of the shared bathroom for room 506 on 08/25/16 at 8:40 AM revealed an unlabeled toothbrush, 2 unlabeled tube of toothpaste, and an unlabeled comb on top of the sink.	F 253		

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An interview was conducted with the Director of Nursing (DON) on 08/25/16 at 9:02 AM. The DON stated she expected resident's personal hygiene products to placed in bags and stored in the bedside table. The DON further stated wash basins, emesis basins, bed pans should be labeled and stored in the top of the closet or bagged and stored off the floor.

On 08/25/16 at 9:05 AM the DON was accompanied to rooms 202, 204, 207, 208, 210, and room 211. The DON observed the unlabeled and improperly stored personal hygiene products and personal care equipment in these rooms and stated it was not acceptable. The DON further stated it would not be necessary to observe the remaining rooms with concerns because she was going to gather the team and go room to room correct this immediately.

An interview with Nurse Aide (NA) #1 on 08/25/16 at 10:16 AM revealed they typically put resident's personal hygiene supplies in an emesis basin and stored them in the bathroom. NA #1 stated they usually labeled the emesis basin with an "A" or "B" so they would know which resident the supplies belonged to but did not label the individual supplies with a resident name. The interview further revealed wash basins and emesis basins were labeled with an "A" or "B" and stored off the floor.

During an interview on 08/25/16 at 3:02 PM the Administrator stated the administrative staff conducted rooms rounds daily and the staff needed to do a better job monitoring residents' rooms. The Administrator further stated he planned to improve the current system to include observing for storage of personal hygiene

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F 253	Continued From page 8 products and personal care equipment.	F 253		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		9/22/16

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This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews, the facility failed to complete Care Area Assessments that addressed the underlying causes and contributing factors for psychotropic drug use, cognitive loss, dementia, psychotropic drug use, and psychosocial well-being for 8 of 14 sampled residents (Residents #2, #60, #21, #12, #48, #96, #113, #112)

The findings included:

1. Resident #2 was admitted on 11/18/15 with diagnoses including Alzheimer's disease, anxiety disorder, and depression.

Review of the significant change Minimum Data Set dated 06/20/16 revealed Resident #2 had severely impaired cognition and there were no behaviors or rejection of care noted. The significant change MDS further revealed Resident #2 received antianxiety and antidepressant medications during the last 7 days.

Review of the Care Area Assessment (CAA) summary for Psychotropic Drug Use dated 06/23/16 revealed Resident #2 received Trazodone and Effexor (antidepressant medications) daily and had as needed Klonopin ordered for anxiety. The CAA Summary further noted Resident #2 was at risk for side effects of these medications. There was no documentation in the summary/analysis of contributing factors, description of the problem, or risk factors related

1 - Residents_ #, #60, #21, #48, #96, #113 and#112 will have CAAs completed as appropriate on their next comprehensive assessment.

2 - All residents have the potential to be affected. An audit of current residents comprehensive assessments was completed on 9/12/16 to verify triggered CAAs addressed the following: causes and contributing factors to the residents problems, any complications effecting the care areas triggered, and any risk factors related to the problem sufficient to ensure that problems are care planned appropriately.

3 - The Director of Clinical Reimbursement educated the IDT team (ADON, RN MDS, Dietary Manager, and Activities - the social worker position is currently vacant) on 9/16/16 regarding ensuring that triggered CAAs are care planned as appropriate.

4 - Nursing administration team members (DON, ADON, SDC & RN Supervisor) will review CAAs from completed comprehensive assessments, per the MDS schedule before transmission, to ensure triggered CAAs contain contributing factors, description of problem, and risk factors sufficient to

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F 272	Continued From page 10 to the care area. The CAA did not indicate if there had been any behavior monitoring, adverse drug reactions or attempted dose reductions. The CAA did not indicate if a referral was necessary or if mental health services had seen Resident #2. An interview was conducted with MDS Coordinator #1 on 08/25/16 at 3:15 PM. MDS #1 confirmed she had completed the CAA Summary for Psychotropic Drug Use dated 06/23/16 for Resident #2. MDS Coordinator #1 stated she had taken the position in November 2015 and had had some training but could not recall how much of the training she had received focused on writing the analysis of findings for the CAA. MDS Nurse #1 stated she typically reviewed the medical record, observed the resident, talked with staff, reviewed medications, and reviewed psychiatric services notes if available. MDS Nurse #1 agreed she should include more resident specific details in the analysis of findings. 2. Resident #60 was admitted on 05/24/12 with diagnoses including dementia, bipolar disorder, anxiety disorder, depression, schizophrenia, and obsessive-compulsive disorder. Review of the annual Minimum Data Set (MDS) dated 07/27/16 revealed Resident #60 was cognitively intact and no behaviors or rejection of care were noted. The annual MDS further revealed Resident #60 received antipsychotic, antidepressant, and antianxiety medications daily during the 7 day assessment period. Review of the Care Area Assessment (CAA) summary for Psychotropic Drug Use dated 08/02/16 revealed Resident #60 had diagnoses including schizophrenia, bipolar disorder,	F 272	ensure problems are care planned appropriately, with corrections made as appropriate. Results of these reviews will be taken to the QAPI Committee meeting monthly until substantial compliance is achieved.	

