STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING _____ B. WING _____	04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365

(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 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum	F 278	This Plan of Correction is prepared and submitted as required by law. By	5/8/17

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

Electronically Signed | 04/20/2017

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F 278	Continued From page 1 Data Set (MDS) for a Level II Preadmission Screening and Resident Review (PASRR) (A screening tool used to assure that individuals with serious mental illness entering or residing in Medicaid-certified nursing facilities receive appropriate placement and services) for 1 of 1 resident (Resident #113) reviewed for PASRR. Findings included: A PASRR Level II authorization dated 9/7/16 was reviewed and revealed a valid PASRR number for Resident #113 which was valid from 9/7/16 through 11/6/16. Resident #113 was admitted to the facility on 9/22/16 with admitting diagnoses which included bipolar disorder. A review of the admission MDS dated 10/1/16 revealed no serious mental illness with or without an organic condition was assessed. Resident #113 was severely cognitively impaired and required extensive to total assistance for all activities of daily living. Active diagnoses included seizure disorder, bipolar disorder, and symbolic dysfunction. The MDS did not indicated the resident had been determined to have a Level II PASRR status. An interview was conducted on 4/5/17 at 3:35 pm with the Admissions Director. She stated, "I obtain PASRR information from the referring source before the resident is admitted. I missed sending out the Level II PASRR for (Resident #113)." An interview was conducted with MDS Nurse #1 on 4/5/17 at 4:00 pm. She stated, "MDS information is obtained from the hospital records, physician notes, resident assessment, consult	F 278	submitting this Plan of Correction, Mount Olive Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. F -278 A Pre-admission Screening and Resident Review level II authorization dated on 9/7/16 was reviewed and revealed a PASRR number for resident #113 which was valid from 9/7/16 through 11/16/16. Resident was admitted to the facility on 9/22/16 with admitting diagnosis which included bipolar disorder. F-278 Addresses the steps taken to resolve the PASRR issue identified during the survey and the steps taken by the facility to resolve the issue with patient # 113. A hundred percent audit was completed on 4/10/17 on all residents in the facility to ensure that all resident have a valid level II PASRR. An in-service was completed on 4/10/17 with Center Nurse Executive, Social Service Director, MDS and Admission Director at 11am to review the PASRR Level II reassessment process. Admission Director (AD)will send a PASRR Level II extension request reminder (via Outlook	

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F 278	Continued From page 2 notes, physician orders, and nursing notes. When a new admit comes in the Admissions Director sends me an e mail telling me we have a new Level II PASRR resident. She also sends out a list of all Level II PASRR residents. I didn't know (Resident #113) was a Level II PASRR when she was admitted so (Resident #113) wasn't coded as a Level II PASRR." An interview was conducted with the Director of Nursing on 4/5/17 at 4:15 pm. She stated it was her expectation the MDS would be completed timely and accurately.	F 278	Calendar)to members of the IDT - seven to ten days prior to expiration date. The Social Service Director is responsible for obtaining PASRR Level II extensions. The PASRR confirmation process will be completed with each new admission along with using the admission check off list to ensure that staff is notified of any new level II PASRR residents. AD maintains a written PASRR tracking log to identify Level II PASRR's in order to process requests for timely extensions. All level II PASRR resident s will be reviewed during the monthly QAPI meeting for 3 months to ensure that they have a current level II PASRR and will identify any trends that need to be addressed. The review process will be extended if continuing issues are identified.	
F 285 SS=D	483.20(e)(k)(1)-(4) PASRR REQUIREMENTS FOR MI & MR (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.	F 285		5/8/17

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F 285	Continued From page 3	F 285		

(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.

(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.

(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:

(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services; or

(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

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F 285	Continued From page 4 (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. (2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. (3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).	F 285		

