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	345283	A. BUILDING _____ B. WING _____	01/05/2018

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MOORESVILLE CENTER	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

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F 000	INITIAL COMMENTS On 01/26/18 an amended Statement of Deficiencies was provided to the facility because the State Agency revised information in tags F-658 and F-697 that was in the facility's original CMS 2567 report. Event ID# FHGU11.	F 000		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have	F 576		2/16/18

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

Electronically Signed | 02/01/2018

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F 576	Continued From page 1 reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to deliver mail to residents on Saturdays. The findings included: On 01/04/18 at 11:43 AM an interview with resident council members revealed that mail is not delivered on Saturdays due to the activity director not working. The nine attending resident council members reported the mail went to the activity director before being delivered to the halls. They reported the mail they received on the weekend was delivered to them on Monday morning. During an interview on 01/04/18 at 11:47 AM with the Activities Director. She stated the mail that is delivered on Saturday is not delivered until Monday Morning. She reported there was "no weekend staff to deliver" the mail. She reported that staff have been informed they will begin to work every other weekend but the mail was currently not delivered until Monday morning. On 01/04/18 at 05:17 PM an interview with the Administrator revealed the facility currently was not delivering mail to the residents on Saturday	F 576	Element 1: The process that was in place before Jan 2018 was that mail was delivered by activity department during normal duty hours Monday-Friday and on the weekends when the activity department was present for manager on duty. Immediate re-education to all staff that participates in the Manager on Duty about timely delivery of resident mail when delivered on Saturday, no later than Sunday. Element 2: Administrator re-educated all staff that participate in the Manager on Duty program. Activities manager will audit each Monday to ensure that the mail was delivered on the weekend. Element 3: Administrator will add "Mail Delivered" to the weekend manager on duty checklist sheet. This will be reviewed on Monday's as well. Element 4: Activity Department Manager is responsible for implementing the acceptable plan of correction. Date of compliance will be 2/16/18. Activity manager will bring this to QAPI on a	

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F 576	Continued From page 2 as the mail delivery is handled by the activity personnel. He stated the current process had the mail delivered on Saturdays placed in the Activity Director's mailbox and then delivered to residents on Monday morning. He stated he began the process of requiring the activity personnel to work every other weekend so Saturday mail will be provided but as of this moment, Saturday mail is placed in the activity's mailbox and delivered on Monday morning. He stated it was his expectation that mail be delivered on Saturday to residents of the facility.	F 576	monthly basis for six months.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		2/16/18

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F 584	Continued From page 3 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain splintered and chipped bedroom and bathroom doors (Rooms 119, 316, 603, 606, 607, 615), splintered laminate on tray tables (Rooms 116, 119, 611), splintered laminate on a foot board (room 603), rusted toilet seat extender (Room 607), a sticky bedroom door (Room 321), a cracked bathroom ceiling (Room 107) and failed to repair several holes located behind bedroom doors (Rooms 105, 114 & 117). The Findings Included: 1. Splintered or chipped bedroom and/or bathroom doors a. An observation made of room 119 on 01/04/18 at 2:49 PM revealed splintered and chipped edges of the bedroom door. b. An observation made of room 316 on 01/04/18 at 2:51 PM revealed splintered and chipped edges of the bathroom door.	F 584	Element 1: The issues that led up to the deficiency included having both members of the maintenance on medical restrictions for completing specific activities. During this time the Maintenance Director resigned leaving one person that was on medical restrictions from completing the maintenance required to run a facility. Bedroom/bathroom doors in rooms 119, 316, 603, 606, 607, 615 were repaired. Trays in room 116, 119, 611 were replaced. Headboard and footboard in room 603 was replaced. Bedroom door on 321 was adjusted to allow it to open and close with ease. Ceiling in room 107 was repaired and the walls in rooms 105, 114, and 117 were repaired behind bedroom doors.	

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F 584	Continued From page 4 c. An observation made of room 603 on 01/04/18 at 2:53 PM revealed splintered and chipped edges of the bedroom and bathroom door. d. An observation made of room 606 on 01/04/18 at 2:55 PM revealed splintered and chipped edges of the bedroom door. e. An observation made of room 607 on 01/04/18 at 2:57 PM revealed splintered and chipped edges of the bedroom and bathroom door. f. An observation made of room 615 on 01/04/18 at 3:01 PM revealed splintered and chipped edges of the bathroom door. Multiple other observations completed on 01/05/18 starting at 8:45 AM and starting again at 3:02 PM revealed these conditions to continue to remain the same. 2. Splintered laminate on bedside trays: a. An observation made of room 116 on 01/04/18 at 2:47 PM revealed splintered and chipped laminate on the bedside tray which was split and had sharp edges. b. An observation made of room 119 on 01/04/18 at 2:49 PM revealed splintered and chipped laminate on the bedside tray which caused areas of the tray to have sharp edges and areas. c. An observation made of room 611 on 01/04/18 at 2:59 PM revealed splintered and chipped laminate on the bedside tray which caused the tray to have sharp and jagged edges. Multiple other observations completed on 01/05/18 starting at 8:45 AM and starting again at 3:02 PM revealed these conditions to continue to remain the same.	F 584	Element 2: 100% audit in the facility will completed by the maintenance director by 2/2/18 to ensure that there were no other doors that needed repair, trays/head boards/foot boards replaced due to delamination, cracks in ceiling, and holes behind doors. Element 3: Administrator/or designee to provide re-education to the maintenance team by 2/2/18on timely repairs and staff education to be completed 2/16/18 to report items in a timely manner to ensure that they can be fixed. Element 4: Maintenance Director is responsible for implementing the acceptable plan of correction. Date of compliance will be 2/16/18. Maintenance Director/administrator will log all maintenance related issues into TELS and track the timeliness of items being fixed. Weekly auditing to ensure that maintenance tickets are placed into TELS system will continue for 2 months, then every 2 weeks for 2 months, then monthly x2 months and taken care of in a timely manner. Maintenance Director will bring this to QAPI on a monthly basis for six months.	

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3. Splintered laminate on a residents footboard:
a. An observation made of room 603 on 01/04/18 at 2:55 PM revealed splintered and chipped laminate on the footboard of Resident #17.

Multiple other observations completed on 01/05/18 starting at 8:45 AM and starting again at 3:02 PM revealed these conditions to continue to remain the same.

4. Rusted toilet seat extender:
a. An observation made of room 607's bathroom on 01/04/18 at 2:57 PM revealed extensively rusted toilet seat extender.

Multiple other observations completed on 01/05/18 starting at 8:45 AM and starting again at 3:02 PM revealed these conditions to continue to remain the same.

5. Bedroom door that sticks:
a. An observation of room 321 on 01/04/18 at 3:15 PM revealed a bedroom door that was very difficult to open when fully shut.

Multiple other observations completed on 01/05/18 starting at 8:45 AM and starting again at 3:02 PM revealed these conditions to continue to remain the same.

6. Cracked and damaged bathroom ceiling:
a. An observation of room 107's shared bathroom on 01/04/18 at 2:43 PM revealed the ceiling to have a winding crack along approximately 75% of the ceiling.

Multiple other observations completed on

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01/05/18 starting at 8:45 AM and starting again at 3:02 PM revealed these conditions to continue to remain the same.

7. Holes in walls behind bedroom doors:
a. An observation of room 105 on 01/04/18 at 2:40 PM revealed a hole in the wall behind the bedroom door entering from the hallway.
b. An observation of room 114 on 01/04/18 at 2:44 PM revealed a hole in the wall behind the bedroom door entering from the hallway.
c. An observation of room 117 on 01/04/18 at 2:45 PM revealed two individual holes in the wall behind the bedroom door entering from the hallway.

Multiple other observations completed on 01/05/18 starting at 8:45 AM and starting again at 3:02 PM revealed these conditions to continue to remain the same.

An interview with the Maintenance Assistant on 01/05/18 at 3:21 PM revealed there to be no active big maintenance projects going on in the facility at this time. He stated he was notified of maintenance requests through word of mouth or telephone calls. He further stated there were also maintenance request logs at each nurse's station. He stated when he was notified by mouth, he would write it down in a notebook. He stated he cannot say he had not forgotten something and had to go back and complete the request but the current system worked pretty good for him. He stated he is the only maintenance man in the facility and attended to requests as soon as possible. He stated he tried to have everything resolved within 24 hours of being notified.

