STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345280	A. BUILDING _____ B. WING _____	03/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	1206 N FULTON STREET RAEFORD, NC 28376

(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 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 157		4/7/17

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

Electronically Signed | 04/03/2017

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F 157	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interview the facility failed to notify the physician of a pressure ulcer for 1 of 3 residents (Resident #179) reviewed for pressure ulcers which resulted in delayed assessment and treatment. The findings included: Resident #179 was admitted 2/28/17 to the facility with diagnoses which included Congested Heart Failure (CHF), Hypertension, Anemia, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease (COPD) and End Stage Renal Disease. Review of the admission minimum data set (MDS) dated 2/28/17 revealed that the resident was moderately cognitively impaired. He required extensive assistance with transfers and toileting. Resident #179 required total assistance with personal hygiene and bathing. The assessment also revealed the resident was admitted with 2 unstageable pressure ulcers to the resident's sacrum and to the buttocks. On 3/10/17 at 10:50AM Nurse #1 in the presence of the Director of Nursing (DON), stated she did not inform the physician about the wound and did	F 157	F157 Steps Taken in regards to those residents found to be affected: MD was notified on 3/10/2017 of resident #179□s wound. Steps Taken in regard to those Residents having the potential to be affected: An audit was conducted by DON and/or designee to determine if those residents with wounds had RP and MD documentation. Re-education for nursing staff on completion of PCNs for all new residents with wounds to be completed by DON and/or designee by 4/7/2017. Re-education for nursing staff on notification of MD and RP on significant changes including admissions with wounds or newly acquired wounds by DON and/or designee to be completed by 4/7/2017. Measures put in place to ensure the	

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F 157	Continued From page 2 not initiate the facility standing orders. On 3/8/17 at 12:20 PM the DON stated that her expectation was for the nurses to complete wound treatments per the physician's orders and for the nurses to use their communication log to make sure treatments that were missed were completed. A review of the physician care notes (PCN) for 2/28/17 revealed Nurse #1 failed to fill out the notification of the pressure ulcer. On 3/10/17 at 11:02 AM interview with physician, he stated he was not made aware of the resident wound upon admission.	F 157	deficient practice does not recur: A new wound audit tool will be completed 5x week for 4 weeks ensuring all newly acquired or admitted wounds are complete with MD and RP notification by the DON and/or designee. Monitoring effectiveness of corrective action: New wound/admission audits will be brought by the DON and/or designee to the Quality Assurance Committee for 3 months for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	
F 224 SS=D	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and	F 224		4/7/17

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F 224	Continued From page 3 (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews and record review the facility failed to provide assistance with toileting causing the resident to soil herself for 1 of 1 sampled residents (Resident #113, failed to obtain the initial treatment until 3 days after admission for 1 of 3 residents (Resident #179), and failed to complete dressing changes per physician's orders for 1 of 3 residents (Resident #179) reviewed for pressure ulcers. Findings included: 1. Resident #113 was admitted to the facility on 01/31/14 with diagnoses that included but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, contracture of hand, personal history of sudden cardiac arrest, generalized muscle weakness, major depressive disorder, anxiety disorder, diabetes type II with unspecified complications, lymphedema and dyspnea. The review of the most recent Minimum Data Sheet (MDS) 12/30/16 identified that Resident #113 was cognitively intact. The MDS indicated the resident was totally dependent for bathing and one person physical assist during bathing and toileting, extensive assistance for bed mobility, transfer and locomotion on the unit and dressing. The resident required total dependence with locomotion off the unit. The resident was independent with all meals and required assistance with set up only.	F 224	F224 Steps Taken in regards to those residents found to be affected: Resident #113 will be provided ADL and incontinence care per plan of care. Resident #179 dressing will be changed per MD orders. Steps taken in regard to those Residents having the potential to be affected: Re-education for all staff by DON and/or designee on call bell timeliness will be completed by 4/7/2017. Re-education for all staff on abuse policy by DON and/or designee to be completed by 4/7/2017. Re-education on Wound Policy and Guidelines by DON and/or designee to be completed by 4/7/2017. Re-education by American Medical Technologies (AMT) and DON and/or designee on wound documentation completed by 4/7/2017. Measures put in place to ensure the deficient practice does to not recur: A call light audit will be conducted by DON	

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F 224	Continued From page 4 A record review of the monthly nursing notes dated 02/12/17 stated that resident was alert and able to verbalize her needs. Interview with Resident #113 on 03/06/17 at 3:17 PM, resident stated that she had often waited to get the care needed after she pushed her call bell for staff assistance. She explained on Sunday, 03/05/17, no residents were able to get out of the bed due to short staffing within the facility. The resident reported that she had become aware that there was only one Certified Nursing Assistant (CNA) on 100 hall and one CNA on 200 hall. She stated that the weekend staffing had been short for routinely as long as she could remember. She stated that on the morning of 03/05/17 she had laid in her bed at least two hours after pushing her call bell for staff to assist her with changing her wet linen and clothing due to incontinence of urine. She stated that if she could have avoided the accident that she would have but that she needed help. Resident stated she felt helpless and that no one cared about the need for routine assistance and care. Staff interviewed on 03/09/17 at 10:15 AM. Certified Nursing Assistant (CNA) #1 stated that Resident #113 required one person assist for toileting, incontinent care and transfers. Staff interview 03/09/17 at 3:07:42 PM. Restorative certified nursing assistant (RCNA) #1 stated they had been working the past couple of months on the hall doing patient care, because they had short staff at least 3 days a week and restorative aide work was undone. Staff interview 03/09/17 at 3:09:15 PM. RCNA #2	F 224	and/or designee 5x week for 4 weeks to ensure appropriate timeliness. A treatment completion audit tool for wounds will be completed by DON and/or designee 5x week for 4 weeks to ensure treatment completion by physician order. Monitoring effectiveness of corrective action: Call light audits and treatment completion audits will be brought by the DON and/or designee to the Quality Assurance Committee for 3 months for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	

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F 224	Continued From page 5	F 224		

stated she has been working the last couple of months on the hall doing direct care because they are short staff at least three days a week and her work as a restorative aid was undone.