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obsessive-compulsive disorder and insomnia. His current medications were listed and it was noted he was at risk for adverse medication side effects and falls. The CAA Summary further noted a family member stated Resident #60 had been on psychotropic mediations for years. There was no documentation in the summary/analysis of contributing factors, description of the problem, or risk factors related to the care area. The CAA did not indicate if there had been any behavior monitoring, adverse drug reactions or attempted dose reductions. The CAA did not indicate if a referral was necessary or if mental health services had seen Resident #60.

An interview was conducted with MDS Coordinator #1 on 08/25/16 at 3:15 PM. MDS #1 confirmed she had completed the CAA Summary for Psychotropic Drug Use dated 08/02/16 for Resident #60. MDS Coordinator #1 stated she had taken the position in November 2015 and had had some training but could not recall how much of the training she had received focused on writing the analysis of findings for the CAA. MDS Nurse #1 stated she typically reviewed the medical record, observed the resident, talked with staff, reviewed medications, and reviewed psychiatric services notes if available. MDS Nurse #1 agreed she should include more resident specific details in the analysis of findings.
3. Resident #21 was admitted to the facility on 07/12/16 with diagnoses including chronic obstructive pulmonary disease, recurrent major depressive disorder, and multiple sclerosis.

The admission Minimum Data Set (MDS) dated 07/19/16 coded her as being cognitively intact, rejecting care 1 to 3 days in the previous 7 days, receiving pain medications for frequent pain that

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affected her day to day activities.

The Care Area Assessment (CAA) for cognition dated 07/11/16 and completed by the social worker stated Resident #21 was unable to recall the word sock. The CAA continued stating the resident was experiencing cognitive loss. The causative factors may include mood state, medical problems,psychiatric/mood disorder and pain. She was noted at risk for increased cognitive loss due to the above factors. A care plan would be developed.

The CAA for behaviors dated 07/19/16 and completed by the social worker stated Resdient #21 refused medication on 07/13 and 07/19/16. The CAA continued stating the resdient was exhibiting behavioral symptoms. The causative factors may include medical problems, pain, and long-standing mental health problems. She ws noted to be at risk for increased exhibition of behavioral symptoms due to the above factors. A care plan was to be developed.

An interview with the social worker was conducted on 08/25/16 at 12:02 PM. He stated he had some training with corporate staff on writing CAAs. He stated he just wrote down what items were checked on the MDS. He stated on the cognitive CAA he wrote what questions the resident got wrong on the brief interview for mental status questions. Regarding behaviors he wrote she refused medications but he did not ask her why she refused medications even though she was interviewable. He stated he was not trained to include any more information or analysis of what was checked on the CAA.

4. Resident #12 was admitted to the facility on

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04/21/01 with diagnoses including paraplegia, history of traumatic brain injury, anxiety, depressive disorder and psychosis.

The annual Minimum Data Set (MDS) dated 04/03/16 coded him with moderately impaired cognition, having no behaviors, requiring extensive assistance with most activities of daily living skills and having upper and lower extremity impairment.

The cognitive Care Area Assessment (CAA) was completed by the social worker and dated 04/13/16. he CAA stated the resdient answered '2015' for the year and required a cue to recall blue and was unable to recall bed. The CAA continued stating the resident was experiencing cognitive loss. The causative factors may include traumatic brain injury, mood state, psychiatric/mood disorder and pain. He was noted to be at risk for further cognitive decline due to the above factors. A care plan would be developed.

The CAA failed to describe Resident #12's strengths and weaknesses, how his cognitive impairment affected him, risk factors due to cognitive impairment, and factors to be considered in developing a care plan.

An interview with the social worker was conducted on 08/25/16 at 12:02 PM. He stated he had some training with corporate staff on writing CAAs. He stated he just wrote down what items were checked on the MDS. He state on the cognitive CAA he wrote what questions the resident got wrong on the brief interview for mental status questions. He further stated that Resident #12 could make his own decisions and

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remember things. He stated he was not trained to include any more information or analysis of what was checked on the CAA.

5. Resident #48 was admitted to the facility on 03/21/16. His diagnoses included encephalopathy, bipolar dementia, personality disorder, major neurocognitive disorder and chronic hypoxemic respiratory failure secondary to chronic obstructive pulmonary disease.