An interview with the Housekeeping Supervisor

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F 584	Continued From page 7 on 01/05/18 at 3:34 PM revealed he expected his people in the resident rooms to clean 3 times per day. He expected them to sweep, mop, dust and clean tables and bathrooms as needed. He stated there is a staggered deep clean day calendar that is used to determine which rooms are deep cleaned each day. He expected 2-3 rooms to be deep cleaned each day. During a walk around with the Housekeeping Director, Maintenance Assistant and Administrator it was revealed the only concern the Maintenance Assistant was aware of was the splintering laminate on some of the tray tables. He reported that nothing had been put into place to remedy the concern. An interview with the Administrator on 01/05/18 at 4:10 PM revealed he expected all maintenance concerns to be handled promptly and appropriately. He reported he was unaware of the concerns identified during the walk around and stated the concerns would be addressed.	F 584		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified	F 636		2/16/18

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by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission,

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F 636	Continued From page 9 excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete Care Area Assessments (CAA) that addressed the underlying causes and contributing factors for the area of psychosocial well-being for 4 of 8 sampled residents reviewed for comprehensive assessments (Residents #17, #18, #88 and #225). Findings included: 1. Resident #17 was admitted to the facility on 08/19/16 with diagnoses which included muscle weakness, diabetes, glaucoma, malnutrition, depression and a stroke with paralysis on one side. A review of the most recent comprehensive (annual) Minimum Data Set (MDS) dated 06/30/17 indicated Resident #17 was cognitively intact for daily decision making. The MDS further indicated Resident #17 required extensive assistance with bed mobility, transfers, locomotion on and off the unit, dressing, toileting and hygiene. A review of the Care Area Assessment dated 06/30/17 indicated psychosocial well-being triggered. A section labeled disease or condition that may impede ability to interact with others indicated depression and a section labeled health	F 636	Element 1: Activity Director misunderstood the process behind completing the Care Area Assessments and initiated a CAA without warrant because they that it was required in order to complete/sign. The completed the CAA and did not input a response and only signed off the CAA. 100% review was completed on other MDS by CRC, they went in and typed did not trigger on those that weren□t necessary. Element 2: Clinical Reimbursement Coordinator will audit activity and Activity Director will spearhead MDS entry for identified areas. Element 3: Activity members re-educated by Clinical Reimbursement Coordinator and online training in completing MDS. Re-education will be completed by 2/2/18. At this time Activity Director will be the staff member doing MDS until other activity staff have fully comprehended the training. CAAs will be audited by a Clinical Reimbursement Coordinator team member. Element 4: MDS team will be doing 100% audit for 6 months on comprehensive	

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F 636	Continued From page 10 status factors that may inhibit social involvement indicated a decline in activities of daily living. There was no individual information explaining why psychosocial well-being was a problem for the resident or how the problem affected their day to day routines and there was no analysis of the findings. During an interview on 01/05/18 at 4:43 PM, the Director of Nursing stated she was not familiar with the CAAs on the residents' MDS but thought they should be accurate. She confirmed MDS staff reported to the Administrator. During an interview on 01/05/18 at 5:29 PM, MDS Nurse #1 explained she and MDS Nurse #2 completed the nursing CAAs but they did not complete the psychosocial well-being section. She further explained the psychosocial well-being section was completed by activities staff and they were expected to complete it and sign off on it. She stated she did not read or review it after it was completed and MDS Nurse #2 did not read or review it because everyone was responsible for accurate completion of their own CAA sections. During an interview on 01/05/18 at 5:50 PM, the Recreation Director explained she was in charge of the facility activity programs. She further explained she had an assistant who completed the section for activities on the MDS and psychosocial well-being on the CAAs. She stated she had been informed by the former Administrator to write a summary for the psychosocial well-being CAA and she had instructed her assistant to complete the summary. She acknowledged she did not review her assistant's work because her assistant had	F 636	assessments. Activity Department Manager is responsible for implementing the acceptable plan of correction. Date of compliance will be 2/16/18. Clinical Reimbursement Coordinator will bring this to QAPI on a monthly basis for six months.	

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worked in the facility for a long time. The Recreation Director stated she had received training from a computer based program for completion of the CAAs but had no formal training. She further stated after review of Resident #17's CAA for psychosocial well-being there was no analysis of findings or a summary on their CAA to explain why this was problem or affected the residents day to day routines.

During a follow up interview on 01/05/18 at 6:16 PM, MDS Nurse #1 verified training had been provided to all staff who completed CAAs but she thought more work needed to be done to improve the documentation on the CAA for psychosocial well-being.

During an interview on 01/05/18 at 7:03 PM, the Administrator stated it was his expectation for the MDS and CAAs to be completed accurately for each resident. He further stated he expected for the MDS and CAAs to reflect the needs of the resident.

2. Resident #18 was re-admitted to the facility on 11/04/16 with diagnoses which included Alzheimer's disease, dementia, heart disease, diabetes, chronic kidney disease, depression and a stroke with paralysis on one side.

A review of the most recent comprehensive (significant change) Minimum Data Set (MDS) dated 06/12/17 indicated Resident #18 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also revealed Resident #18 required extensive assistance with activities of daily living.

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A review of a Care Area Assessment dated 06/12/17 indicated psychosocial well-being triggered. A section labeled disease or condition that may impede ability to interact with others indicated Alzheimer's disease, other dementia and depression. A section labeled health status factors that may inhibit social involvement indicated health problems such as falls, pain or fatigue and a change in communication related in part to cognition. There was no individual information explaining why psychosocial well-being was a problem for the resident or how the problem affected their day to day routines and there was no analysis of the findings.

During an interview on 01/05/18 at 4:43 PM, the Director of Nursing stated she was not familiar with the CAAs on the residents' MDS but thought they should be accurate. She confirmed MDS staff reported to the Administrator.

During an interview on 01/05/18 at 5:29 PM, MDS Nurse #1 explained she and MDS Nurse #2 completed the nursing CAAs but they did not complete the psychosocial well-being section. She further explained the psychosocial well-being section was completed by activities staff and they were expected to complete it and sign off on it. She stated she did not read or review it after it was completed and MDS Nurse #2 did not read or review it because everyone was responsible for accurate completion of their own CAA sections.

During an interview on 01/05/18 at 5:50 PM, the Recreation Director explained she was in charge of the facility activity programs. She further explained she had an assistant who completed the section for activities on the MDS and

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psychosocial well-being on the CAAs. She stated she had been informed by the former Administrator to write a summary for the psychosocial well-being CAA and she had instructed her assistant to complete the summary. She acknowledged she did not review her assistant's work because her assistant had worked in the facility for a long time. The Recreation Director stated she had received training from a computer based program for completion of the CAAs but had no formal training. She further stated after review of Resident #18's CAA for psychosocial well-being there was no analysis of findings or a summary on their CAA to explain why this was problem or affected the residents day to day routines.

During a follow up interview on 01/05/18 at 6:16 PM, MDS Nurse #1 verified training had been provided to all staff who completed CAAs but she thought more work needed to be done to improve the documentation on the CAA for psychosocial well-being.

During an interview on 01/05/18 at 7:03 PM, the Administrator stated it was his expectation for the MDS and CAAs to be completed accurately for each resident. He further stated he expected for the MDS and CAAs to reflect the needs of the resident.

3. Resident #88 was admitted to the facility on 05/20/15 with diagnoses which included a difficulty walking, muscle weakness and dementia.

A review of the most recent comprehensive (annual) Minimum Data Set (MDS) dated 03/03/17 indicated Resident #88 had short and

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long term memory problems and was severely impaired in cognition for daily decision making. The MDS further indicated Resident #88 required extensive assistance by staff for activities of daily living.

A review of a Care Area Assessment dated 03/03/17 indicated psychosocial well-being triggered. A section labeled disease or condition that may impede ability to interact with others indicated other dementia. A section labeled health status factors that may inhibit social involvement indicated a change in communication related in part to cognition. There was no individual information explaining why psychosocial well-being was a problem for the resident or how the problem affected their day to day routines and there was no analysis of the findings.