Staff Interview 03/09/17at 3:11 PM. RCNA #2 stated she worked 10 am to 6 pm and my duties as a restorative aide went undone; had worked the hall at least 3-4 days a week providing direct care because they had been short staffed here.

Staff interview 3/9/17 at 3:12 PM. CNA #2 stated she left at 7 pm on 3/5/17 and there were only 2 CNAs to work the A hall 3 PM to 11 PM shift.

Staff interview 3/9/17 at 3:29 PM. CAN #3 stated there were 2 CNAs for A hall and they teamed up and worked together on Sunday 3/5/17.

Administrator interviewed on 03/09/17 at 4:56 PM. She stated it was her expectation that call bells were answered to assist residents with their needs.

2. Review of facility protocol entitled, "Pressure Ulcer Guide." Read in part, "9. The admitting nurse will be responsible for obtaining the initial treatment ..."
Resident #179 was admitted 2/28/17 to the facility with diagnoses which included Congested Heart Failure (CHF), Hypertension, Anemia, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease (COPD) and End Stage Renal Disease. On the admission wound assessment dated 2/28/17 revealed the resident had an open area to the sacral crease and a pinpoint area to the right buttocks. There was no documentation of the measurements or staging of the wounds. Review of the admission minimum data set

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(MDS) dated 3/7/17 revealed that the resident was moderately cognitively impaired. He required extensive assistance with transfers and toileting. Resident #179 required total assistance with personal hygiene and bathing. The assessment also revealed the resident was admitted with 2 unstageable pressure ulcers to the resident's sacrum and to the buttocks.

A review of the resident's care plan dated 2/28/17 revealed that an intervention was to assess the effectiveness of the wound care and notify the physician for changes as needed.

A review of the physician treatment orders dated 3/3/17 revealed Resident # 179 was to receive treatment to the sacrum and right buttocks with wound cleanser, pat dry and to apply Santyl Ointment 250 unit/gram (debriding agent) to the wound bed, cover the wound with xeroform daily and as needed.

On 3/8/17 at 9:38 AM Resident #179 was observed receiving a treatment to the sacrum and the right buttocks. During the observation, the old dressing was observed to be dated 3/5/17.

On 3/8/17 at 12:15PM Nurse #1 stated she did not complete the dressing change on 3/6/17 because Resident #179 had gone to dialysis. Nurse #1 also stated she did not complete the dressing change on 3/7/17 because, "I did not have time." Nurse #1 stated she had not documented on the communication log concerning not completing the dressing changes.

On 3/8/17 at 12:20 PM the Director of Nursing (DON) stated that her expectation was for the nurses to complete wound treatments per the physician's orders and for the nurses to use their communication log to make sure treatments that were missed were complete.

On 3/10/17 at 10:50 AM Nurse #1 with the Director of Nursing (DON) present stated she

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F 224	Continued From page 7 called the physician about the admission but did not mention about the wound and no treatment initiated. On 3/10/17 at 11:02 AM the physician stated that he was not made aware of the resident's wound on admission.	F 224		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews and record review the facility failed to treat a resident in a dignified manner by not responding to her request for assistance for incontinent care for 1 of 1 sampled residents. (Resident #113) Findings included: Resident #113 was admitted to the facility on 01/31/14 with diagnoses that included but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, contracture of hand, personal history of sudden cardiac arrest, generalized muscle weakness, major depressive disorder, anxiety disorder, diabetes type II with unspecified complications, lymphedema and dyspnea. The review of the most recent Minimum Data Sheet (MDS) 12/30/16 identified that Resident	F 241	F241 Steps Taken in regards to those residents found to be affected: Resident #113 will be provided ADL and incontinence care per plan of care. Resident #179 dressing will be changed per MD orders. Steps taken in regard to those Residents having the potential to be affected: Re-education for all staff by DON and/or designee on call bell timeliness will be completed by 4/7/2017. Re-education for all staff on abuse policy by DON and/or designee to be completed by 4/7/2017.	4/7/17

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F 241	Continued From page 8 #113 was cognitively intact. The MDS indicated the resident was totally dependent for bathing and one person physical assist during bathing and toileting, extensive assistance for bed mobility, transfer and locomotion on the unit and dressing. The resident required total dependence with locomotion off the unit. The resident was independent with all meals and required assistance with set up only. Resident #113 interviewed on 03/06/17 at 3:17 PM. The resident stated that she had often had to wait to get the care needed after pushing her call bell for staff assistance. She stated that on the morning of 03/05/17 she had laid in her bed at least two hours after pushing her call bell for staff to assist her with changing her wet linen and clothing due to incontinence of urine. She stated that if she could have avoided the accident that she would have but that she needed help. Resident stated she felt helpless and that no one cared about the need for routine assistance and care. Resident #113 was interviewed on 03/09/17 at 2:55PM. The resident stated on 03/05/17 the certified CNAs were not able to change her wet linens and clothing for 2 hours. Resident also stated that she wished that she could obtain the strength needed to assist herself with the care needed so that she didn't have to lay in a wet bed so long because it was cold and it made her feel very uncomfortable. She stated that she had also been left sitting on the toilet in the bathroom for 30 minutes after having pulled the call light cord for assistance. She stated that she has been aware of the time it has taken to get assistance because she remembered looking at the time on her phone and/or tablet. The resident stated that	F 241	Measures put in place to ensure the deficient practice does to not recur: A call light audit will be conducted by DON and/or designee 5x week for 12 weeks to ensure appropriate timeliness. Monitoring effectiveness of corrective action: Call light audits and treatment completion audits will be brought by the DON and/or designee to the Quality Assurance Committee for 3 months for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	

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she feels helpless when there isn't enough staff to help her and everyone else.