The admission Minimum Data Set (MDS) dated 03/28/16 coded him with severely impaired cognitive abilities, having mood issues, and daily rejection of care. He was coded with being independent with most activities of daily living skills including bed mobility, transfers, walking, dressing and eating.

The Care Area Assessment (CAA) for cognition, dated 03/28/16 and completed by the social worker, stated the resident answered 'I don't know' for the year and 'October' for the month and he was unable to recall bed (during the brief interview for mental status). The CAA continued stating he was experiencing cognitive loss. Causative factors may include dementia, mood state, medical problems, psychiatric/mood disorder and insufficient sleep. He was noted at risk for increased cognitive loss due to those factors. A care plan would be developed.

The CAA failed to describe Resident #48's strengths and weaknesses, how his cognitive impairment affected him, risk factors due to cognitive impairment, and factors to be considered in developing a care plan.

An interview with the social worker was

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conducted on 08/25/16 at 12:02 PM. He stated he had some training with corporate staff on writing CAAs. He stated he just wrote down what items were checked on the MDS. He state on the cognitive CAA he wrote what questions the resident got wrong on the brief interview for mental status questions. He stated he was not trained to include any more information or analysis of what was checked on the CAA.

6. Resident #96 was admitted to the facility on 09/22/14 with the current diagnoses of dementia, seizure disorder, anxiety disorder, depression and psychotic disorder.

Review of the annual Minimum Data Set (MDS) dated 07/29/16 revealed Resident #96 was severely cognitively impaired.

Review of the Care Area Assessment (CAA) dated 07/29/16 for Cognitive Loss/Dementia revealed Resident #96 was unable to answer any questions related to temporal orientation. He required a cue to recall sock, blue and bed. The CAA further stated Resident #96 experienced severe cognitive loss with the causative factors including dementia, psychiatric/mood disorder and pain. Resident #96 was at risk for increased cognitive loss due to the above factors. Will proceed to care plan based on risk factors.

During an interview conducted on 08/25/16 at 12:02 PM the Social Worker (SW) stated he had written the CAA for Resident #96 for cognitive loss/dementia. He stated he had training from the corporate staff on how to write CAAs. The SW stated he wrote the CAA from the items that were checked on the MDS and from the questions the resident missed on the brief interview for mental

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status questions. He further stated he had not been trained to include any more information or analysis about the resident on the CAA.

7. Resident #113 was admitted to the facility on 03/23/16 with diagnoses of Alzheimer's disease, anxiety, depression and psychotic disorders.

Review of the annual Minimum Data Set (MDS) dated 03/30/16 revealed Resident #113 was severely cognitively impaired.

Review of the Care Area Assessment (CAA) dated 03/30/16 for Cognitive Loss/Dementia revealed Resident #113 was unable to participate in the assessment. Staff report she was not able to make choices regarding clothing or food. The CAA revealed Resident #113 experienced cognitive loss with the causative factors including delirium, dementia and insufficient reorientation reminders. Resident #113 was at risk for increased cognitive loss due to the risk factors. Will proceed to care plan.

During an interview conducted on 08/25/16 at 12:02 PM the Social Worker (SW) stated he had written the CAA for Resident #113 for cognitive loss/dementia. He stated he had training from the corporate staff on how to write CAAs. The SW stated he wrote the CAA from the items that were checked on the MDS and from the questions the resident missed on the brief interview for mental status questions. He further stated he had not been trained to include any more information or analysis about the resident on the CAA.

8. Resident # 112 was readmitted on 4/12/16 with diagnoses that included acute kidney failure, diabetes, heart failure, anxiety, and recurrent

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major depressive disorder.

The quarterly Minimum Data Set (MDS) dated 7/14/16 coded Resident # 112 as cognitively intact and required extensive to total assistance of 2 staff persons for all activities of daily living except eating. The MDS further indicated that Resident #112 had received antianxiety, antidepressant and pain medications daily during the 7 day assessment period.

The Care Area Assessment (CAA) for psychosocial well-being dated 4/22/16 and completed by the social worker on 5/6/16, indicated that Resident #112 answered it was not very or at all important for him to do his favorite activities during the interview for activity preferences. The CAA further indicated Resident #112 was at risk for declining psychosocial well-being due to causative factors that may include depression and health problems. The CAA summary/analysis did not include a description of the problem, contributing factors or related risk factors.

An interview was conducted with the Social Worker (SW) on 8/25/16 at 12:02 PM. The SW confirmed that he had completed the psychosocial well-being CAA for Resident #112. The SW stated that he had received training from corporate staff on how to write CAAs and based his summary on the items checked on the MDS. The SW stated that he was not trained to include any more information or description about a Resident in the CAA summary other than what had been checked.