During an interview on 01/05/18 at 4:43 PM, the Director of Nursing stated she was not familiar with the CAAs on the residents' MDS but thought they should be accurate. She confirmed MDS staff reported to the Administrator.

During an interview on 01/05/18 at 5:29 PM, MDS Nurse #1 explained she and MDS Nurse #2 completed the nursing CAAs but they did not complete the psychosocial well-being section. She further explained the psychosocial well-being section was completed by activities staff and they were expected to complete it and sign off on it. She stated she did not read or review it after it was completed and MDS Nurse #2 did not read or review it because everyone was responsible for accurate completion of their own CAA sections.

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During an interview on 01/05/18 at 5:50 PM, the Recreation Director explained she was in charge of the facility activity programs. She further explained she had an assistant who completed the section for activities on the MDS and psychosocial well-being on the CAAs. She stated she had been informed by the former Administrator to write a summary for the psychosocial well-being CAA and she had instructed her assistant to complete the summary. She acknowledged she did not review her assistant's work because her assistant had worked in the facility for a long time. The Recreation Director stated she had training from a computer based program for completion of the CAAs but had no formal training. She further stated after review of Resident #88's CAA for psychosocial well-being there was no analysis of findings or a summary on their CAA to explain why this was problem or affected the residents day to day routines.

During a follow up interview on 01/05/18 at 6:16 PM, MDS Nurse #1 verified training had been provided to all staff who completed CAAs but she thought more work needed to be done to improve the documentation on the CAA for psychosocial well-being.

During an interview on 01/05/18 at 7:03 PM, the Administrator stated it was his expectation for the MDS and CAAs to be completed accurately for each resident. He further stated he expected for the MDS and CAAs to reflect the needs of the resident.

4. Resident #225 was admitted to the facility on 08/10/17 with diagnoses which included hypertension, diabetes mellitus type 2, end stage

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renal disease (ESRD) with dialysis.

A review of the admission Minimum Data Set (MDS) dated 08/17/17 indicated Resident #225 was cognitively intact for daily decision making. The MDS further indicated Resident #225 required limited assistance with bed mobility, walking in corridor, locomotion on and off the unit, dressing, toileting and personal hygiene and extensive assistance with transfers and bathing.

A review of the Care Area Assessment (CAA) dated 08/17/17 indicated psychosocial well-being triggered. A section labeled health status factors that may inhibit social involvement indicated a mood or behavior problem that impacts interpersonal relationships or that arises because of social isolation. There was no individual information explaining why psychosocial well-being was a problem for the resident or how the problem affected their day to day routines and there was no analysis of the findings.

An interview on 01/05/18 at 4:43 PM with the Director of Nursing (DON) revealed she was not familiar with the CAAs on the residents' MDS but thought they should be accurate. She confirmed MDS staff reported to the Administrator.

An interview on 01/05/18 at 5:29 PM with MDS Nurse #1 revealed she and MDS Nurse #2 completed the nursing CAAs but did not complete the psychosocial well-being section. She explained the psychosocial well-being section was completed by Activities staff and they were expected to complete it and sign off on it. Additionally, MDS Nurse #1 stated she did not read or review that section and MDS Nurse #2 did not read or review it because everyone was

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F 636	Continued From page 17 responsible for their own sections. An interview on 01/05/18 at 5:50 PM with the Recreation Director revealed she was in charge of the facility activity programs and she completed resident care plans. She further explained she had an assistant who completed the section for activities and the psychosocial well-being on the CAAs on the resident's MDS. She stated the former Administrator had told them they needed to put something in the summary box and she had instructed her assistant to write a summary for the CAAs. She stated she did not review her assistant's work because she had worked in the facility for a long time. She stated she had training in a computer system for completion of the CAAs. She further stated after review of Resident #225s CAA for psychosocial well-being that other residents who had triggered psychosocial well-being did not have an analysis of findings or summary on their CAAs. An interview on 01/05/18 at 7:03 PM with the Administrator revealed it was his expectation for the MDS and CAAs to be completed accurately for each resident. He further stated he expected for the MDS and CAAs to reflect the needs of each resident.	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the	F 641	Element 1: When researching and	2/16/18

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F 641	Continued From page 18 facility failed to accurately code a Significant Change Minimum Data Set (MDS) dated 10/16/17 for oxygen for 1 of 1 resident reviewed for a tracheostomy (Resident #35). The findings included: Resident #35 was admitted to the facility on 07/28/16 with diagnoses which included traumatic brain injury. Review of Resident #35's Physician orders dated 10/12/17 indicated Oxygen via tracheostomy continuously at 3 L/m (liters per minute). Review of Resident #35's Significant Change Minimum Data Set (MDS) dated 10/16/17 revealed Oxygen was not coded on the MDS. Interview with the MDS Nurse #1 on 01/05/18 at 5:29 PM stated it was an oversight on her behalf and she would expect to see oxygen coded on the MDS since Resident #35 received oxygen through the tracheostomy.	F 641	looking through resident records, order for O2 was written to be administered with trach collar, however did not catch the error due to not being on separate orders. Resident #35 MDS was modified by the MDS Coordinator to reflect accurate coding and care plan was corrected. Element 2: The Director of Nursing or designee shall audit 100% MDS□s in progress to ensure Oxygen N0100C is accurately coded prior to ARD. Element 3: Clinical Reimbursement Manager (Regional MDS Nurse) will educate Clinical Reimbursement Coordinator (Facility MDS Nurse) on the Resident Assessment Instrument (RAI) for MDS for Section N 0100C by 1/29/18. Element 4: Clinical Reimbursement Coordinator will audit 10% of weekly MDS for Section N0100C for accuracy prior to transmission x2 months and then randomly thereafter to determine compliance. Director of Nursing will submit results of audits to the monthly QAPI meeting for review. Clinical Reimbursement Coordinator is responsible for implementing the acceptable plan of correction. Date of compliance will be 2/16/18. Clinical Reimbursement Coordinator will bring this to QAPI on a monthly basis for six months.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		2/16/18

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F 656	Continued From page 19 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656		

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F 656	Continued From page 20 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to develop a care plan for the use of oxygen for 1 of 1 resident reviewed for oxygen delivered via tracheostomy (Resident #35). The findings included: Resident #35 was admitted to the facility on 07/28/16 with diagnoses which included traumatic brain injury. Review of Resident #35's Physician orders dated 10/12/17 noted Oxygen via tracheostomy continuously at 3 L/m (liters per minute). Review of Resident #35's care plan revealed there was no plan of care developed for the use of continuous oxygen. Interview with the MDS Nurse #1 on 01/05/18 at 5:29 PM revealed Resident #35 should have had a care plan for Oxygen since the resident received oxygen through the tracheostomy. MDS Nurse #1 looked back at Resident #35's previous care plan for Oxygen and stated it was her fault because she overlooked it.	F 656	Element 1: When researching and looking through resident records, order for O2 was written to be administered with trach collar. Failure to identify this on MDS resulted no documentation on care plan. Resident #35 MDS was modified by the MDS Coordinator to reflect accurate coding and care plan was corrected. Element 2: The Director of Nursing or designee shall review and audit 100% of existing O2 patient care plans to ensure oxygen is accurately documented. Element 3: The Director of Nursing/Designee to re-educate all staff who complete care plans to ensure all necessary interventions are in place by 2/16/18. Element 4: Director of Nursing or designee will complete 10% audit of new admission care plans to ensure accuracy for x2 months and then randomly x4 months thereafter to determine compliance. Director of Nursing is responsible for implementing the acceptable plan of correction. Date of compliance will be 2/16/18. Clinical Reimbursement Coordinator will bring this to QAPI on a monthly basis for six months.	
F 658 SS=G	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		2/16/18