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F 285	Continued From page 5 (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. (k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to re-evaluate a Level II Preadmission Screening and Resident Review program (PASRR) (A screening tool used to assure that individuals with serious mental illness entering or residing in Medicaid-certified nursing facilities receive appropriate placement and services) for 1 of 1 resident (Resident #113) with an expired PASRR number reviewed for PASRR. Findings included: A PASRR Level II authorization dated 9/7/16 was reviewed and revealed a PASRR number for Resident #113 which was valid from 9/7/16 through 11/6/16. Resident #113 was admitted to the facility on 9/22/16 with admitting diagnoses which included bipolar disorder. A review of the admission Minimum data Set (MDS) dated 10/1/16 revealed no serious mental illness with or without an organic condition was assessed. Resident #113 was severely cognitively impaired and required extensive to total	F 285	F-285 A Pre-admission Screening and Resident Review Level II authorization dated on 9/7/16 was reviewed and revealed a valid PASRR number for resident #113 which was valid from 9/7/16 through 11/6/16. Resident #113 invalid PASRR was identified by the facility on 2/28 (date of re-admission) and a new PASRR Screen was submitted on 3/1/17 and the updated valid PASRR was received on 3/8/17. The PASRR for resident #113 is now current. A hundred percent audit was completed on 4/10/17 on all residents in the facility to ensure that all resident have a valid level II PASRR and was coded correctly on the Minimum Data Set. An in-service was completed on 4/10/17 with Center Nurse Executive, Social Service Director, MDS and Admission Director at 11am to review the PASRR confirmation process The SSD	

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F 285	Continued From page 6 assistance for all activities of daily living. Active diagnoses included seizure disorder, bipolar disorder, and symbolic dysfunction. A review of the quarterly MDS dated 1/1/17 revealed no serious mental illness with or without an organic condition was assessed. Resident #113 was severely cognitively impaired and required extensive to total assistance for all activities of daily living. Active diagnoses included seizure disorder, bipolar disorder, and symbolic dysfunction. A review of the care plans dated 9/22/16 and revised on 1/5/17 revealed a problem of distress or fluctuating mood symptoms related to a psychiatric disorder (bipolar disorder). The listed goal read "the resident will demonstrate increased stability related to psychiatric diagnosis." Interventions included monitoring for worsening signs and symptoms of psychiatric disorder (mania, hypomania), physician notification if behaviors worsened, and a psychiatric or behavioral health consult as needed. A PASRR Level II authorization dated 3/8/17 was reviewed and revealed a PASRR number for Resident #113 which was valid from 3/8/17 through 6/6/17. A care plan dated 3/16/17 revealed a care plan focus which read, "Resident meets PASRR II Level of determination secondary to bipolar serious mental illness." The goal stated revealed the resident would be appropriately evaluated and re-evaluated for specialized services as needed, and per State requirements.	F 285	department will code all level II PASRR under section A in the MDS and will be reviewed by the MDS department before submission for payment. All level II PASRR resident s will be reviewed during the monthly QAPI meeting for 3 months to ensure that they have a current level II PASRR and will identify any trends that need to be addressed and are coded correctly in the MDS. Any continuing issues at the end of the 3 month cycle will be reason to extend the monitoring period.	

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F 285	Continued From page 7	F 285		

An interview was conducted on 4/5/17 at 3:15 pm with the Social Services Director (SSD). She stated every new admission came to the facility with a PASRR number. Level II PASRR numbers expired in 30, 60, or 90 days and was used for residents with intellectual disabilities or mental health disorders. She also stated the Admission Director ensured PASRR was present for newly admitted residents and would send out an electronic mail (e mail) notification to the SSD to alert her to a new Level II PASRR admission. She also stated the Admissions Director included the expiration date of the Level II PASRR so the PASRR number could be re-applied for if necessary. She also stated (Resident #113 was a Level II PASRR resident since she was admitted 9/22/16 and her Level II PASRR number had expired 11/6/16 and was re-validated 3/8/17.

An interview was conducted on 4/5/17 at 3:35 pm with the Admissions Director. She stated, "I obtain PASRR information form the referring source before the resident is admitted. Level II PASRR's expire in 30, 60, or 90 days and need to be re-applied for before the expiration date. (Resident #113) is a Level II PASRR. She was originally admitted 9/22/16 as a Level II PASRR and it expired 11/6/16. Her renewal wasn't completed until 3/8/17. The SSD didn't know to apply for a Level II PASRR renewal for (Resident #113) because I missed sending out a notice that she (Resident #113) was going to expire. The way I knew her Level II PASRR was expired was when (Resident #113) was re-admitted to the facility after a hospitalization. The SSD is responsible for sending out renewal requests. I notify the interdisciplinary team, which includes the SSD, of Level II PASRR admissions. I put the expiration date into our computerized calendar

