STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 01/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

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F 000	INITIAL COMMENTS The survey team entered the facility on 1/16/18 to conduct a recertification with complaints survey and was unable to return to the facility on 1/17/18 due to adverse weather of snow, ice, and unsafe travel conditions. The survey team returned to the facility on 1/19/18 and completed the survey on 1/21/18. Event ID #N4GK11. Past-noncompliance was identified at CFR 483.25 at tag F695 at a scope and severity (G). There were other current tags cited during this survey. Per management review the scope and severity of tag F761 was changed from a D to an E.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		2/16/18

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

Electronically Signed | 02/08/2018

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview the facility failed to treat Resident #16, 1 of 2 residents reviewed, with dignity. Resident #16's bed linen (fitted sheet and mattress cover) were observed to have dried, dark yellowish, brown stains and had a strong odor of urine. Resident #16 was admitted to the facility on 6/5/14 with diagnoses of Autism and Bipolar Disorder. A review of the most recent Minimum Data Set (MDS) quarterly assessment dated 10/4/17 revealed Resident #16 required total assistance with all activities of daily living, such as, turning in bed, transfers to and from her wheelchair, bathing, dressing, toileting, grooming, and eating. The MDS assessment also revealed Resident #16 was severely cognitively impaired	F 550	F550 Element 1: The process of linens to be changed when heavily soiled that was in place for January 16, 2018. The staff failed to complete a full bed linen change after incontinent episode. Upon notification to nursing leadership, linens were immediately changed. Element 2: The nurse management team completed 100% audit to ensure no other resident had soiled linens. Element 3: Director of Nursing/Nurse Practice Educator re-educated nursing staff that provide patient care. All linens	

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F 550	Continued From page 2 for daily decision making. Observation on 1/20/18 at 1:30 pm revealed Resident #16 was bathed in her bed by two family members. Resident #16 was then moved to her wheelchair. The draw sheet under Resident #16 appeared clean with no stains. There was a strong odor of urine from Resident #16's bed. The family member removed the draw sheet and the fitted sheet had an approximate 12 inch by 12 inch area with a dried, dark yellow stained areas. The family member removed the fitted sheet and there was an approximate 15 inch by 15 inch dark yellow to light brown stain to the mattress cover. The family member removed the sheets and placed clean linen on the bed. Interview on 1/20/18 at 2:57 pm with NA #2 revealed she had provided incontinence care for Resident #16 twice between 7:00 am and 11:00 am. NA #2 stated the draw sheet was clean when she changed her and she hadn't noticed any odor to her sheets. Phone interview on 1/21/18 at 3:21 pm with NA #3 revealed she provided incontinence care for Resident #16 at 5:30 am on 1/20/18. She stated she had not removed the draw sheet during the night and did not see a stain or notice an odor to Resident #16's bed. Interview on 1/21/18 at 4:05 pm with the Director of Nursing revealed that her expectation is all residents should be washed thoroughly with soap and water after each incontinent episode and the linens should be changed if there is any soiling and the draw sheet should have been lifted to ensure there was not soiling to the sheets.	F 550	to be inspected for soiled areas after any care provided. If linen is soiled, it is to be removed and clean linens applied. Element 4: Unit Managers will complete audit of 3 random residents for soiled linens on each unit 3 days a week X 4 weeks, then weekly X 4 weeks, then monthly X 4 months. 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 to QAPI on a monthly basis X 6 months.	

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F 561	Continued From page 3	F 561		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews Resident #52 (1 of 2 residents reviewed for choices) was not provided a shower twice a week as he requested. A review of Resident #52's record revealed he	F 561	F561 Element 1: The process of resident choosing their shower preference that was in place before January 16, 2018. The staff failed to honor/accommodate	2/16/18