A record review of the monthly nursing notes dated 02/12/17 stated that resident was alert and was able to verbalize her needs.

Certified Nursing Assistant (CNA) #1 was interviewed on 03/09/17 at 10:15 AM and stated that Resident #113 was a one person assist for transfers, toileting and incontinent care. Stated resident did more upper body bathing/care with some assistance. Stated that she is bathed in the bed when not showered. CNA stated that the resident was scheduled for showers on Monday, Wednesday and Fridays and required one person assist.

Staff interview 3/9/17 at 3:07:42pm- Restorative certified nursing assistant (RCNA)#1 stated they have been working the pass couple of months on the hall doing patient care, because they are short staff at least 3 days a week and restorative aide work was undone.

Staff interview 3/9/17 at 3:09:15pm- RCNA #2 stated she has been working the last couple of months on the hall doing direct care because they are short staff at least three days a week and her work as a restorative aid was undone.

Staff Interview 3/9/17at 3:11 pm- RCNA #2 I work 10 am - 6 pm my duties as a restorative aide just goes undone, I work the hall at least 3-4 days a week providing direct care because they are short staff here.

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F 241	Continued From page 10 Staff interview 3/9/17 at 3:12 pm- certified nursing assistant (CNA) #1 states she left at 7 pm on 3/5/17 and there was 2 CNA's to work the A hall 3-11 shift. Staff interview 3/9/17 at 3:29 pm- CNA#2 stated there were 2 CNA's for A hall we just team up and worked together on Sunday 3/5/17 On 03/09/17 at 4:56 PM the Administrator was interviewed. She stated that it was her expectation that call bells are to be answered to assist residents as needed.	F 241		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to follow physician treatment order for 1 of 3 residents (Resident #179) reviewed with pressure ulcers. The findings included: Resident #179 was admitted 2/28/17 to the facility with diagnoses which included Congested Heart Failure (CHF), Hypertension, Anemia, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease (COPD) and End Stage Renal Disease.	F 281	F281 Steps Taken in regards to those residents found to be affected: Resident #179 dressing will be changed per MD orders. Steps taken in regard to those Residents having the potential to be affected: Re-education on Wound Care Policy and Guidelines by DON and/or designee to be	4/7/17

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F 281	Continued From page 11 Review of the admission minimum data set (MDS) dated 3/7/17 revealed that the resident was moderately cognitively impaired. He required extensive assistance with transfers and toileting. Resident #179 required total assistance with personal hygiene and bathing. The assessment also revealed the resident was admitted with 2 unstageable pressure ulcers to the resident's sacrum and to the buttocks. Review of the resident's care plan dated 2/28/17 revealed follow the facility skin protocol. Review of the physician treatment order dated 3/3/17 revealed a treatment to the sacrum and right buttocks with wound cleanser, pat dry and the apply Santyl Ointment 250 unit/gram to the wound bed, cover with xeroform everyday and as needed. There was no reason given by the facility as to why they waited three days before they got an order for wound treatment. On 3/8/17 at 9:38 AM Resident #179 was observed receiving a treatment to the sacrum and the right buttocks. During the observation the old dressing was observed to be dated on 3/5/17. On 3/8/17 at 12:15 Nurse #1 stated she did not complete the dressing change on 3/6/17 because Resident #179 had gone to dialysis. Nurse #1 also stated she did not complete the dressing change on 3/7/17 because, "I did not have time." On 3/8/17 at 12:20 PM the Director of Nursing (DON) stated that her expectations were for the nurses to complete wound treatments per the physician's orders and for the nurses to use their communication log to make sure treatments that were missed were complete.	F 281	completed by 4/7/2017. Re-education by American Medical Technologies (AMT) and DON and/or designee on wound documentation completed by 4/7/2017. Measures put in place to ensure the deficient practice does to not recur: A treatment completion for wounds audit tool will be completed by DON and/or designee 5x week for 4 weeks to ensure treatment completion by physician order. Monitoring effectiveness of corrective action: The treatment completion wound audit tool will be brought by the DON and/or designee to the Quality Assurance Committee for 3 months for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	

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	345280	A. BUILDING _____ B. WING _____	03/10/2017

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F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to provide restorative services as outlined by the Comprehensive Care Plan (CCP) for 2 of 20 residents (Resident #113) reviewed care plan, failed to provide assistance for incontinent care for 1 of 1 sampled residents. (Resident #113), and failed to provide physician ordered treatment for wound healing, until three days after admission for 1 of 3 residents (Resident #179) reviewed for pressure ulcer. Findings Included: 1. Resident #113 was admitted to the facility on 01/31/14 with diagnoses that included but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, contracture of hand, personal history of sudden cardiac arrest, generalized muscle weakness, major depressive disorder, anxiety disorder, diabetes type II with unspecified complications, lymphedema and dyspnea. The review of the most recent Minimum Data Sheet (MDS) on 12/30/16 identified that Resident #113 was cognitively intact. The MDS indicated the resident was totally dependent for bathing and one person physical assist during bathing,	F 282	F282 Steps Taken in regards to those residents found to be affected: Resident #113 will be provided ADL and incontinence care per plan of care. Resident #113 is currently receiving Occupational Therapy for ROM services and splint re-evaluation. Resident #179 dressing will be changed per MD orders. Steps taken in regard to those Residents having the potential to be affected: Re-education was provided to the restorative aides on 3/28/2017 by the SDC on providing restorative services to meet the plan of care. Re-education for all staff by DON and/or designee on call bell timeliness will be completed by 4/7/2017.	4/7/17