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to develop a care plan which met the needs of the residents as stated in the assessment. This affected 2 of 14 residents reviewed for care planning. Resident #10's mood care area assessment indicated a care plan would be developed which was not completed. Resident #21's smoking assessment did not match the smoking care plan. The findings included: 1. Resident #10 was admitted to the facility most	F 279	(1)Resident # 10 Care Plan for Mood was initiated on 8/26/16. Resident #21 Care Plan was updated on 8/25/16 to reflect requires supervision during designated smoking times. (2)Residents who trigger on the care area assessment have the potential to be affected. Current residents MDS were reviewed to verify triggered CAAs and Care plan were correct on 9/12/16. Residents who smoke have the potential to be affected. Care plans for residents	9/22/16

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F 279	Continued From page 19 recently on 11/01/13. Her diagnoses include peripheral vertigo, heart disease, atrial fibrillation, and post traumatic osteoarthritis. Her annual Minimum Data Set, dated 08/01/16, coded her with intact cognition. Per the resident mood interview, she was coded on the MDS as having little interest or pleasure in doing things and feeling down, depressed or hopeless 2 to 6 days out of the previous 14 days. She also was coded as having thoughts of being better off dead or of hurting herself in someway 2 to 6 days out of the last 14 days. The Care Area Assessment (CAA) dated 08/01/16, and written by the social worker, for mood stated she answered she had been feeling depressed, having difficulty sleeping and feeling tired every day over the last two weeks. She reported having little interest in doing things and having thoughts she would be better off dead without thoughts of self harm on several days over the last two weeks. The CAA noted the psychologist had been notified. The CAA indicated a referral was made to the psychologist and the facility would proceed to care planning based on these factors. Review of the care plans revealed there were no care plans developed which addressed her depressed mood, being tired, having little interests in doing things, thoughts of being better off dead or need for a psychologist intervention. Interview with the social worker on 08/25/16 at 3:10 PM revealed the social worker was responsible for writing the care area assessments, however, the MDS Coordinator was responsible for developing the care plan.	F 279	who smoke have been reviewed and corrections made as appropriate. (3)The Director of Clinical Reimbursement educated the IDT team (ADON, RN MDS, Dietary Manager, and Activities - the social work position is currently vacant) on 9/16/16 regarding ensuring triggered CAAs are care planned as appropriate. Nurse Managers were educated on 9/12/16 regarding updating and verifying information regarding supervised smokers. (4)The MDS Coordinator will audit care plans upon completion to ensure triggered CAAs have been properly and correctly care planned weekly X 4 weeks, then monthly X 3 months. MDS Coordinators will audit care plans for supervised smokers to ensure accuracy of care plan to smoking assessment 3 X week X 4 weeks, then weekly X 4 weeks, then monthly X 3 months. Nursing administration team members (DON, ADON, SDC & RN Supervisor) will review CAAs from completed comprehensive assessments, per the MDS schedule before transmission, to ensure triggered CAAs contain contributing factors, description of problem, and risk factors sufficient to ensure problems are care planned appropriately, with corrections made as appropriate. Results of these audits will be taken to the monthly QAPI Committee meeting X 4 months to ensure ongoing substantial compliance.	

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Interview with MDS Coordinator #1 on 08/25/16 at 3:11 PM revealed that she received the mood care area assessment from the social worker and then developed the care plan. She reviewed the care area assessment and reviewed the V section on the MDS where both indicated a care plan for mood would be developed. She then reviewed the care plans and stated she missed developing a care plan for mood.

2. Resident #21 was admitted to the facility on 07/12/16. Her diagnoses included chronic obstructive pulmonary disease, heart failure, recurrent major depressive disorder, degenerative arthritis, multiple sclerosis and tobacco abuse.

The Smoking Safety Evaluation dated 07/12/16 noted her cognition was intact, she had impaired vision with or without glasses, she did not demonstrate the ability to light a cigarette safely, and she did not demonstrate appropriate use of an ashtray. Handwritten notes indicated she was to start a medication to help her stop smoking when it was available from the pharmacy. The evaluation noted she required supervision of a staff or family member to light the cigarette and/or remain in attendance while the cigarette was burning. Interventions to be implemented included the use of a smoking apron, direct observation by staff and smoking materials to be maintained by staff.

Her admission Minimum Data Set dated 07/19/16 coded her with intact cognition, rejecting care 1 to 3 days over the previous 7, and having severe pain that limited day to day activity.