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F 658	Continued From page 21 §483.21(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 observation, record review, resident, and staff interviews, the facility failed to follow physician orders for a dressing change for 1 of 1 residents (Resident #110) reviewed for wound care. The resident experienced pain during the removal of the incorrect dressing that was applied to a wound. Findings included: Resident #110 was admitted to the facility on 04/28/16 and re-admitted on 11/04/16. Her diagnoses included hypertension, diabetes mellitus type 2, end stage renal disease and venous ulcer to her right lower extremity. Review of Resident #110's most recent quarterly minimum data set (MDS) dated 12/12/17 revealed she was cognitively intact and had some behavioral symptoms not directed toward others. The resident required extensive assistance of 1 staff with dressing, toileting, personal hygiene and bathing. Review of Resident #110's care plan dated 12/21/17 revealed she was care planned for exhibiting or being at risk for alterations in comfort related to the wound to her lower extremity and her chronic pain. The goal was that the resident would achieve an acceptable level of pain control for the next 90 days with a	F 658	Element 1: The nurse that changed the dressing prior to observation failed to follow through with physician□s orders. Dressing on resident #110 was immediately changed to MD appropriate order by attending staff nurse on 1/4/18. Element 2: The Director of Nursing or designee shall complete 100% audit on all wounds to ensure appropriate dressings in place by 2/9/18. Element 3: The Director of Nursing/designee to re-educate all staff who provide wound care to ensure dressing being applied is compliant with physician orders by 2/16/18. If an error is observed during audits DON/designee will ensure immediate correction. Element 4: Director of Nursing or designee will complete a weekly audit on wounds. 75% of all wounds will be audited weekly x1 month, 75% of wounds will be audited monthly x 5 months to ensure appropriate treatment is in place per physician's order. Director of Nursing is responsible for implementing the acceptable plan of correction. Date of compliance will be 2/16/18. Director of Nursing will bring this to QAPI on a	

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F 658	Continued From page 22 target date of 03/27/18. Interventions included in part: 1. Evaluate pain characteristics: quality, severity, location, precipitating/relieving factors, 2. Utilize pain scale, 3. Advise resident to request pain medication before pain becomes severe, and 4. Encourage and assist resident to eliminate additional stressors or sources of discomfort. Review of a physician order written 01/02/18 revealed the wound care physician had written the following order for wound care: "Continue with daily wound cleansing with saline or wound cleanser. Apply gentamycin cream from the hospital stay to all wounds daily. Use ABD pads (which are non-adherent) to ankle to cover all wounds. Two layer compression wrap to be changed daily. Wound Care Clinic (WCC) may use silvercel if patient does not have cream with her." Review of Resident #110's pain medication orders revealed there were no orders for pain medication to be given prior to her dressing change. An interview on 01/03/18 at 9:42 AM with Resident #110 revealed she had been at the facility for approximately 3 years. The resident stated that she had a wound on her right leg below her knee due to venous ulcer and had had the wound for 2 years. She stated that she had been to the wound clinic yesterday and the physician had debrided her wound and showed a picture on her phone of the wound. The resident stated she was also being seen at the pain clinic and she had told the physician she was having pain with the dressing changes and stated the physician wanted her to stay on the current pain regimen for at least 6 weeks before she changed the orders. She stated that she had complained about pain during the dressing changes but had	F 658	monthly basis for six months.	

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been told they were giving her all the medication she had ordered for pain. The resident stated she just had to get through the dressing change and try to tolerate the pain. The resident acknowledged she had not asked them to stop the dressing change because she knew it had to be done and she knew they would not give her anything additionally for the pain.

An observation of Resident #110's dressing change on 01/04/18 at 4:20 PM revealed the resident had been pre-medicated by Nurse #2 for the procedure at 3:25 PM. The 2nd shift nurse supervisor and Nurse #1 were in the room and getting their supplies ready for the dressing change. The supervisor washed her hands and donned her gloves and started cutting the dressing away from the wound and the resident had tolerated it well. The cut part of the dressing which was Kerlix was removed by the supervisor. Upon removal of the rest of the dressing, the supervisor and Nurse #1 ascertained that the wrong dressing had been applied to the resident's wound on 01/03/18 when the nurse had changed it on second shift. The orders were written for a non-adherent dressing to be applied to the wound and gauze which is adherent had been applied to the wound instead. The nurses cleaned the excess cream from the skin surrounding the wound and some from the wound itself. Nurse #1 using aseptic technique applied a thin layer of gentamycin cream on the wound, rubbing from top to bottom. The nurse then applied 5 non-adherent abdominal (ABD) pads to cover the wound completely and wrap around the ankle. The 2 step compression was then layered over the ABD pads and taped in place and the dressing was covered with a stockinette. Nurse #1 stated the dressing came in a kit which

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contained the 2 compression dressings and the stockinette. The nurse stated there was a supply of the kits in the clean utility room and a kit was kept in the treatment cart.

The supervisor and Nurse #1 went back into the resident's room and continued to try to remove the dressing and the resident continued to cry out, with a grimaced face and had tears rolling down her cheeks. The supervisor asked the resident at 4:35 PM if she wanted her scheduled dose of pain medication and the resident stated no, she wanted to wait until the dressing change was done. The supervisor continued to try to remove the dressing that was saturated but it was stuck to the wound bed and the resident continued to cry in pain. At 5:20 pm the supervisor went out of the room to get the Director of Nursing (DON) for her to try to remove the dressing. The supervisor stated she had not seen Resident #110 cry out in this much pain.

The DON came into the room, saturated the dressing again and attempted to loosen the dressing and the resident again cried out in pain, was grimacing and had tears rolling down her face. The DON stated to Resident #110 why don't you take your additional pain medication and the resident agreed at 5:30 pm to take the medication. The DON stated to the resident "why are you acting like this? You don't usually cry out in pain like this, what is different?" The resident stated to the DON "I don't know what is different it just hurts and the nurse put too much medicine on it last night when she changed it and it hurts." The DON kept trying to get the dressing off and finally was able to remove the top dressing but the wound bed dressing was still attached. At 5:30 PM, the supervisor returned with Resident

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#110's pain pill and asked the nurses if they would wait to give the pill a chance to kick in before they continued with the dressing change. The supervisor and Nurse #1 stated they would return in 20 to 30 minutes to continue with the dressing change.

At 5:23 PM an interview with Resident #110 revealed the pain associated with the dressing change was much worse today than previously. She stated there was always some pain associated with the dressing change but the dressing had not been sticking to the wound like it had this time. She stated that she had usually yelled in pain but not like this and stated that it had not previously hurt this bad.

At 5:53 PM the supervisor and Nurse #1 returned to the resident's room to try to remove the dressing again. The supervisor started working with the dressing after saturating it again and the resident again cried out in pain so the supervisor stopped. Nurse #1 stated she would try to remove the dressing and started working with the dressing and after a while was finally able to remove the rest of the dressing. Resident #110 continued to cry during the removal of the dressing but stated the medication had helped a little bit. The wound had a circular area at the top and then a larger wider open area down to the ankle. The wound bed had granulating tissue but there was an excess of cream on the skin and on the wound that had not been absorbed. Upon the dressing being removed the supervisor and Nurse #1 ascertained that the wrong dressing had been applied to the resident's wound on 01/03/18 when the second shift nurse had changed it.

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The orders were written for ABD pads (which are non-adherent) to be applied to the wounds and gauze (which is adherent) had been applied to the wound instead. The nurses cleaned the excess cream from the skin surrounding the wound and some from the wound itself. Nurse #1 using aseptic technique applied a thin layer of gentamycin cream on the wound, and applied 5 ABD pads to cover the wound completely and wrap around the ankle. The 2 step compression was then layered over the ABD pads and taped in place and the dressing was covered with a stockinette. Nurse #1 stated the dressing came in a kit which contained the 2 compression dressings and the stockinette. The nurse stated there was a supply of the kits in the clean utility room.

An interview on 01/05/18 at 10:01 AM with the wound care clinic physician revealed they had been battling Resident #110's wound for some time and had tried various treatments and had finally seen some improvement with the wound. The physician stated he had just debrided the wound on 01/02/18 and changed her orders for her dressing to a non-adherent dressing. He stated that gauze on a wound after debridement would legitimately cause pain with the removal of the dressing. The physician also stated the pain she had with the removal of the gauze dressing demonstrated why you would have used and why he had ordered a non-adherent dressing. The wound care physician stated he expected the facility to follow the orders he had written for dressing changes to the extent possible. He also stated that trying to follow the orders as much as possible would be advantageous for Resident #110.