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F 282	Continued From page 13 extensive assistance for bed mobility, transfer and locomotion on the unit and dressing. The resident required total dependence with locomotion off the unit. The resident was independent with all meals and required assistance with set up only. Resident #113 was interviewed on 03/09/17 at 2:55PM. The resident stated that the certified nursing assistants (CNA) were expected to perform the restorative care needed to gain mobility and independence. She stated that the facility had been so short staffed that the restorative care had not been completed as ordered. The CCP /restorative dated 12/29/16 focused on 2 areas; first was the resident ability to tolerate a device; had splint to right upper extremity related to contracture. Goal stated that the resident will wear device as indicated daily, resident will have increased range of motion (ROM) to extremity with device and resident will be able to have enhanced mobility. Interventions to obtain enhanced ROM included that skill was practiced 6 to 7 days/week. The second area of focus was the resident's capability to perform 10 repetitions (reps) per joint to bilateral lower extremities to prevent further contractures. This goal stated that the resident would continue to perform 10 reps with each session. Interventions to increase ability to perform reps included skill practice 6 to 7 days/week, practice skill 15 minutes per day, active ROM, encourage resident to participate, complete 10 reps to each extremity below hands, fingers, elbow, shoulder, neck, knees, legs and feet, never go beyond point of resistance/never force the extremity ranging, observe resident for signs of pain, expressions or verbal, facial	F 282	Re-education for all staff on abuse policy by DON and/or designee to be completed by 4/7/2017. Re-education on Wound Care Policy and Guidelines by DON and/or designee to be completed by 4/7/2017. Re-education by American Medical Technologies (AMT) and DON and/or designee on wound documentation completed by 4/7/2017. Measures put in place to ensure the deficient practice does to not recur: A call light audit will be conducted by DON and/or designee 5x week for 4 weeks to ensure appropriate timeliness. A treatment completion for wounds audit tool will be completed by DON and/or designee 5x week for 4 weeks to ensure treatment completion by physician order. Monitoring effectiveness of corrective action: Call light audits and treatment completion audits will be brought by the DON and/or designee to the Quality Assurance Committee for 3 months for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	

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grimacing and/or body gestures, encourage resident to assist with the ROM, never force the extremity ranging and refer to OT and PT as needed.

Staff interview 03/09/17 at 3:07 PM. Restorative Certified Nursing Assistant (RCNA) #1 stated they have been working the past couple of months on the hall doing patient care, because they are short staff at least 3 days a week and restorative aide work was undone.

Staff interview on 03/09/17 at 3:09 PM. RCNA #2 stated she has been working the last couple of months on the hall doing direct care because they are short staff at least three days a week and her work as a restorative aid was undone.

Staff Interview on 03/09/17 at 3:11 PM. RCNA #2 I work 10 AM to 6 PM my duties as a restorative aide just goes undone, I work the hall at least 3-4 days a week providing direct care because they are short staff here.

2. The review of the most recent Minimum Data Sheet (MDS) 12/30/16 identified that Resident #113 was cognitively intact. The MDS indicated the resident was totally dependent for bathing and one person physical assist during bathing and toileting, extensive assistance for bed mobility, transfer and locomotion on the unit and dressing. The resident required total dependence with locomotion off the unit. The resident was independent with all meals and required assistance with set up only.

Interview with Resident #113 on 03/06/17 at 3:17 PM, resident stated that she had often waited to get the care needed after she pushed her call bell

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for staff assistance. She stated that on 03/05/17, no residents were able to get out of the bed due to short staffing within the facility. The resident reported that she had become aware that there was only one Certified Nursing Assistant (CNA) on 100 hall and one CNA on 200 hall. She stated that the weekend staffing had been short for routinely as long as she could remember. She stated that on the morning of 03/05/17 she had laid in her bed at least two hours after pushing her call bell for staff to assist her with changing her wet linen and clothing due to incontinence of urine. She stated that if she could have avoided the accident that she would have but that she needed help. Resident stated she felt helpless and that no one cared about the need for routine assistance and care.

A record review of the monthly nursing notes dated 02/12/17 stated that resident was alert and was able to verbalize her needs.

Certified Nursing Assistant (CNA) #1 was interviewed on 03/09/17 at 10:15 AM and stated that Resident #113 was a one person assist for transfers, toileting and incontinent care. Stated resident did more upper body bathing/care with some assistance. Stated that she is bathed in the bed when not showered. CNA stated that the resident was scheduled for showers on Monday, Wednesday and Fridays and required one person assist.

Staff interview 3/9/17 at 3:07:42pm- Restorative certified nursing assistant (RCNA)#1 stated they have been working the pass couple of months on the hall doing patient care, because they are short staff at least 3 days a week and restorative aide work was undone.

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Staff interview 3/9/17 at 3:09:15pm- RCNA #2 stated she has been working the last couple of months on the hall doing direct care because they are short staff at least three days a week and her work as a restorative aid was undone.

Staff interview 3/9/17 at 3:12 pm- certified nursing assistant (CNA) #1 states she left at 7 pm on 3/5/17 and there was 2 CNA's to work the A hall 3-11 shift.

Staff interview 3/9/17 at 3:29 pm- CNA#2 stated there were 2 CNA's for A hall we just team up and worked together on Sunday 3/5/17

Interviewed Administrator on 03/09/17 at 4:56 PM. She stated that it was her expectation that care plans were to be followed as written.

3. Review of facility protocol entitled, "Pressure Ulcer Guide." Read in part, "9. The admitting nurse will be responsible for obtaining the initial treatment ..."
Resident #179 was admitted 2/28/17 to the facility with diagnoses which included Congested Heart Failure (CHF), Hypertension, Anemia, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease (COPD) and End Stage Renal Disease. On the admission wound assessment dated 2/28/17 revealed the resident had an open area to the sacral crease and a pinpoint area to the right buttocks. There was no documentation of the measurements or staging of the wounds. Review of the admission minimum data set (MDS) dated 3/7/17 revealed that the resident was moderately cognitively impaired. He required extensive assistance with transfers and toileting.