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F 279	Continued From page 21 The initial care plan identified the problem onset as 07/23/12 (sic date) identified the problem of Resident #21 being at risk for injury related to smoking. The goal was to have no smoking related injury through the next review period. Interventions included that Resident #21 was able to smoke independently at this time, she was to leave her oxygen inside the facility while she was outside smoking and she was to turn in smoking materials to the nurse when not in use. The care plan indicated Resident #21 was present when the care plans were reviewed on 07/28/16. On 08/24/16 at 10:11 AM and on 08/24 at 4:19 PM, Resident #21 was observed in the courtyard wearing a smoking apron and smoking under direct staff supervision. On 08/25/16 at 9:58 AM, MDS Coordinator #1 was interviewed. MDS Coordinator stated the original smoking assessment was completed by the admission nurse upon admission and the MDS staff completed the quarterly smoking assessments. MDS Coordinator #1 stated that the facility currently had no residents who were deemed safe to smoke independently. She then reviewed the smoking assessment dated 07/12/16 and the care plan. MDS Coordinator stated that she was careless when the smoking care plan was established as it was incorrect and Resident #21 needed to be supervised during smoking.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		9/22/16

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F 281	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interviews the facility failed to follow a physician's order for referral to an orthopedic doctor for 1 of 3 sampled residents reviewed for pain (Resident #18). Findings included: Resident #18 was admitted on 6/14/16 with diagnoses that included vascular dementia, morbid obesity, hypertension, and chronic pain. The admission Minimum Data Set (MDS) dated 6/21/16 coded Resident #18 as having mild cognitive impairment but able to make her needs known. The MDS indicated that Resident #18 required limited assistance of one staff person for transfers, dressing, toileting, and bathing. MDS coded Resident #18 as having frequent pain that interfered with her sleeping and limited her day-to-day activities. A review of Resident #18's care plan, dated 6/21/16, revealed an active plan in place for pain. The pain care plan included a goal that Resident #18 would verbalize that her pain had decreased to an intensity of 3 or less. Interventions included to evaluate Resident #18's pain daily using a 1-10 pain level scale, administer pain medication as ordered and monitor for worsening pain symptoms.	F 281	Resident #18 was seen by the Orthopedist on 9/1/16. All residents have the potential to be affected. An audit of resident appointments was completed on 8/24/16 by the Ward Secretary with appointments made as necessary. SDC initiated education on 8/24/16, which was completed on 9/12/16 for licensed staff regarding the process for scheduling appointments. The Unit Manager will review MD orders received for appointments 5 X weekly and take to daily stand up meeting. If there is an order for an appointment, the Unit Manager will follow up with the Unit Secretary to ensure appointment has been scheduled. Results for these reviews will be taken to the QAPI Committee meeting until substantial compliance is achieved.	

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F 281	Continued From page 23 A review of the Medication Administration Record (MAR) for August 2016 revealed that Resident #18 received scheduled pain medication as ordered on a daily basis. The MAR revealed that Resident #18 received PRN pain medication daily and on 12 days, had received an additional 2-3 doses due to complaints of pain. Pain assessments documented on the MAR for each shift indicated Resident #18's pain level was 8-10 on most days. A review of the physician telephone orders revealed an order dated 7/21/16 to "consult Ortho due to chronic low back pain for possible steroid injection." The physician order also revealed that Resident #18 had been notified of the consult referral on 7/21/16. A review of the restorative therapy notes for July 2016 revealed that Resident #18 received restorative therapy for range of motion to upper and lower extremities and ambulation for the period 7/5/16 through 7/31/16. Restorative therapy notes revealed that Resident #18 refused all programs due to back pain on 7/5/16, 7/7/16, 7/8/16, 7/9/16, 7/10/16, 7/11/16, 7/19/16, 7/22/16, 7/23/16, 7/24/16, and 7/25/16. An interview on 8/22/16 at 3:11 PM with Resident #18 revealed that her pain had been ongoing for several years after slipping on a piece of ice while at work. Resident #18 stated that on a daily basis she experienced pain from migraine headaches, leg cramps and lower back. Resident # 18 stated "they have changed my medications numerous	F 281		

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F 281	Continued From page 24 times but can't seem to get the dose right." Resident #18 confirmed that she had not had an appointment with an orthopedic physician while a resident of the facility. An interview on 8/24/16 with the Unit Secretary (US) revealed that when an order for a consult referral is received, the nurse would place a copy of the order into her box for the appointment to be scheduled. US stated that the box is checked daily and the specialist's office would be contacted to schedule an appointment. US reviewed the physician order for Resident #18 and stated she had not remembered getting the original order for the referral. US confirmed that no appointment had been scheduled for Resident #18 to see an orthopedic physician but would call and make the appointment. An interview was conducted on 8/24/2016 at 4:20 PM with the Director of Nursing (DON). DON confirmed that no appointment for an orthopedic referral had been scheduled for Resident #18 as ordered by the physician. DON stated it was her expectation that all appointments would be scheduled when the initial order was received from the physician. Once the appointment had been arranged, she would then expect for the date/time of the appointment to be communicated to the transport driver and responsible party.	F 281		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment	F 319		9/22/16