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F 658	Continued From page 27 An interview on 01/05/18 at 11:55 AM with the Medical Director revealed that he expected when he wrote an order for the nurses to follow his orders as written. An interview on 01/05/18 at 12:03 PM with the facility's Nurse Practitioner revealed that she expected when she wrote an order for the nurses to follow the orders as written. An observation on 01/05/18 at 1:18 PM of the clean utility room revealed there were 6 kits for Resident #110's dressing available for use. An interview on 01/05/18 at 3:21 PM with Nurse #3 revealed she had done the dressing on 01/03/18 for Resident #110 on second shift. She stated she had followed the physician order as written on the Medication Administration Record (MAR). Nurse #3 reviewed the MAR and realized the orders for the dressing had been changed on 01/02/18 by the wound care physician and stated that she had not followed the new orders for wound care which took effect on 01/02/18. Nurse #3 stated she had looked at the old orders and followed them instead of the new orders. An interview on 01/05/18 at 3:33 PM with the Director of Nursing (DON) revealed her expectation was for the nurses to follow physician orders as written. An interview on 01/05/18 at 6:50 PM with the DON and Administrator revealed the Administrator expected the nurses to follow the physician orders as written.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		2/16/18

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F 684	Continued From page 28 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews the facility failed to follow the bowel movement protocol for 1 of 5 residents reviewed for unnecessary meds (Resident #26) and failed to change a resident's skin tear dressing as ordered for 1 of 1 resident (Resident #51) reviewed for skin conditions. The findings included: 1. Review of Resident #26's medical record revealed she was admitted to the facility on 04/04/14 with diagnoses which included hypertension, depression and dementia. The most recent quarterly Minimum Data Set (MDS) dated 10/06/17 indicated her cognitive skills for daily decision making were severely impaired, she required extensive assistance for most of her activities of daily living (ADL) and was totally depend on staff for toilet use. The MDS also noted that Resident #26 was incontinent of bowel. Review of Resident #26's care plan for ADLs dated 10/03/17 noted she was at risk for decreased ability to perform her ADLs due to her cognitive loss. The care plan did not include a problem of constipation.	F 684	Element 1: The attending nurse failed to follow through with bowel protocol. Nothing could be accomplished for resident #26 because they have had a bowel movement between failure to follow protocol and identification of deficient practice. The nurse providing initial dressing care failed to identify accurate dating on the treatment record. Dressing on resident #51 was immediately changed to MD appropriate order. Element 2: The Director of Nursing or designee shall complete a 100% audit on BM reports from the last two weeks to identify any resident that has had no BM within 72 hours to ensure proper protocol was followed. The Director of Nursing or designee shall complete 100% audit on all wounds to ensure appropriate and timely dressings are in place. Element 3: The Director of Nursing/designee to re-educate all staff who provide BM management to ensure proper follow-up and protocol execution by 2/16/18. Re-education to all staff who	

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F 684	Continued From page 29 Review of Resident #26's monthly Physician's orders dated from December 1, 2017 through December 31, 2017 indicated she had an order to give MOM (milk of magnesia) 30 ml (milliliters) by mouth if no bowel movement in 3 days. She also had an order to give a Dulcolax suppository rectally if she had no results from the MOM within the next shift. The monthly orders continued to indicate that if she had no results from the suppository within 2 hours to give a Fleets enema then lastly if no results from the enema to call the Physician for further orders. Review of Resident #26's bowel movement record dated from December 6, 2017 through January 4, 2018 revealed no bowel movement was recorded from December 17, 2017 through December 23, 2017. Review of Resident #26's monthly Medication Administration Record (MAR) for December 2017 indicated Resident #26 was given 30 mls of MOM on December 21, 2017 at 9:00 PM for no bowel movement in 3 days. The MAR also noted that on December 22, 2017 at 5:00 AM the suppository was documented and circled as not given due to Resident #26 was already up in the wheelchair. An interview conducted with Nurse #4 on 01/05/18 at 3:46 PM revealed it was the second shift nurse's responsibility to check the resident's bowel movement record for needed laxatives. Nurse #4 stated she gave Resident #26 a laxative of MOM on 12/21/17 at 9:00 PM for no bowel movement for 3 days and the third shift Nurse #5 should have followed up with the suppository on 12/22/17 if Resident #26 had no bowel movement by the end of third shift.	F 684	provide wound care to ensure dressing being applied is complaint with being changed during an appropriate time frame by 2/16/18. Element 4: Director of Nursing or designee will complete a daily audit x 4 weeks, then bi-weekly audit x 4 weeks, monthly x 4 months of Bowel Reports to ensure appropriate interventions completed. Director of Nursing or designee will complete a weekly audit on wounds. 75% of all wounds will be audited weekly x1 month, 75% of wounds will be audited monthly x 5 months to ensure timely dressing changes completed. Director of Nursing will submit results of audits to the monthly QAPI meeting for review. Director of Nursing is responsible for implementing the acceptable plan of correction. Date of compliance will be 2/16/18. Director of Nursing will bring this to QAPI on a monthly basis for six months.	

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On 01/05/18 at 3:55 PM Nurse #5 was unable to be reached via telephone.

An interview with the Director of Nursing (DON) on 01/05/18 at 4:00 PM stated it was not acceptable for Nurse #5 not to give Resident #26 the rectal suppository because she was up in the wheelchair. The DON stated it would be her expectation for the Nurse to have given the suppository to Resident #26 before she was gotten up in her wheelchair.

2. Review of Residents #51's medical record revealed she was readmitted to the facility on 12/10/17 with diagnoses which included diabetes mellitus and heart failure. The most recent quarterly Minimum Data Set (MDS) dated 10/30/17 indicated she had intact cognition and required extensive assistance by two staff assist for most of her activities of daily living (ADL). The MDS also noted that Resident #51 currently received non-surgical dressings (with or without topical medications) other than to feet.

Review of Resident #51's undated care plan for skin break down revealed she was at risk for skin breakdown related to incontinence and immobility. The goal for Resident #51 would be to be free of skin breakdown by utilizing interventions including weekly skin assessments, observe skin condition and assisting Resident #51 in repositioning.

Review of Resident #51's January 2018 Physician's orders revealed two orders:
12/11/17 Simply saline wound wash 0.9% solution to cleanse right elbow with wound cleanser, steri-strips applied and Optifoam

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bordered gauze every 7 days and as needed
12/23/17 Cleanse skin tear to left lower arm with wound cleanser, sureprep periwound, apply Optifoam gentle every 7 days and as needed.

Observations of Resident #51's arms on 01/02/18 at 11:57 AM revealed her left lower arm had a foam dressing initialed and dated for 12/26/17 and near her right elbow was a foam dressing initialed and dated for 12/25/17.

Observations of Resident #51's arms on 01/04/18 at 12:28 PM revealed a foam dressing on her left lower arm initialed and dated for 12/26/17 and a foam dressing near her right elbow was initialed and dated for 12/25/17.

Observations of Resident #51's arms on 01/05/17 at 3:02 PM revealed a foam dressing initialed and dated for 12/25/17 near her right elbow and a foam dressing on her left lower arm initialed and dated for 12/26/17.

Interview with the Treatment Nurse (TN) on 01/05/18 at 3:02 PM revealed she performed the treatments on the more critical wounds such as the diabetic ulcers, venous and pressure ulcers but she sometimes helped the hall nurses when she had time. The TN stated the skin tear dressings were normally changed every 7 days unless there was a specific order to change them otherwise. Upon observation of Resident #51's dressings on her arms the TN stated they should have been changed before now.