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Resident #179 required total assistance with personal hygiene and bathing. The assessment also revealed the resident was admitted with 2 unstageable pressure ulcers to the resident's sacrum and to the buttocks.
A review of the resident's care plan dated 2/28/17 revealed that an intervention was to assess the effectiveness of the wound care and notify the physician for changes as needed.
A review of the physician treatment orders dated 3/3/17 revealed Resident # 179 was to receive treatment to the sacrum and right buttocks with wound cleanser, pat dry and to apply Santyl Ointment 250 unit/gram (debriding agent) to the wound bed, cover the wound with xeroform daily and as needed.
On 3/8/17 at 9:38 AM Resident #179 was observed receiving a treatment to the sacrum and the right buttocks. During the observation, the old dressing was observed to be dated 3/5/17.
On 3/8/17 at 12:15PM Nurse #1 stated she did not complete the dressing change on 3/6/17 because Resident #179 had gone to dialysis. Nurse #1 also stated she did not complete the dressing change on 3/7/17 because, "I did not have time." Nurse #1 stated she had not documented on the communication log concerning not completing the dressing changes.
On 3/8/17 at 12:20 PM the Director of Nursing (DON) stated that her expectation was for the nurses to complete wound treatments per the physician's orders and for the nurses to use their communication log to make sure treatments that were missed were complete.
On 3/10/17 at 10:50 AM Nurse #1 with the Director of Nursing (DON) present stated she called the physician about the admission but did not mention about the wound and no treatment initiated.

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F 282	Continued From page 18 On 3/10/17 at 11:02 AM the physician stated that he was not made aware of the resident's wound on admission.	F 282		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview the facility failed to obtain the initial treatment until 3 days after admission for 1 of 3 residents (Resident #179), and failed to complete dressing changes per physician's orders for 1 of 3 residents (Resident #179) reviewed for pressure ulcers. The findings included: Review of facility protocol entitled, "Pressure Ulcer Guide" Dated 7/2012, handed by the facility, Read in part, "9. The admitting nurse will be	F 314	F314 Steps Taken in regards to those residents found to be affected: Resident #179 dressing will be changed per order. MD was notified on 3/10/2017 on resident #179□s wound. Steps Taken in regard to those Residents having the potential to be affected:	4/7/17

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F 314	Continued From page 19 responsible for obtaining the initial treatment ..." Resident #179 was admitted 2/28/17 to the facility with diagnoses which included Congested Heart Failure (CHF), Hypertension, Anemia, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease (COPD) and End Stage Renal Disease. On the admission wound assessment dated 2/28/17 revealed the resident had an open area to the sacral crease and a pinpoint area to the right buttocks. There was no documentation of the measurements or staging of the wounds. Review of the admission minimum data set (MDS) dated 3/7/17 revealed that the resident was moderately cognitively impaired. He required extensive assistance with transfers and toileting. Resident #179 required total assistance with personal hygiene and bathing. The assessment also revealed the resident was admitted with 2 unstageable pressure ulcers to the resident's sacrum and to the buttocks. A review of the resident's care plan dated 2/28/17 revealed that an intervention was to assess the effectiveness of the wound care and notify the physician for changes as needed. A review of the physician treatment orders dated 3/3/17 revealed Resident # 179 was to receive treatment to the sacrum and right buttocks with wound cleanser, pat dry and to apply Santyl Ointment 250 unit/gram (debriding agent) to the wound bed, cover the wound with xeroform daily and as needed. On 3/8/17 at 9:38 AM Resident #179 was observed receiving a treatment to the sacrum and	F 314	An audit was conducted by DON and/or designee to determine if those residents with wounds had RP and MD documentation. Re-education for nursing staff on completion of PCNs for all new residents with wounds to be completed by DON and/or designee by 4/7/2017. Re-education for nursing staff on notification of MD and RP on significant changes including admissions with wounds or newly acquired wounds by DON and/or designee to be completed by 4/7/2017. Re-education for all staff on abuse policy by DON and/or designee to be completed by 4/7/2017. Re-education on Wound Care Policy and Guidelines by DON and/or designee to be completed by 4/7/2017. Re-education by American Medical Technologies (AMT) and DON and/or designee on wound documentation completed by 4/7/2017. Measures put in place to ensure the deficient practice does not recur: A new wound audit tool will be completed 5x week for 4 weeks ensuring all newly acquired or admitted wounds are complete with MD and RP notification by the DON and/or designee.	

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F 314	Continued From page 20 the right buttocks. During the observation, the old dressing was observed to be dated 3/5/17. On 3/8/17 at 12:15PM Nurse #1 stated she did not complete the dressing change on 3/6/17 because Resident #179 had gone to dialysis. Nurse #1 also stated she did not complete the dressing change on 3/7/17 because, "I did not have time." Nurse #1 stated she had not documented on the communication log concerning not completing the dressing changes. On 3/8/17 at 12:20 PM the Director of Nursing (DON) stated that her expectation was for the nurses to complete wound treatments per the physician's orders and for the nurses to use their communication log to make sure treatments that were missed were complete. On 3/10/17 at 10:50 AM Nurse #1 with the Director of Nursing (DON) present stated she called the physician about the admission but did not mention about the wound and no treatment initiated. On 3/10/17 at 11:02 AM the physician stated that he was not made aware of the resident's wound on admission.	F 314	A call light audit will be conducted by DON and/or designee 5x week for 4 weeks to ensure appropriate timeliness. A treatment completion for wounds audit tool will be completed by DON and/or designee 5x week for 4 weeks to ensure treatment completion by physician order. Monitoring effectiveness of corrective action: Call light audits and treatment completion audits will be brought by the DON and/or designee to the Quality Assurance Committee for 3 months for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		4/7/17