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F 319	Continued From page 25 difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow through with a referral to the psychologist for 1 of 2 sampled residents reviewed with referrals to the psychologist (Resident #10). The findings included: Resident #10 was most recently admitted to the facility on 11/01/13. Her diagnoses included peripheral vertigo, heart disease, atrial fibrillation, and post traumatic osteoarthritis. The annual Minimum Data Set dated 08/01/16 coded her with intact cognition, scoring a 15 out of 15 on the brief interview for mental status, having little interest or pleasure in doing things and feeling down, depressed or hopeless 2 to 6 days in the previous 14 days. She was noted a being tired 12 to 14 days in the previous 14 days and having thoughts she would be better off dead or of hurting herself in some way 2 to 6 days in the previous 14 days. The Care Area Assessment (CAA) dated 08/01/16, and written by the social worker, for mood stated she answered she had been feeling depressed, having difficulty sleeping and feeling tired every day over the last two weeks. She reported having little interest in doing things and having thoughts she would be better off dead without thoughts of self harm on several days over the last two weeks. The CAA noted the	F 319	Resident #10 was referred for psych consult, evaluation and treatment on 8/29/16. All residents had the potential to be affected. An audit of current residents medical records was completed by the MDS Coordinators on 8/26/16 to ensure all psych consults had been followed through. The MDS Coordinator educated the Social Worker on 8/26/16 regarding the proper method of referring residents for psych consults. MD orders will be reviewed during the morning stand up meeting; any orders for psych consults will be given to the SW/Designee, the SW/Designee will then notify the consulting psych services provider of the referral and place the order in the psych book. In the event of an emergency psych need, the resident will be sent to the local acute care facility. The SDC will audit the MD orders for psych consults and ensure that the referrals have been completed as ordered. Results for these reviews will be taken to the QAPI Committee meeting until substantial compliance is achieved.	

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psychologist had been notified. The CAA indicated a referral was made to the psychologist and the facility would proceed to care planning based on these factors.

Review of the care plans revealed there were no care plans developed which addressed her depressed mood, being tired, having little interests in doing things, thoughts of being better off dead or need for a psychologist intervention.

Review of the medical record revealed no physician's order for a psychologist visit or any psychologist visit note.

Resident #10 was observed on 08/23/16 at 1:59 PM going to a tea party activity. She was observed by the nursing station on 08/24/16 at 9:23 AM talking with another resident. On 08/24/16 at 9:31 AM she actively participated in walking with restorative staff.

Interview with the social worker on 08/25/16 at 12:02 PM revealed he did not need an order for the psychologist to see a resident. He stated sometimes he will email the psychologist or tell him as he passes in the hall his concerns. The social worker further stated that he was not aware who the psychologist saw on his visits or what his impressions were of the visit. The social worker stated sometimes the psychologist would see who the social worker mentioned and sometimes he would not. The social worker never followed up to ensure a resident received the psychologist services and never read the notes in the chart if there were some as he did not consider it his business. The social worker stated the psychologist asked about Resdient #10 today.

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F 319	Continued From page 27 An interview with the psychologist was conducted on 08/25/16 at 12:35 PM. The psychologist stated he had seen Resident #10 a long time ago and was unaware of any need to see her recently. He stated he received no referral this month regarding Resident #10. He stated he has been to the facility about 3 times this month. He further stated that after he sees a resident, he will email the social worker of concerns or recommendations he may have following his visit unless his concerns relate to immediate danger to the resident or others. If he has immediate concerns he will relate those to the Director of Nursing or the physician. He will also leave his visit notes in the file to be placed in the medical record the following week. Interview with the Director of Nursing (DON) and Administrator on 08/25/16 at 3:29 PM revealed that when the psychologist comes to the facility he will tell the DON who he going to see as a new patient, based on the social worker's recommendation, so that she can obtain a physician's order. The DON further stated that she does not read the CAAs and will not know who the social worker refers to the psychologist in order to obtain the physician's order.	F 319		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning;	F 328		9/22/16