Interview with the 300 hall nurse (Nurse #2) on 01/05/18 at 3:20 PM revealed the nurses on the halls were responsible for changing the dressings on the skin tears. She continued to explain that

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F 684	Continued From page 32 the skin tear dressings were normally changed every 7 days and as needed. Nurse #2 stated she tried to look at the areas when she when she worked with the residents in case the skin tear dressings needed to be changed before the 7 days. When Nurse #2 observed the foam dressings on Resident #51's arms she stated the dressings should have been changed before today. An interview with the Director of Nursing (DON) on 01/05/18 at 4:11 PM revealed she was not sure what the system was for the dressing changes and stated the January 2018 Treatment Administration Record (TAR) should not have been marked off for the dressing change date until the skin tears dressings were changed the last time in December 2017. The DON also stated her expectation was for the skin tears to be assessed every day.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff and physician interviews, the facility failed to secure smoking materials, specifically, a lighter for 1 of 1 resident (Resident #225) reviewed for safe smoking.	F 689	Element 1: The process that led to deficiency was that the staff were not educated on proper storage procedures for smoking materials according to the corporate policy. Secured smoking	2/16/18

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F 689	Continued From page 33 Findings included: A review of the facility's smoking policy with an effective date of 06/01/96 and revision date of 06/15/17 read in part "For Centers that allow smoking: 2.6 Smoking supplies (including, but not limited to, tobacco, matches, lighters, lighter fluid, etc.) will be labeled with the patient's name, room number, and bed number, maintained by staff, and stored in a suitable cabinet kept at the nursing station. 2.6.1 if the patient is cognitively and physically able to secure all smoking materials, the Center may allow him/her to maintain his/her own tobacco or electronic cigarette products in a locked compartment, 2.6.2. Patients will not be allowed to maintain their own lighter, lighter fluid, or matches." Resident #225 was admitted to the facility on 08/10/17 with diagnoses that included hypertension, chronic obstructive pulmonary disease (COPD) and end stage renal disease (ESRD) with dialysis. A review of the most recent quarterly minimum data set (MDS) dated 11/17/17 for Resident #225 revealed the resident was cognitively intact and required limited assistance with most ADL. The MDS also revealed the resident was able to use her walker and wheelchair for ambulation. A review of a safe smoking evaluation dated 08/30/17 revealed the facility had assessed the resident as a safe smoker that could smoke independently. A review of Resident #225s care plan dated 01/04/18 revealed the resident was care planned	F 689	materials from resident #225. Element 2: All current smoking residents in a skilled bed will have lighters/matches removed from their room and placed in a smoking box kept at each nursing desk. The box will be labeled with each resident□s name and room number. Each resident will have a new smoking assessment signed with the facility□s policy provided and reviewed. Signed smoking assessment will be kept in resident□s medical record. If a resident is an independent smoker and chooses to maintain his/her own cigarettes, a key for the top drawer of the nightstand will be provided to keep items locked. Otherwise, cigarettes will be kept in the smoking box with lighter/matches and labeled with their name and room number. Social Services Department along with Nurse Practice Educator will educate all staff of Genesis smoking policy and installation of smoking boxes at nursing desks. Education will be completed by 2/16/18. Signed smoking assessments will be maintained in the resident□s charts. Element 3: The Admissions Director/designee will give all new admissions education of the smoking policy upon admission. The resident will be assessed by nursing using the Smoking Assessment. Once the assessment is completed the resident and/or responsible party will sign the assessment acknowledging an understanding of the facility□s smoking policy. A bulleted memo of the policy will	

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F 689	Continued From page 34 to smoke independently per her smoking assessment. The goal was for the resident to smoke safely for 90 days with target date for 04/25/18. The interventions included: 1. Educate patient/health care decision maker on the facility's smoking policy, 2. Ensure that there is no oxygen use in smoking area(s), 3. Ensure that appropriate cigarette disposal receptacles are available in smoking areas, 4. Monitor patient's compliance to smoking policy, and 5. Provide education/material regarding smoking cessation. An observation on 01/05/18 at 10:15 AM of Resident #225 out in the courtyard smoking revealed she had her smoking materials in a pouch around her neck. The resident was observed taking her cigarettes and lighter out of her pouch, lighting her cigarette, properly disposing of her ashes and putting out her cigarette. The resident was observed putting the cigarettes and lighter back in the pouch around her neck. An interview on 01/05/18 at 10:46 AM with Resident #225 revealed the resident had been out to smoke and stated that she had been assessed by the facility as a safe smoker. She stated that she kept her smoking materials (cigarettes and lighter) in her pouch in her room at all times. The resident was observed with the pouch around her neck. Resident #225 stated she had not wanted anyone else to keep her smoking materials and kept them with her even when she went to dialysis. The resident stated that the dialysis staff took her pouch with her cigarettes and lighter when she got there and then gave it back to her when she was finished with dialysis.	F 689	be provided to the resident upon admission. Lighters/matches/electronic cigarettes will be placed in the smoking box labeled with the resident□s name and room number. Smoking assessments will be signed quarterly review assessments indicating the policy has been reviewed with resident. Element 4: Social Services Director/designee will complete audits on smoker□s rooms to ensure no smoking materials are present and that nursing department is following facility policies. Weekly x 8 weeks, monthly x 4 months. Social Service Director is responsible for implementing the acceptable plan of correction. Date of compliance will be 2/16/18. Social Service Director will bring this to QAPI on a monthly basis for six months.	

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F 689	Continued From page 35 An interview on 01/05/18 at 3:40 PM with the Director of Nursing (DON) revealed she felt Resident #225 should be an exception to the policy and procedure for smoking. The DON stated Resident #225 had given no indication that she would be a problem keeping her smoking materials in her room and had been allowed to keep them with her in a pouch. The DON stated she expected the nurses and resident to technically follow the facility's smoking policy. An interview on 01/05/18 at 6:48 PM with the Administrator revealed he expected the nurses and resident to follow the smoking policy.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		2/16/18

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F 690	Continued From page 36 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide catheter care by allowing a resident's catheter bag to drape the floor for one of one resident (#317). Findings included: Resident #317 was initially admitted to the facility on 10/20/17 with diagnoses that included: seizure disorder, hypertension, anemia, muscle weakness, difficulty walking, cognitive communication deficit and acute kidney disorder among others. Review of Resident #317's most recent comprehensive assessment dated 10/27/17 and coded as an admission assessment revealed resident to be cognitively impaired with no signs of psychosis or noted behaviors. Resident #317 was coded as needing extensive assistance with all ADL's except supervision with eating. Further review of resident's comprehensive assessment revealed resident was not on a toileting program, frequently incontinent of bladder and bowel and did not have a catheter at the time of this assessment.	F 690	Element 1: The attending Certified Nursing Assistant failed to ensure proper placement of catheter bag due to resident□s unsafe disposition for falling out of bed. Resident #317 was immediately corrected by raising bed to appropriate level and staffing in serviced. Element 2: 100% audit in the facility was completed by Director of Nursing/designee, by 2/16/18, to ensure that there were no other residents that had a catheter bag making contact with the floor. Element 3: The Director of Nursing/designee to re-educate all nursing staff on catheter care/positioning by 2/16/18. Element 4: Director of Nursing or designee will audit catheters for appropriate placement to ensure not touching the floor 5 x week X 4 weeks,	

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F 690	Continued From page 37 Review of Resident #317's care plan dated 01/02/18 revealed a care plan area for "Resident requires indwelling catheter due to: urinary retention". Interventions included: follow-up with urology on 01/05/18, monitor for signs and symptoms of infections and report to the physician, leg bag when appropriate, provide a privacy bag and "keep catheter off floor". On 01/02/18 an observation of resident at 10:23 AM revealed Resident #317 to be in bed. Further observation revealed Resident #317's bed to be in low position and Resident #317's catheter bag to be hung on the side of the bed. The observation of Resident #317's catheter bag revealed it to be draping on the floor. An observation completed on 01/03/18 at 8:49 AM revealed Resident #317 to be in bed with his catheter bag hung on the bedside. Further observation revealed Resident #317's catheter bag continued to be in contact with the floor. An observation on 01/04/18 at 9:15 AM of Resident #317's catheter bag revealed it to continue to drape on the floor while resident was in bed. During an interview with a Hall Nurse Supervisor on 01/05/18 at 11:50 AM revealed that Resident #317's catheter bag should never touch the ground. She reported it was unacceptable and would address the situation with her staff. An interview completed on 01/05/18 at 3:32 PM with the Director of Nursing revealed it was her expectation that all catheter bags be off of the ground at all times.	F 690	then weekly audit x4 weeks then monthly x4. Director of Nursing is responsible for implementing the acceptable plan of correction. Date of compliance will be 2/16/18. Director of Nursing will bring this to QAPI on a monthly basis for six months.	