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F 318	Continued From page 21 (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to provide Range of Motion (ROM) exercises as care planned for 1 of 1 resident (Resident #113) reviewed for ROM. Findings included: Resident #113 was admitted to the facility on 01/31/14 with diagnoses that included but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, contracture of hand, personal history of sudden cardiac arrest, generalized muscle weakness, major depressive disorder, anxiety disorder, diabetes type II with unspecified complications, lymphedema and dyspnea. The review of the most recent Minimum Data Sheet (MDS) on 12/30/16 identified that Resident #113 was cognitively intact. The MDS indicated the resident was totally dependent for bathing and one person physical assist during bathing, extensive assistance for bed mobility, transfer and locomotion on the unit and dressing. The resident required total dependence with locomotion off the unit. The resident was independent with all meals and required assistance with set up only. Resident #113 was interviewed on 03/09/17 at 2:55PM. The resident stated that the certified nursing assistants (CNA) were expected to	F 318	F318 Steps Taken in regards to those residents found to be affected: Resident #113 is currently receiving Occupational Therapy for ROM services and splint re-evaluation. Steps Taken in regard to those Residents having the potential to be affected: A restorative program audit tool will be completed by DON and/or designee to determine appropriateness of programs in place and accuracy of orders and care plans. Re-education was provided to the restorative aides on 3/28/2017 by the SDC on providing restorative services to meet the plan of care. A minimum of one restorative aide will work 6-7 x per week. Measures put in place to ensure the deficient practice does not recur: A restorative audit tool will be completed 5 x week for 4 weeks by DON and/or designee to ensure residents are	

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F 318	Continued From page 22 perform the restorative care needed to gain mobility and independence. She stated that the facility had been so short staffed that the restorative care had not been completed as ordered. Resident stated that she wished that she could obtain the strength needed to assist herself with the care needed. The restorative nursing care plan dated 12/29/16 focused on 2 areas; first was the resident ability to tolerate a device; had splint to right upper extremity related to contracture. Goal stated that the resident will wear device as indicated daily, resident will have increased range of motion (ROM) to extremity with device and resident will be able to have enhanced mobility. Interventions to obtain enhanced ROM included that skill was practiced 6 to 7 days/week. The second area of focus was the resident's capability to perform 10 repetitions (reps) per joint to bilateral lower extremities to prevent further contractures. This goal stated that the resident would continue to perform 10 reps with each session. Interventions to increase ability to perform reps included skill practice 6 to 7 days/week, practice skill 15 minutes per day, active ROM, encourage resident to participate, complete 10 reps to each extremity below hands, fingers, elbow, shoulder, neck, knees, legs and feet, never go beyond point of resistance/never force the extremity ranging, observe resident for signs of pain, expressions or verbal, facial grimacing and/or body gestures, encourage resident to assist with the ROM, never force the extremity ranging and refer to OT and PT as needed. Record review for nursing rehabilitation orders stated that restorative nursing was to apply splint to right upper extremity and splint should have	F 318	receiving restorative services per order and care plan. Monitoring effectiveness of corrective action: Restorative audits will be brought by the DON and/or designee to the Quality Assurance Committee for 3 months for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	

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	345280	A. BUILDING _____ B. WING _____	03/10/2017

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F 318	Continued From page 23	F 318		

been on 3 hours per day for 6 days a week. The following were recorded:

1. The number of minutes documented as having provided splint assistance was 20 minutes on 03/01/17, 03/07/17, 03/08/17 and 03/09/17 and was not applicable on 03/03/17 and 03/04/17. Documentation that resident tolerated splint application was viewed on 03/01/17, 03/07/17, 03/08/17 and 03/09/17 and was not applicable on 03/03/17 and 03/04/17.

2. Participation/cooperation was documented on 03/01/17, 03/07/17, 03/08/17 and 03/09/17 and was not applicable on 03/03/17 and 03/04/17. Level of assistance/total dependence was documented on 03/01/17, 03/07/17, 03/08/17 and 03/09/17 and was not applicable on 03/03/17 and 03/04/17.

3. Transfer resident sit to stand for transfers with contact guard assistance and activity participation was documented as not applicable on 02/28/17, 03/03/17 and 03/04/17. The number of minutes spent training and skill practice in transfer was documented as not applicable on 02/28/17, 03/03/17 and 03/04/17. Balance while moving from seated to standing position was documented as not applicable on 02/28/17, 03/03/17 and 03/04/17.

4. Active ROM to right and left lower extremity 20 reps per joint was documented as completed on 03/01/17, 03/07/17, 03/08/17, 03/09/17 and not applicable on 03/03/17 and 03/04/17. Documentation of 20 reps per joint was documented as completed on 03/01/17, 03/07/17, 03/08/17, 03/09/17 and not applicable on 03/03/17 and 03/04/17.

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5. Resident's ability to tolerate and participate was documented as completed on 03/01/17, 03/07/17, 03/08/17, 03/09/17 and not applicable on 03/03/17 and 03/04/17. The level of assistance/total dependence was documented as completed on 03/01/17, 03/07/17, 03/08/17, 03/09/17 and not applicable on 03/03/17 and 03/04/17.

Monthly nurse's note on 2/12/1 states resident #113 was alert and able to verbalize her needs, she denied pain or discomfort and had voiced no complaints. The note also indicated that resident continued to have edema to bilateral lower extremities that correlated with diagnosis of lymphedema. ROM was ordered and care planned.

Resident #113 was interviewed on 03/09/17 at 2:55PM. Resident stated that she wished that she could obtain the strength needed to assist herself with her care. She stated that she had not gained the strength to increase her independence because the restorative care isn't performed as often as ordered.

Staff interview 03/09/17 at 3:07 PM. Restorative Certified Nursing Assistant (RCNA) #1 stated they have been working the past couple of months on the hall doing patient care, because they are short staff at least 3 days a week and restorative aide work was undone.

Staff interview on 03/09/17 at 3:09 PM. RCNA #2 stated she has been working the last couple of months on the hall doing direct care because they are short staff at least three days a week and her work as a restorative aid was undone.