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F 328	Continued From page 28 Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide physician ordered continuous oxygen therapy to 1 of 2 residents reviewed for respiratory care (Resident #61). The findings included: Resident #61 was admitted on 06/30/16 with diagnoses including acute on chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease. Review of the medical record revealed a physician's order dated 07/01/16 for Resident #61 to be administered continuous oxygen at 2 L/min (liters per minute) via NC (nasal cannula). Review of the admission Minimum Data Set dated 07/08/16 revealed Resident #61 was cognitively intact and received oxygen therapy. Review of a care plan dated 07/08/16 revealed Resident #61 had COPD and was at risk for fatigue and shortness of breath. Interventions included: check oxygen saturations as directed, notify the physician if she becomes symptomatic of a respiratory infection, administer medications as ordered, pace activities to conserve energy, and administer oxygen as directed. Observations of Resident #61's August 2016	F 328	Resident #61 oxygen was adjusted to 2 LPM as ordered on 8/24/16. All residents have the potential to be affected. An audit of residents receiving oxygen was initiated on 8/24 and completed on 8/25/16 to ensure that oxygen was set at the correct flow rate. 1:1 verbal education with Nurse #2 was completed by the SDC on 8/24/16. SDC initiated education for licensed staff on 8/24/16 and completed on 9/12/16 related to the provision of oxygen therapy per MD order, to include a visual check of the flow rate meter as verification oxygen delivery at the ordered rate. DON/ADON will conduct audits, to include the visualization of oxygen flow meters to ensure oxygen delivery per MD order 3 times weekly X 4 weeks, then weekly X 4 weeks, then monthly. Results for these reviews will be taken to the QAPI Committee meeting until substantial compliance is achieved.	

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Medication Administration Record (MAR) revealed and order for Oxygen at 2 L/min via NC continuous. Nurses had initialed the MAR once on each of the three shifts daily including 08/24/16 for the 7:00 AM to 3:00 PM shift.

Observations of Resident #61 were as follows:
- On 08/22/16 at 3:21 PM Resident #61 was awake in bed with a NC in her nostrils. The oxygen tubing was attached to an oxygen concentrator set at 3.5 L/min.
- On 08/22/16 at 6:50 PM Resident #61 was awake in bed with a NC in her nostrils. The oxygen tubing was attached to an oxygen concentrator set at 3.5 L/min.
- On 08/23/16 at 3:28 PM Resident #61 was awake in bed with a NC in her nostrils. The oxygen tubing was attached to an oxygen concentrator set at 3.5 L/min.
- On 08/24/16 at 9:42 AM Resident #61 was awake in bed with a NC in her nostrils. The oxygen tubing was attached to an oxygen concentrator set at 3.5 L/min.

During an interview on 08/24/16 at 11:09 AM Nurse #2 reviewed Resident #61's order for Oxygen at 2 L/min via NC continuous on the August 2016 MAR. Nurse #2 confirmed she had initialed the block for 08/24/16 on the 7:00 AM to 3:00 PM shift. Nurse #2 stated when she initialed the MAR it meant the resident had their NC in place and she also usually glanced at the setting on the oxygen concentrator. Nurse #2 did not recall if she had checked the setting on Resident #61's oxygen concentrator before she initialed the MAR on 08/24/16. Nurse #2 indicated Resident #61's oxygen saturation was 95% when she checked it this morning.

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F 328	Continued From page 30 On 08/24/16 at 11:12 AM Nurse #2 was accompanied to Resident #61's room and confirmed the oxygen concentrator was set at 3.5 L/min. Nurse #2 could not explain how the oxygen concentrator setting had been changed to 3.5 L/min and turned the setting on the oxygen concentrator to 2 L/min. An interview was conducted with the Director of Nursing (DON) on 08/25/16 at 8:56 AM. The DON stated she expected the nurses to check the setting on resident's oxygen concentrators every shift before they initialed the resident's MAR.	F 328		
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: Based on observations, record review and staff interviews, the facility failed to maintain the convection oven and deep fryer clean and free of grease and dust. The findings included: 1. a. The deep fryer:	F 371	The convection oven, to include the back of the oven, which was removed and the sides of the deep fat fryer were cleaned on 8/24/16. All residents have the potential to be affected. A dietary/kitchen audit was completed on 8/25/16 with identified	9/22/16