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F 690	Continued From page 38 An interview with the Administrator on 01/05/18 at 3:40 PM revealed it was his expectation that catheter bags be off of and never in contact with the floor.	F 690		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff, and physician interviews, the facility failed to provide effective pain management during a dressing change for 1 of 1 resident (Resident # 110) reviewed for wound care. Findings included: Resident #110 was admitted to the facility on 4/28/16 and re-admitted on 11/04/16. Her diagnoses included hypertension, diabetes mellitus type 2, end stage renal disease and venous ulcer to her right lower extremity. Review of Resident #110s most recent quarterly minimum data set (MDS) dated 12/12/17 revealed she was cognitively intact and had some behavioral symptoms not directed toward others. The resident required extensive assistance of 1 staff with dressing, toileting, personal hygiene and bathing. Resident #110 used a walker or wheelchair for locomotion and was always	F 697	Element 1: The attending nurse failed to reassess pain of the resident during treatment. Resident #110 was remedicated and given ample time for medication to be effective. Wound clinic was called and treatment discussed for appropriateness. Order was changed to decrease the amount of discomfort during dressing changes. Element 2: 100% audit in the facility will be completed by Director of Nursing/designee, by 2/16/18, to ensure that there were no other residents identified that were in pain during dressing change. If pain is identified during dressing change attending nurse is to stop immediately, assess resident, and notify MD for further instructions as necessary. Element 3: In-service nurses on pain	2/16/18

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F 697	Continued From page 39 continent of urine and occasionally incontinent of stool. Review of Resident #110s care plan dated 12/21/17 revealed she was care planned for exhibiting or being at risk for alterations in comfort related to the wound to her lower extremity and her chronic pain. The goal was that the resident would achieve an acceptable level of pain control for the next 90 days with a target date of 03/27/18. Interventions included in part: 1. Evaluate pain characteristics: quality, severity, location, precipitating/relieving factors, 2. Utilize pain scale, 3. Advise resident to request pain medication before pain becomes severe, and 4. Encourage and assist resident to eliminate additional stressors or sources of discomfort. Review of a physician order written 01/02/18 revealed the wound care physician had written the following order for wound care: "Continue with daily wound cleansing with saline or wound cleanser. Apply gentamycin cream from the hospital stay to all wounds daily. Use ABD pads (which are non-adherent) to ankle to cover all wounds. Two layer compression wrap to be changed daily. Wound Care Clinic (WCC) may use silvercel if patient does not have cream with her." Review of Resident #110s pain medication orders revealed there were no orders for pain medication to be given prior to her dressing change. An interview on 01/03/18 at 9:42 AM with Resident #110 revealed she had been at the facility for approximately 3 years. The resident stated that she had a wound on her right leg below her knee due to venous ulcer and had had the wound for 2 years. She stated that she had	F 697	management related to wound care/treatment procedures, by Director of Nursing/designee by 2/16/18. Element 4: Director of Nursing or designee will complete a weekly audit on pain management while completing audit on wound care. 75% of all wounds will be audited weekly x1 month, 75% of wounds will be audited monthly x 5 months. Director of Nursing is responsible for implementing the acceptable plan of correction. Date of compliance will be 2/16/18. Director of Nursing will bring this to QAPI on a monthly basis for six months.	

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been to the wound clinic yesterday and the physician had debrided her wound and showed a picture on her phone of the wound. The resident stated she had been dealing with the treatment for 2 years and the physician numbed it at the wound clinic before changing her dressing, but they had not done that at the facility. The resident stated the dressing changes were painful but her pain pill helped after the dressing changes. The resident stated she was also being seen at the pain clinic and she had told the physician she was having pain with the dressing changes and stated the physician wanted her to stay on the current pain regimen for at least 6 weeks before she changed the orders. She stated that she had complained about pain during the dressing changes but had been told they were giving her all the medication she had ordered for pain. The resident stated she just had to get through the dressing change and try to tolerate the pain. The resident acknowledged she had not asked them to stop the dressing change because she knew it had to be done and she knew they would not give her anything additionally for the pain.

Observation of Resident #110s dressing change on 01/04/18 at 4:20 PM revealed the resident had been pre-medicated by Nurse #2 for the procedure at 3:25 PM. The supervisor using aseptic technique started cutting the dressing away from the wound and the resident had tolerated it well. The supervisor had begun to remove the dressing and the resident started yelling that it was hurting, crying, visibly grimacing with tears running down her face. The supervisor was asked to stop and Nurse #2 stated "I will continue to try to remove the dressing," and they were both asked to step out in the hall. The

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supervisor stated the resident "always had pain with the dressing change, but not usually this bad" and stated they were usually able to talk to her and continue with the dressing change.

The supervisor stated Resident #110 had been on the same pain regimen for approximately 6 weeks and it had not controlled her pain and the resident usually complained of pain during the dressing change. The supervisor stated Resident #110 had been on Dilaudid 4 milligrams (mg) at 5:00 PM scheduled and Dilaudid 4 mg as needed (prn) times one dose daily and had still had pain with her dressing changes. The supervisor stated they had contacted the pain clinic for additional orders for dressing changes and the physician had not wanted to change the resident's orders. The supervisor stated the pain clinic physician wanted the resident to remain on the current pain regimen at least 6 weeks and it had been approximately 4 weeks. The supervisor also stated the Nurse Practitioner and attending physician at the facility had not wanted to write any additional orders for pain since the pain clinic was managing her pain medication.

The supervisor and Nurse #1 went back into the resident's room and continued to try to remove the dressing and the resident continued to cry out, with a grimaced face and had tears rolling down her cheeks. The supervisor asked the resident at 4:35 PM if she wanted her scheduled dose of pain medication and the resident stated no, she wanted to wait until the dressing change was done. The supervisor continued to try to remove the dressing that was saturated but it was stuck to the wound bed and the resident continued to cry in pain. At 5:20 pm the supervisor went out of the room to get the

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Director of Nursing (DON) for her to try to remove the dressing. The supervisor stated she had not seen Resident #110 cry out in this much pain.

The DON came into the room, saturated the dressing again and attempted to loosen the dressing and the resident again cried out in pain, was grimacing and had tears rolling down her face. The DON stated to Resident #110 why don't you take your additional pain medication and the resident agreed at 5:30 pm to take the medication. The DON stated to the resident "why are you acting like this? You don't usually cry out in pain like this, what is different?" The resident stated to the DON "I don't know what is different it just hurts and the nurse put too much medicine on it last night when she changed it and it hurts." The DON kept trying to get the dressing off and finally was able to remove the top dressing but the wound bed dressing was still attached. At 5:30 PM, the supervisor returned with Resident #110's pain pill and asked the nurses if they would wait to give the pill a chance to kick in before they continued with the dressing change. The supervisor and Nurse #1 stated they would return in 20 to 30 minutes to continue with the dressing change.

At 5:23 PM an interview with Resident #110 revealed the pain associated with the dressing change was much worse today than previously. She stated there was always some pain associated with the dressing change but the dressing had not been sticking to the wound like it had this time. She stated that she had usually yelled in pain but not like this and stated that it had not previously hurt this bad.

At 5:53 PM the supervisor and Nurse #1 returned

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to the resident's room to try to remove the dressing again. The supervisor started working with the dressing after saturating it again and the resident again cried out in pain so the supervisor stopped. Nurse #1 stated she would try to remove the dressing and started working with the dressing and after a while was finally able to remove the rest of the dressing. Resident #110 continued to cry during the removal of the dressing but stated the medication had helped a little bit. The wound had a circular area at the top and then a larger wider open area down to the ankle. The wound bed had granulating tissue but there was an excess of cream on the skin and on the wound that had not been absorbed. Upon the dressing being removed the supervisor and Nurse #1 ascertained that the wrong dressing had been applied to the resident's wound on 01/03/18 when the second shift nurse had changed it.

The orders were written for ABD pads (which are non-adherent) to be applied to the wounds and gauze (which is adherent) had been applied to the wound instead. The nurses cleaned the excess cream from the skin surrounding the wound and some from the wound itself. Nurse #1 using aseptic technique applied a thin layer of gentamycin cream on the wound, and applied 5 ABD pads to cover the wound completely and wrap around the ankle. The 2 step compression was then layered over the ABD pads and taped in place and the dressing was covered with a stockinette. Nurse #1 stated the dressing came in a kit which contained the 2 compression dressings and the stockinette. The nurse stated there was a supply of the kits in the clean utility room.