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F 318	Continued From page 25 Staff Interview on 03/09/17 at 3:11 PM. RCNA #2 I work 10 AM to 6 PM my duties as a restorative aide just goes undone, I work the hall at least 3-4 days a week providing direct care because they are short staff here. Staff interview 03/09/17 at 3:12 pm. CNA #1 states she left at 7 pm on 03/05/17 and there was 2 CNAs to work the A hall 3PM-11PM shift. Staff interview 03/09/17 at 3:29 pm. CNA #2 stated there were 2 CNAs for A hall we just team up and worked together on Sunday 03/05/17. Interviewed Administrator on 03/09/17 at 4:56 PM. She stated that it was her expectation that restorative nursing care plans were to be followed as written.	F 318		
F 353 SS=D	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]	F 353		4/7/17

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F 353	Continued From page 26 (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews and record review of staffing record, the facility failed to respond to resident's request for assistance for incontinent care and for incontinent care for a dependent resident for 1 of 1 resident (Resident #113), the facility failed to provide treatment to pressure ulcer as ordered for 1 of 3 residents (Resident #179), the facility failed to follow	F 353	F353 Steps Taken in regards to those residents found to be affected: Resident #113 will be provided ADL and incontinence care per plan of care.	

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F 353	Continued From page 27 doctors order for treatment of pressure ulcer of 1 of 3 residents (Resident #179) and the facility failed to provide ROM exercises as care planned for 1 of 1 resident (Resident #113). The findings included: 1.a This tag was crossed reference to F241. Based on observations, resident interview, staff interviews and record review the facility failed to treat a resident in a dignified manner by not responding to her request for assistance for incontinent care for 1 of 1 sampled residents. (Resident #113). b. This tag was crossed reference to F224. Based on observations, resident interview, staff interviews and record review, the facility failed to provide assistance with toileting causing the resident to soil herself for 1 of 1 sample resident (Resident #113), the facility failed to obtain the initial treatment until 3 days after admission for 1 of 3 residents (Resident #179), and failed to complete dressing changes per physician's orders for 1 of 3 residents (Resident #179) reviewed for pressure ulcers. c. This tag was crossed reference to F281. Based on record review, observation and staff interviews the facility failed to follow physician treatment order for 1 of 3 residents reviewed (Res#179) with pressure ulcers. d. This tag was crossed reference to F314. Based on record review, observation and staff interview the facility failed to obtain the initial treatment until 3 days after admission for 1 of 3 residents (Resident #179), and failed to complete dressing changes per physician's orders for 1 of 3 residents (Resident #179) reviewed for	F 353	Resident #113 is currently receiving Occupational Therapy for ROM services and splint re-evaluation. Resident #179 dressing will be changed per MD orders. MD was notified of resident #179□s wound on 3/10/2017. Steps Taken in regard to those Residents having the potential to be affected: An audit was conducted by DON and/or designee to determine if those residents with wounds had RP and MD documentation. Re-education for nursing staff on completion of PCNs for all new residents with wounds to be completed by DON and/or designee by 4/7/2017. Re-education for nursing staff on notification of MD and RP on significant changes including admissions with wounds or newly acquired wounds by DON and/or designee to be completed by 4/7/2017. Re-education for all staff by DON and/or designee on call bell timeliness will be completed by 4/7/2017. Re-education for all staff on abuse policy by DON and/or designee to be completed by 4/7/2017. Re-education on Wound Care Policy and	

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F 353	Continued From page 28 pressure ulcers. e. This tag was crossed reference to F318. Based on observation, interviews and record review, the facility failed to provide Range of Motion (ROM) exercises as care planned for 1 of 1 resident (Resident #113) reviewed for ROM. 3/9/17 2:02 pm- An interview with the facility scheduler was conducted. She stated she was "when we have a call out we get the med aides or restorative aides that are working on call states when we have a call out we get the med aids or restorative aids that is working; then I start calling the as needed staff (PRN) or part time staff to cover the floors. Our minimum on 7-3 Hall is 4 certified nursing assistants (CNAs) and 2 nurses, B Hall 4 CNA's and 2 nurses, C Hall 3 CNAs and 1 nurse. 3-11 shift A and B Hall 2 nurses and 3 CNAs. We do not have different staffing numbers for the weekend". 3/9/17 2:30 pm An interview was conducted with Director of Nursing (DON) she stated she was on call Monday through Friday and every other weekend. She added "when people call out I start calling the staff and calling the staff and calling PRN staff also, we are in the process of offering bonuses if people will come in." Staff interview 3/9/17 at 3:07 pm with Restorative Certified Nursing Assistant, (RCNA) #1 stated they have been working the pass couple of months on the hall doing patient care, because they are short staff at least 3 days a week and "my work I can't do as a Restorative aide goes undone." Staff interview 3/9/17 at 3:09 pm with RCNA#2	F 353	Guidelines by DON and/or designee to be completed by 4/7/2017. Re-education by American Medical Technologies (AMT) and DON and/or designee on wound documentation completed by 4/7/2017. Re-education was provided to the restorative aides on 3/28/2017 by the SDC on providing restorative services to meet the plan of care. A minimum of one restorative aide will work 6-7 times per week. Measures put in place to ensure the deficient practice does not recur: A call light audit will be conducted by DON and/or designee 5x week for 4 weeks to ensure appropriate timeliness. A treatment completion for wounds audit tool will be completed by DON and/or designee 5x week for 4 weeks to ensure treatment completion by physician order. A new wound audit tool will be completed 5x week for 4 weeks ensuring all newly acquired or admitted wounds are complete with MD and RP notification by the DON and/or designee. Monitoring effectiveness of corrective action: Call light audits, treatment completion	