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F 285	Continued From page 8 program so if an extension of Level II PASRR is needed the SSD knows when to send out a renewal request. I missed sending out the Level II PASRR for (Resident #113)." An interview was conducted with the Director of Nursing (DON) on 4/5/17 at 4:15 pm. She stated it was her expectation that a Level II PASRR resident had a valid PASRR number while the resident resided in the facility. An interview was conducted on 4/5/17 at 4:20 pm with the facility Administrator. The Administrator stated he expected Level II PASRR residents to be tracked by staff and for renewals to be applied for when necessary.	F 285		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview the facility failed to remove facial hair for 1 of 3 residents (Resident #118) reviewed who were dependent on staff and required extensive to total assistance for personal hygiene. The findings included: Resident #118 was admitted to the facility on 11/16/16 with diagnoses of non-Alzheimer's dementia.	F 312	F-312 On 4/5/2017 at 2:30pm Resident #118 was shaven by NA#2. On 4/5/2017 at 2:30pm assessments of all Residents having long chin hairs and beards were started by the Center Nurse Executive (CNE) and Unit Managers. Assessments were completed by the CNE and Unit Managers on 4/6/2017. Residents identified in need of shaving where shaved by staff by 4/6/2017	5/8/17

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F 312	Continued From page 9 A review of Resident #118's care plan dated 11/17/16 revealed that the resident was at risk for decreased ability to perform activities of daily living ADL(s) in personal hygiene. For an intervention staff were to provide total assistance for personal hygiene (grooming). A review of the Care Area Assessment (CAA) dated 11/26/16 revealed Resident #118 was admitted to the facility on 11/16/16 from the hospital after a right hip fracture. The staff were to anticipate and meet all of her needs due to requiring total staff assistance with all of her activities of daily living (ADL's). A review of Resident #118 admission Minimum Data Set (MDS) dated 11/29/16, revealed that the resident was severely cognitively impaired and did not resist care. She was totally dependent on staff for personal hygiene. On 4/3/17 at 12:09 PM Resident #118 was observed her lower chin with ½ inch long thick, white, facial chin hairs. On 4/4/17 at 9:22 AM and on 4/5/17 at 2:05 PM Resident #118 was observed again with ½ inch long thick, white, facial chin hairs. On 4/5/17 at 2:11 PM Resident #118's assigned nursing assistant (NA#1) stated that she had not given Resident #118's morning care and had not worked with the resident for the past 3 days. She stated that the resident's chin hairs were long and should be shaved. NA#1 stated that another nursing assistant (NA#2) had completed resident #118's morning personal hygiene. On 4/5/17 at 2:16 PM NA#2 stated that she had	F 312	NA#1 and NA#2 were in-serviced by the CNE on 4/7/2017 on Personal Hygiene & Grooming including the shaving of chin hairs of female residents and shaving and trimming of beards of male residents. The CNE will in-service all nursing staff on Personal Hygiene & Grooming including the shaving of chin hairs of female residents and shaving and trimming of beards of male residents. Clinical Staff will complete a Clinical Competency on Shaving a Resident by 4/21/2017. The CNE, Unit Managers and Supervisor will conduct random audits of residents for long chin hairs and shaven beards weekly for 4 weeks on the first and second shifts, then every two weeks for 8 weeks on the first and second shifts. Results of the audits will be reviewed by the facility QAPI meeting monthly for three months and by the CNE to track progress toward improvement	

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F 312	Continued From page 10 given Resident #118 her morning bed bath and had also taken care of her on Monday (4/3/17) and saw that her chin hairs were too long. She stated she got busy and forgot to shave her. On 4/5/17 at 2:17 PM the Nurse Supervisor stated that her expectation was that when the resident's chin hairs were long staff should shave her.	F 312		
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:	F 371		5/8/17