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An interview on 01/05/18 at 10:01 AM with the wound care clinic physician revealed they had been battling Resident #110's wound for some time and had tried various treatments and had finally seen some improvement with the wound. The physician stated he had just debrided the wound on 01/02/18 and changed her orders for her dressing to a non-adherent dressing. He stated that the resident had a low pain tolerance and they were actually anesthetizing the wound prior to her dressing change at the wound clinic. The physician stated he expected Resident #110 would need a little something prn for pain prior to her dressing being done at the facility. He stated that gauze on a wound after debridement would legitimately cause pain with the removal of the dressing. The physician also stated the pain she had with the removal of the gauze dressing demonstrated why you would have used and why he had ordered a non-adherent dressing.

An interview on 01/05/18 at 11:55 AM with the Medical Director revealed that he expected when he wrote an order for the nurses to follow his orders as written.

An interview on 01/05/18 at 12:03 PM with the facility's Nurse Practitioner revealed that she expected when she wrote an order for the nurses to follow the orders as written.

An observation on 01/05/18 at 1:18 PM of the clean utility room revealed there were 6 kits for Resident #110's dressing available for use.

An interview on 01/05/18 at 3:21 PM with Nurse #3 revealed she had done the dressing on 01/03/18 for Resident #110 on second shift. She stated she had followed the physician order as

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F 697	Continued From page 45 written on the Medication Administration Record (MAR). Nurse #3 reviewed the MAR and realized the orders for the dressing had been changed on 01/02/18 by the wound care physician and stated that she had not followed the new orders for wound care. Nurse #3 stated she had looked at the old orders and followed them instead of the new orders. An interview on 01/05/18 at 3:33 PM with the Director of Nursing (DON) revealed she felt like Resident #110 was being dramatic during her dressing change and stated the resident was crying out when she wasn't even touched. The DON stated that she had never seen the resident cry out to that level during a dressing change. She stated to her knowledge the dressing was the same process and there had been no difference yesterday. The DON stated she had even come in on weekends and done the dressing before so it was not a strange or new person who had done the dressing. The DON revealed her expectation was for the nurses to follow physician orders as written and to manage the resident's pain during her dressing change. An interview on 01/05/18 at 6:50 PM with the DON and Administrator revealed the Administrator would have expected the resident's pain to be managed during her dressing change.	F 697		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		2/16/18

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F 812	Continued From page 46 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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to discard a pan of frozen sauce that was outdated, had a tear in the covering and was in the freezer available for use. The findings included: An observation on 01/02/18 at 10:40 AM during the initial tour of the kitchen revealed there was a container of sauce that was dated 12/18/17 and use 12/23/17. There was a tear in the corner of the covering of the frozen sauce. The outdated and compromised sauce was observed by the dietary manager. An interview with the dietary manager on 01/02/18 at 11:06 AM revealed the sauce had been made on 12/18/17 and the leftovers had been stored in the freezer to be used on 12/23/17. The manager acknowledged there was a tear in the corner of the covering of the sauce and it should have been discarded. The manager stated it was her expectation for the dietary aide	F 812	Element 1: The dietary aides failed to identify the torn covering on the sauce pan when being maneuvered in the freezer. The sauce in the freezer was immediately thrown away at the time it was discovered. Element 2: Director of Dining Services to complete a 100% audit in Dietary controlled areas to ensure regulatory compliance by 2/3/18. Director of Dining Services/designee will monitor all dietary refrigerators/freezers and dry storage areas to verify that all food is properly stored and dated labeled. Element 3: Director of Dining Services/designee will re-educate all dietary staff on proper food storage and date labeling procedures by 2/16/18. Element 4: Director of Dining Services or representative will document a shift	

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F 812	Continued From page 47 to have discarded the sauce once it was not used on 12/23/17 and was compromised with a tear in the covering. An interview on 01/05/18 at 6:50 PM with the Director of Nursing (DON) and Administrator revealed the Administrator would have expected the dietary staff to have discarded the outdated and compromised frozen sauce.	F 812	inspection for 4 weeks, then daily inspection for 4 weeks, and then weekly inspection for 4 weeks of all dietary refrigerators, freezers and dry storage areas to maintain proper food storage and date labeling compliance. Director of Dining Services is responsible for implementing the acceptable plan of correction. Date of compliance will be 2/16/18. Director of Dining Services will bring this to QAPI on a monthly basis for three months.	
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(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. §483.75(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 observations, record reviews and resident and staff interviews the facility's Quality Assessment and Assurance Committee failed to	F 865	Element 1: The repeat deficiencies were in the area of: Quality of Care for urinary catheter care (F315), Quality of Care to	2/16/18

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F 865	Continued From page 48 maintain implemented procedures and monitor these interventions that the committee put into place in December of 2016 for three cited deficiencies. One recited deficiency was originally cited in November 2016 on a Recertification survey and again on the current Recertification survey. The repeat deficiency was in the area of Quality of Care for urinary catheter care (F315). A second deficiency was originally cited in November 2016 on a Recertification survey and again on the current Recertification survey. The repeat deficiency was in the area of Quality of Care to be free of accident hazards (F323). A third deficiency was originally cited in January of 2015 on a Recertification survey, recited again in October 2015 on a Recertification survey, subsequently recited in November 2016 on a Recertification survey and again on the current Recertification survey. The deficiency was in the area of Food and Nutrition Services (F371). The continued failure of the facility during four federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1. a. 483.25 Quality of Care - urinary catheter care: Based on observations, staff interviews and record review the facility failed to provide catheter care by allowing a resident's catheter bag to drape the floor for one of one resident (#317). During a recertification survey on November 16, 2016 the facility was cited for failure to maintain the indwelling urinary catheter bag below the level of the bladder for 1 of 2 sampled residents who	F 865	be free of accident hazards (F323), Food and Nutrition Services (F371). Element 2: Administrator completed a re-education with facility QAPI Committee, related to the facility process and intent of the Quality Assurance Performance Improvement (QAPI), which included the responsibilities of the QAPI Committee to ensure sustainability with identified areas of opportunity, with members of the QAPI committee, which included, MDS Nurses, Director of Nursing, Social Services and Activities. Element 3: Facility met with the facility Medical Director, to review the current survey outcome and reviewed preliminary plan of correction for this survey. Element 4: The Administrator and/or Clinical Quality Specialist (Regional Nurse) will review weekly (x 4 weeks) the audits for deficiencies to ensure compliance with intended regulations. Then monthly x 3 months to ensure continued focus.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	01/05/2018

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F 865	Continued From page 49	F 865		

were observed transferred with a catheter in place (Resident #62).

During the current Recertification survey this regulation was cited for failure to provide catheter care by allowing a urinary catheter bag to drape the floor.

b. 483.25 Quality of Care - free from accident hazards: Based on observation, record review, resident, staff and physician interviews, the facility failed to secure smoking materials, specifically, a lighter for 1 of 1 resident (Resident #225) reviewed for safe smoking.

During a recertification survey on November 16, 2016 the facility was cited for failure to put effective interventions in place to reduce the risk of falls for 1 of 5 residents with repeated falls (Resident #91).

During the current recertification survey this regulation was cited for failure to secure smoking materials, specifically, a lighter for 1 of 1 resident (Resident #225) reviewed for safe smoking.

c. 483.60 Food and Nutrition Services: During the recertification survey of January 8, 2015 the facility was cited for failure to store the ice machine scoop in a clean container and keep the floor of the dry goods storage room clean. During the recertification survey of October 29, 2015 the facility was cited for failure to maintain kitchen equipment in a clean and sanitary manner to prevent food borne illness by failing to clean the walk in freezer floor, a steam table shelf and a fan in the dish room. During the recertification survey of November 16, 2016 the facility was cited for failure to maintain kitchen equipment in a

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F 865	Continued From page 50	F 865		

clean and sanitary manner to prevent food borne illness by failing to clean the walk in freezer floor, a steam table shelf and a fan in the dish room.

During the current recertification survey the facility was cited again for failure to discard a pan of frozen sauce that was outdated, had a tear in the covering and was in the freezer available for use.

During an interview on 01/05/18 at 6:51 PM, the Administrator confirmed he was responsible for the Quality Assessment and Assurance Committee however, he had only worked in the facility since October 2017. He acknowledged he was familiar with the citations the facility had received last year during their recertification survey. He stated it was his expectation that repeat deficiencies would not happen again. He explained he was in the process of overhauling systems in the facility and management and staff were going through a period of restructuring.