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F 353	Continued From page 29 stated she had been working the last couple of months on the hall doing direct care because they are short staffed at least three days a week and I can't do my work as a Restorative Aide. Staff Interview 3/9/17at 3:11 pm with Restorative #2 I work 10 am - 6 pm my duties as a restorative aide just goes undone, I work the hall at least 3-4 days a week providing direct care because they are short staffed here. Staff interview 3/9/17 at 3:12 pm nursing assistant (CNA) #1 states she left at 7 pm on 3/5/17 and there were 2 CNA's to work the A hall 3-11 shift Staff interview 3/9/17 at 3:29 pm NA#2 stated there were 2 NA's for A hall we just teamed up and worked together on Sunday 3/5/17 Staff Interview 3/9/17 at 3:49 pm CNA #2 stated "they stack the schedule to make it look like we got help and we ain't got no help". Staff interview 3/9/17 at 3:49 pm with nurse #1 stated there were only 2 CNA's to cover A hall from 7 pm to 11pm. A staff interview was conducted on 3/10/17 at 9:27am with the facility Director of Nursing (DON), she stated it was not an optimal situation, I had 2 nurses, 2 2 CNA's on A Hall for Sunday 3/5/17. 3/9/17 2:02:18pm- Interview with scheduler and DON both stated that facility does not use an outside staffing agency. Interviewed Administrator on 03/09/17 at 4:56	F 353	audits and new wound audit tool will be brought by the DON and/or designee to the Quality Assurance Committee for 3 months for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	

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F 353	Continued From page 30 PM. She stated that it was her expectation that care plans were to be followed as written.	F 353		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to store and label food food such as cranberry juice, eggs, and meat in the refrigerator. The facility also failed to clean and maintain the ice maker machine in the kitchen resulting in a pink substance on the inside flap.	F 371	F371 Steps Taken in regards to those residents found to be affected: The cranberry juice was discarded on 3/6/2017.	4/7/17

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F 371	Continued From page 31 Findings included: 1. Initial tour of kitchen on 03/06/17 at 11:00 AM revealed the following: a) In reach in refrigerator, one 64-ounce bottle of cranberry juice was found opened with ¾ of contents gone and not labeled. b) In the same reach in refrigerator, found a cracked egg on a gray cardboard tray with other eggs on the tray. c) In another reach in refrigerator, a personal staff drink bottle of Mountain Dew 16 oz. was found opened and unlabeled. d) In another reach in refrigerator, a large ham was found on a drip proof brown tray with a label dated 03/01/17 (date the ham was placed in refrigerator to thaw) and a discard date of 03/04/17. This was found on 03/06/17. The unlabeled and opened cranberry juice bottle, cracked egg, staff Mountain Dew bottle and out of date ham were removed from the refrigerators and thrown away by Kitchen Manager on 03/06/17 at 11:25 AM Interview with Kitchen Manager on 03/06/17 at 11:30 AM. Stated that it is not acceptable to have unlabeled drinks or bottles in the refrigerators including staff personal drinks. Stated that the cracked egg was not touching any other egg inside of the tray but felt it was appropriate to discard the entire tray. Stated that the eggs are pasteurized. Stated that the label on the large ham had to be dated incorrectly but discarded it anyway. 2. Another observation on 03/06/17 at 11:40 AM	F 371	The cracked egg was discarded on 3/6/2017. The personal drink was discarded on 3/6/2017. The ham was discarded on 3/6/2017. The ice machine was cleaned on 3/8/2017. Steps Taken in regard to those Residents having the potential to be affected: Dietary staff were educated on pasteurized eggs on 3/8/2017 by the dietary manager. Dietary staff were educated on labeling open items in the refrigerator, storing personal items in the refrigerator, following discard dates on food items and discarding cracked eggs by the Dietary Manager and completed on 3/24/2017. Maintenance personnel were educated by the Administrator on 3/8/2017 on the time frame to complete ice machine cleaning and ice machine monthly check list. Measures put in place to ensure the deficient practice does not recur: Maintenance personnel will complete the ice machine check list monthly and turn into the administrator indefinitely. Dietary manager and/or designee will	

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F 371	Continued From page 32 showed a pink slimy substance in the corners of the white flap inside of ice maker. The pink slime was directly in contact with the ice sliding down from the flap of ice maker into the ice. Interview with Maintenance Supervisor 03/08/17 at 11:55 AM indicated that the facility had a contract with an outside Refrigeration company and that they were supposed to come every 3 months for inspection and cleaning of ice makers. A receipt invoice #12662 from a refrigeration company was supplied which showed documentation of last cleaning of the Ice Machine in kitchen was performed on 11/10/16. The icemaker machine was not cleaned within 3 months from the last date of the company visit. Interview Kitchen Manager 03/08/17 at 12:00 PM comprised of expectations of serving prepared drinks with ice to residents for lunch when ice was removed from an ice maker with pink slimy substance. He stated that the ice should be removed but he was unsure of the timeliness to replace the prepared drinks already on the trays for resident lunch meal. Interviewed Administrator 03/08/17 12:03 PM. Administrator stated that the expectations included cleaning pink, slimy substance from ice maker in kitchen. She stated that the ice machines are to be cleaned once per month by maintenance staff or more often if needed. She stated that the machine needed to be emptied and cleaned immediately. She stated that all the prepared drinks were to be discarded and replaced with new drinks/cups before serving to residents. Kitchen manager agreed that the prepared drinks needed to be removed from the resident trays and replaced with new drinks/cups	F 371	complete the dry storage good audit 5x week x 4 weeks and weekly thereafter. Monitoring effectiveness of corrective action: The ice machine check list will be brought by the Maintenance Director and/or designee to the Quality Assurance Committee for 3 months for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan. The dry storage goods audit will be brought by the Dietary Manager and/or designee to the Quality Assurance Committee for 3 months for review. Any areas of continued concern will be brought back to the Quality Assurance Committee for further action plan.	

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F 371	Continued From page 33 for the lunch meal.	F 371		