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F 371	Continued From page 11 Based on observation and staff interview the facility failed to keep chilled desserts made with milk at or below 41 degrees Fahrenheit during the operation of the trayline, failed to air dry kitchenware before stacking it in storage, and failed to monitor storage areas for labeling/dating, disposal of leftovers, and refrigeration of perishable food items which were opened. Findings included: 1. At 11:54 AM on 04/05/17 the AM cook took the temperature of all hot foods on the steam table using a calibrated thermometer. The lunch trayline began operation at 12:05 PM on 04/05/17. At this time the dietary aide brought a pan containing bowls of banana mousse from the walk-in refrigerator. No initial temperature was taken for this chilled dessert. At 12:22 PM on 04/05/17 the AM cook used a calibrated thermometer to check the temperature of the last bowl of banana mousse in the pan beside the steam table. The other bowls had been placed on resident meal trays. The thermometer registered 51.2 degrees Fahrenheit. At 12:23 PM on 04/05/17 the AM cook used a calibrated thermometer to check the temperature of the first bowl of banana mousse just removed from the new pan which was also stored in the walk-in refrigerator. The thermometer registered 46.2 degrees Fahrenheit. At 12:25 PM on 04/05/17 a dietary aide stated she finished preparation of the banana mousse at approximately 11:00 AM on 04/05/17, placed the product in individual dessert bowls, and stored them on multiple pans in the walk-in refrigerator	F 371	F-371 There were no specific residents affected by the deficient practices outlined in F-371. Any residents receiving meals from the kitchen had the potential to be affected by the deficient practices outlined in F-371. As directed, the facility has arranged for professional in-service training to be provided by North Carolina Safety Solutions. Two training sessions are being scheduled on 5/3/17 at a time between breakfast and lunch and between lunch and supper. The various training times will permit all dietary staff ample opportunity to attend one of the two sessions. The training will address sanitary practices in the area of dietary with of focus on labeling and dating opened food items, proper storage of pans and dishware to avoid wet nesting and proper preparation and service of food to assure required temperatures are maintained. The Dietary Manager in place at the time of the survey left the organization on 4/9/17. Effective 4/7/17 and ongoing for the next month the Center Executive Director (CED) will conduct weekly Sanitation Surveys to monitor compliance with the deficient practices outlined in F-371. Following completion of the required	

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	345126	A. BUILDING _____ B. WING _____	04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 12 until the trayline started operation at 12:05 PM on 04/05/17. At 12:27 PM on 04/05/17 the AM cook stated there were still at least four more meal carts that needed to go out to residents for the lunch meal. However, he reported the facility could not serve any more of the banana mousse until it could be chilled to 41 degrees Fahrenheit or below. At 10:05 AM on 04/06/17 the dietary manager (DM) stated the banana mousse should have either been prepared the day before it was served and stored in refrigeration or prepared the first thing in the morning if the preparation had to occur on the same day it was served. Since the mousse preparation was not completed until about an hour before trayline operation began on 04/05/17, the DM reported it should have been stored in the walk-in freezer. He commented if chilled foods containing protein such as mayonnaise or dairy products stayed above 41 degrees Fahrenheit for extended periods of time bacteria could grow in them and make residents sick. According to the DM, the temperature of the banana mousse should have been taken as the trayline started operation so no residents would have been served the dessert unless it was within temperature range which was 41 degrees Fahrenheit or below. He also stated he expected the banana mousse to stay at or below 41 degrees Fahrenheit during the operation of the entire trayline. At 10:22 AM on 04/06/17 the AM cook stated he learned through in-servicing that chilled foods were supposed to remain at 41 degrees Fahrenheit or below during the entire operation of the trayline in order to reduce the chance that	F 371	in-service education provided by North Carolina Safety Solutions, the CED will conduct additional weekly Sanitation Surveys to assure continued compliance by dietary staff with proper sanitary procedures related to temperature control, wet nesting and labeling and dating of open food items. When weekly audits indicate substantial compliance, audits will be completed every two weeks for a month and if compliance is maintained, audits will be done monthly for a minimum of six months from survey date (October 2017). The Registered Dietitian will complete the same audit each month through October 2017 to validate the audit results of the CED. Results of the audits and any recommendations for changes in the frequency of the audits will be reviewed monthly at the facility QAPI meeting through October 2017. Audit results will dictate future changes to the frequency and duration of the audit period/schedule. No changes can be made to the schedule except to increase frequency until October 2017.	

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F 371	Continued From page 13	F 371		

bacteria could grow in them.

2. During initial tour of the kitchen, beginning at 10:50 AM on 04/03/17, 2 of 15 tray pans were stacked on top of one another in a storage unit with moisture trapped inside of them.

At 9:25 AM on 04/05/17 9 tray pans were stacked on top of one another on the draining board of the three compartment sink system. At this time the dietary aide stated these tray pans had been washed, rinsed, and sanitized.

At 9:32 AM on 04/05/17 8 of 18 tray pans were stacked on top of one another in a storage unit with moisture trapped inside of them.

At 11:48 AM on 04/05/17 the 9 tray pans stacked on top of one another still remained on the draining board of the three compartment sink system.

At 10:05 AM on 04/06/17 the dietary manager (DM) stated dietary staff were trained to make sure kitchenware was completely dry and free of dried food particles before stacking it in storage. He reported water trapped between pieces of kitchenware could eventually grow bacteria and mold.