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F 371	Continued From page 31 On 08/24/16 during the kitchen inspection beginning at 10:37 AM the deep fryer was observed full of clean clear grease but the fryer had thick sticky grease covering both sides of the fryer. The left side had thicker greasy residue attached which could be scraped off with a fingernail. Interview with the Dietary Manager at this time revealed the deep fryer was cleaned every week and after fish was fried. She further stated the sides were wiped down but the build up could not be cleaned off. The Dietary Manager referred to the cleaning schedule which showed the fryer was cleaned 08/23/16. On 08/24/2016 2:07 PM the dietary cook stated during interview when she cleaned the fryer on 08/23/16, she wiped the sides of the fryer down but the greasy residue could not be removed. Per the dietary cook, maintenance staff will occasionally take the deep fryer outside and scrub it down. On 08/25/2016 9:09 AM the Maintenance Director was interviewed and revealed that the cleaning of the deep fryer was done by the kitchen staff not the maintenance department. b. On 08/24/16 during the kitchen inspection beginning at 10:37 AM the open weave patterned back of the convection oven that faced the deep fryer was observed with a thick coating of grease and dust. The Dietary Manager present at this observation stated that the maintenance department cleaned it for the kitchen. On 08/25/2016 9:09 AM the Maintenance Director was interviewed and revealed that he cleaned the back of the convection oven about a year ago at the Dietary Manager's request. He further stated	F 371	areas/items cleaned as appropriate. The CDM was educated by the Administrator on 8/25/16 regarding storing, preparing, distributing and serving food under sanitary conditions, to include ensuring the cleaning schedule is followed. The dietary staff was educated by the CDM on 8/26/16 regarding following the cleaning schedule, who is responsible for checking the cleaning schedule for completion at the end of the shift and who is responsible for ensuring scheduled tasks have been accomplished. The CDM will conduct daily audits to ensure the cleaning schedule from the previous day was completed, in the event something was not completed, the CDM will immediately ensure it is cleaned as appropriate. The Administrator/Designee will conduct weekly dietary rounds with the CDM to ensure dietary cleanliness/sanitation. RD consultant will monitor dietary sanitation every other month. Results for these reviews will be taken to the QAPI Committee meeting until substantial compliance is achieved.	

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F 371	Continued From page 32 that it was not on his cleaning schedule and he only cleaned it upon the Dietary Manager's request. c. On 08/24/16 during the kitchen inspection beginning at 10:37 AM the top half of the convection oven was observed soiled with dark greasy debris over the window area and bottom of the oven. The Dietary Manager who was present at this observation stated that the convection oven was to be cleaned weekly. Review of the cleaning schedule revealed the last time it was cleaned was on 08/08/16. The dietary cook's initials were next to the 08/08/16 date of the last cleaning. The dietary cook stated during interview at the time of the observation she was supposed to clean it weekly but sometimes ran out of time. When asked what she did when she ran out of time, she responded that she informed the Dietary Manager. At this time the Dietary Manager was asked if she was aware the cook did not have time to clean it and the Dietary Manager stated she was aware the cook had not cleaned the oven. When asked what the Dietary Manager did in response, The Dietary Manager stated she instructed the cook to clean it.	F 371		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520		9/22/16

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F 520	Continued From page 33 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in July of 2015. This was for two recited deficiencies which occurred in July of 2015 and on the current recertification survey. The deficiencies were in the areas of maintenance and housekeeping and food storage/sanitation. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: 1. a. F 253 Maintenance and Housekeeping:	F 520	The facility will ensure the QAPI committee maintains and effective plan to monitor continued compliance of deficiencies identified. All residents have the potential to be affected. The facility Quality Assurance Performance Improvement committee members were educated by the Director of Clinical Operations on 9/15/16 regarding the revised QAPI process to include the new forms and format. This includes the facility will identify areas for continuous quality monitoring and the monitoring tools to be used. These monitoring activities should focus on those processes that affect resident	

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F 520	Continued From page 34 Based on observations and staff interviews, the facility failed to label and properly store personal hygiene products and resident care equipment on 4 of 5 resident halls. The facility was recited for F 253 for failure to label and properly store personal hygiene products and resident care equipment. F 253 was originally cited during the July 2015 recertification survey for failure to make repairs to walls and baseboards, repair constant dripping water faucet, replace a burnt out light bulb and clean a soiled privacy curtain on 3 of 4 halls. b. F 371 Food Storage/Sanitation: Based on observations, record review and staff interviews, the facility failed to maintain the convection oven and deep fryer clean and free of grease and dust. The facility was recited for F 371 for failure to clean the convection oven and deep fryer. F 371 was originally cited during the July 2015 survey for failure to perform hand hygiene and remove soiled gloves between tasks during 2 of 2 tray line observations. During an interview on 8/25/16 at 3:59 PM the Administrator stated that a Quality Assessment and Assurance meeting had been held, with the previous Administrator in attendance, after the recertification survey on 7/10/15 to discuss and develop a plan of action to correct the deficiencies. The Administrator stated he was committed to improve the current system and had identified more Quality Assurance staff to ensure more measures were put into place for continual monitoring	F 520	outcomes most significantly, to include previous survey deficiencies. This ongoing monitoring is used to establish the facility□s baseline and the predictability of various outcomes. The QAPI Committee will continue to meet on a monthly basis to continue monitoring identified areas of improvement, to include survey deficiencies for compliance. The QAPI Committee will address the identified area, examine and improved the identified need through improvement (action) plans and monitoring the effectiveness of such plans. The Director of Clinical Operations/Designee will review the facility QAPI Committee meeting minutes monthly until substantial compliance is achieved.	