At 10:22 AM on 04/06/17 the AM cook stated he did not like to stack pieces of kitchenware on top of one another, but if it had to be done due to shortage of storage space then all the kitchenware should be clean and dry. He reported the prolonged presence of moisture on kitchenware could breed bacteria.

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	345126	A. BUILDING _____ B. WING _____	04/06/2017

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F 371	Continued From page 14	F 371		

3. During initial tour of the kitchen, beginning at 10:50 AM on 04/03/17, a plastic storage bag of cheese crackers and an opened bag of bread crumbs in the dry storage room had no labels or dates on them to indicate when they were opened or placed in storage. Also in dry storage an 8-pound, 10-ounce jug of chunky salsa had been opened, but not placed in refrigeration after opening as directed on the product label. In the walk-in refrigerator a tray pan of leftover stuffed pasta shells had a discard date of 04/02/17, stew meat which was thawing had no label on it indicating when it was placed in refrigeration or for how long it could stay refrigerated before it needed to be discarded, and an opened gallon container of Italian dressing had no label or date on it. In the walk-in freezer two plastic storage bags of fish, an opened bag of pizza dough, an opened bag of pepperoni, an opened bag of biscuit dough, 3 plastic storage bags of lasagna noodles, and an opened bag of mixed vegetables did not have labels or dates on them.

At 9:40 AM on 04/05/17 in the dry storage room a bag of opened egg noodles was without a label and date, and an 8-pound, 10-ounce jug of chunky salsa had been opened, but not placed in refrigeration after opening as directed on the product label.

At 10:28 AM on 04/05/17 turkeys thawing in the walk-in refrigerator had no label on them indicating when they were placed in refrigeration or for how long they could stay refrigerated before they needed to be discarded.

At 10:05 AM on 04/06/17 the dietary manager (DM) stated he received food trucks once a week, and his stock person checked the storage areas

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	345126	A. BUILDING _____ B. WING _____	04/06/2017

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F 371	Continued From page 15 at that time. He also reported he tried to walk through and monitor all his storage areas each morning to make sure opened items were labeled and dated, foods past their expiration or use-by dates were disposed of, and items were stored per instructions on their labeling or packaging. He stated leftovers were only kept for three days, and meats to be thawed in refrigeration were supposed to be labeled with a pull date and use-by date. According to the DM, following these storage practices helped to ensure food quality was good and food spoilage was avoided. At 10:22 AM on 04/06/17 the AM cook stated all employees were supposed to monitor storage areas as they went in and out of them. He reported the facility did not use any food items past their use-by or discard date, and the facility followed all storage instructions on the labeling of food products. He commented all opened food items, all foods removed from their original packaging, all leftovers, and all thawing meats were supposed to have labels and dates on them. According to the cook, dating and labeling help ensure the older foods was used up first and residents were not served foods which could be spoiled.	F 371		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and	F 441		5/8/17

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F 441	Continued From page 16	F 441		

communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 441	Continued From page 17 contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on facility policy, record review, observation and interview the facility failed to wash their hands between resident care by lifting a resident (Resident 190) and then feeding a resident (Resident #87). The findings included: A review of the facility infection control policy entitled, "Hand Hygiene" read in part, " Process 1. Perform hand hygiene: 1.1 Before patient care; ....1.5 After contact with the patient's environment." Resident #87 was admitted to the facility on 5/3/14 with diagnoses of Alzheimer's disease. A review of her most recent quarterly Minimum Data Set (MDS) dated 2/24/17 revealed she had short and long term memory loss and was severely impaired with cognitive skills for daily	F 441	F-441 NA#2 was in-serviced by the Center Nurse Executive (CNE) on 4/7/2017 of the requirement to wash her hands after contact with each resident before going to another resident. The deficient practice had the potential to affect other residents in the facility. No other staff was identified as not washing their hands after contact with each resident and going to another resident. All nursing staff will be in-serviced by 4/21/2017 by the CNE on Handwashing and the importance of hand washing between each resident and before giving care to another resident. All nursing staff will complete the Handwashing Competency by 4/21/2017.	

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F 441	Continued From page 18 decision making. Resident #87 was totally dependent on staff for eating. On 4/3/17 at 12:50 PM Nursing Assistant (NA #2) was observed lifting a resident (Resident #190) and after lifting the resident was not observed washing her hands. On 4/3/17 at 12:52 PM NA#2 was observed entering Resident #87 ' s room and setting up her meal tray. NA#2 placed a straw into Resident #87 ' s beverage and the resident was observed drinking from the straw. On 4/3/2017 3:09 PM NA#2 stated that she lifted the resident (Resident #190) and should have washed her hands between resident care. During an interview on 4/6/17 at 8:03 AM the Director of Nursing stated that her expectation was for staff to wash their hands between resident care, especially before feeding a resident.	F 441	The CNE or Unit Managers will conduct random audits of hand washing between resident contacts for 6 patients 2 x a week for four weeks, then 6 patients 2 x a week for 3 weeks, then 6 patients for 1 x a week for 2 weeks then random 2 patients a month for 3 months. Results of the audits will be taken to the facility QAPI meeting monthly by the CNE to track progress toward improvement.	
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's	F 520		5/8/17

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F 520	Continued From page 19 staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. 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 observation, staff interview and record review, the facility's Quality Assessment and Assurance (QA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in May of 2016. This was for one recited deficiency which was originally cited in 4/4/13, and was recited on 3/6/14, 5/9/15 and 5/26/16 on Recertification/Complaint surveys. The deficiency was in the area of food procurement,	F 520	F-520 Please refer to the responses provided for F-371. The facility and it□s leadership takes the QAPI process very seriously and has worked diligently to achieve and maintain compliance as outlined in the survey report.	

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F 520	Continued From page 20 storage, preparation and distribution. This continued failure of the facility during five federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross-referenced to: F 371: Food Storage/Sanitation: Based on observation and staff interview the facility failed to keep chilled desserts made with milk at or below 41 degrees Fahrenheit during the operation of the tray line, failed to air dry kitchenware before stacking it in storage, and failed to monitor storage areas for labeling/dating, disposal of leftovers, and refrigeration of perishable food items which were opened. During the recertification /complaint survey of 4/4/13, the facility was originally cited for F 371 for failing to maintain a cold salad made with mayonnaise at 41 degrees Fahrenheit or below during operation of the tray line. During the recertification/complaint survey of 3/6/14, the facility was recited for F 371 for failing to offer an alternative vegetable of the same nutritive value as the scheduled vegetable on the menu for a lunch meal. During the recertification/complaint survey of 5/9/15, the facility was recited for F 371 by failing to clean the face of a wall fan blowing into the dish machine area where sanitized kitchenware was unloaded, failed to air dry and remove food particles from kitchenware before stacking it in storage, failed to monitor wash/rinse gauges	F 520	Recruiting and retaining a qualified manager for the dietary department has been challenging with at least 4 different directors in the last 3 years. The most recent left our organization on 4/9/17. The Sanitation/Safety audit process has been refined to focus specifically on the items cited during this survey. The previously used more comprehensive audit will continue to be used on at least a monthly basis unless the need is seen to increase frequency. The specialized audits designed to address the issues cited during this survey will be used as stated in the response for F-371 above. The Center Executive Director (CED)and Registered Dietitian will be conducting audits during the monthly review cycle and report findings to the QAPI Committee during monthly/quarterly meetings. Additional staff training will be provided for any staff member not in compliance with the food safety/sanitation practices required to assure the safe handling, storage and service of food products from the kitchen. Results of the audits and any recommendations for changes in the frequency of the audits will be reviewed monthly at the facility QAPI meeting through October 2017. Audit results will	

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F 520	Continued From page 21 during the operation of the dish machine, failed to clean walls/corners/floors in the kitchen, and failed to label and date opened food items. During the recertification/complaint survey of 5/26/16, the facility was recited for F 371 for failing to maintain potato salad made with mayonnaise at or below 41 degrees Fahrenheit during operation of the tray line, failed to maintain final rinse temperatures at 180 degrees Fahrenheit or higher at the dish machine, failed to discard compromised kitchenware, failed to clean kitchen equipment, and failed to monitor storage areas to ensure food quality. On 4/6/17 at 1:57 PM the facility Administrator stated that the facility plan last year (2016) for the food storage/sanitation citation had been for the Administrator to do weekly sanitation audits and lately the Administrator had changed the audits to monthly. The Administrator further stated that during the audits the Dietary Manager would see areas that needed to be improved but he failed to correct his staff and the root problem, the Administrator, stated he believed there was a lack of training and supervision.	F 520	dictate future changes to the frequency and duration of the audit period/schedule. No changes can be made to the schedule except to increase frequency until October 2017.	