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F 561	Continued From page 4 was admitted on 10/28/17 with diagnoses of Parkinson's disease and Major Depressive Disorder. The Admission Minimum Data Set Assessment dated 10/13/17 revealed Resident #52 is cognitively intact and required limited assistance of staff for activities of daily living, such as, turning in bed, transfers to his wheelchair, toileting, bathing, and dressing. Review of the ADL record for November 2017, December 2017, and January 2018 revealed Resident #52 received one shower per week and was not noted to have refused a shower during those months. On 1/16/18 at 11:03 am, during an initial interview, Resident #52 revealed he was only given one shower a week. He stated he would like to have at least two showers a week but staff had told him they couldn't accommodate his request. Nurse #1 was interviewed 1/20/18 at 11:01 am and she stated Resident #52 should be getting two showers a week or more if he wants them. Interview on 1/20/18 at 12:31 with NA #4 revealed Resident #52 was scheduled for showers on 3:00 pm to 11:00 pm shift on Wednesday and Saturday. She stated Resident #52 had not refused a shower that she was aware of. Interview with the Director of Nursing on 1/21/18 at 3:55 pm revealed her expectation was all resident should have a shower twice a week and whenever they request a shower.	F 561	resident #52 shower preference. Resident #52 has been discharged. Element 2: The nurse management team will complete 100% validation of alert and oriented resident□s shower preference by 2-9-18 and update shower schedule accordingly. Element 3: Director of Nursing/Nurse Practice Educator re-educated nursing staff regarding honoring residents shower preference will be reviewed upon admission and quarterly with care plans. Staff will give shower as scheduled and as indicated by resident and/or family member. Element 4: Unit managers will complete 3 random audit for shower preference being honored on each unit 2 times week X 4 weeks, then weekly X 4 weeks, then monthly X 4 months. 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 to QAPI on a monthly basis X 6months.	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)	F 565		2/16/18

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F 565	Continued From page 5 §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to record and resolve	F 565	F565 Element 1. The dietary manager and /or	

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F 565	Continued From page 6 grievances that were reported in the resident council meetings for 3 of 3 consecutive months. Findings included: Observation of a Resident Council Meeting was conducted on 1/20/18 at 2:15 PM and revealed an issue with recording and resolution of grievances. The residents in the meeting reported having expressed concerns about the food including temperature, variety, timeliness of being served, and overall quality of the food. The residents stated they had discussed their concerns of the food in a food service meeting which followed each Resident Council Meeting. Multiple members of the resident council explained for several months they had expressed a variety of concerns, many repeatedly, in the subsequent food council meeting and had not received a response to their expressed concerns. The Resident Council President stated all concerns regarding dietary were not discussed during the general Resident Council meeting but in the separate Food Council meeting which was an extensionof the Resident Council. During the Food Council meeting a member of the dietary staff attended the Food Council meeting to represent the dietary department and address concerns. Review of the Resident Council Meeting minutes from 7/7/17, 8/4/17, 9/1/17, 10/6/17, 11/3/17, 12/1/17, and 1/5/18 was completed. Each month's meeting had a section labeled "Dietary (Any new concerns? Compliments)." Under the Dietary section for each month there were comments which included: See Dietary or see	F 565	executive chef failed to record minutes during Food Council Meetings. Element 2. Food Council will be combined with Resident Council with all food related concerns being recorded in Resident Council Minutes. A Department Response Form will be sent to the Dietary Manager and/or executive chef outlining each concern voiced in Resident Council. The Dietary Manager and/or executive chef will address each concern in writing and submit to Recreation Director to be presented to residents in the next Resident Council meeting. Element 3. Administrator re-educated Dietary Manager, Executive Chef and Recreation Director on 2/8/18 on collapsing Food Council into Resident Council and dietary's responsibility to respond to grievances using the Department Response Form. Recreation Director will submit Department Response form to Administrator with Dietary Managers responses to each voiced dietary concern, for signature and approval. This will be done 1x monthly x 6 months then on going monthly to ensure residents dietary concerns are being addressed. Element 4. Dietary Manager will be responsible for implementing the acceptable Plan of Correction. Date of compliance will be 2/16/18. Dietary Manager will bring this to QAPI on a monthly basis for 3 months.	

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F 565	Continued From page 7	F 565		

Food Council notes. There was a note under Administration for 7/7/17 which read, have company come in to represent dietary. There was a note under nursing for the 12/1/17 and 1/5/18 Resident Council minutes which read, meals are not delivered simultaneously with roommate.

Review of a facility Grievance Report from 7/1/17 through 1/15/18 revealed no grievances from the Resident Council meeting or from the Food Council meeting.

An interview was conducted with the Recreation Director (RD) on 1/21/18 at 9:00 AM. The RD stated she did not attend the Food Council meeting and did not have minutes or notes from the Food Council meeting. The RD further stated the Dietary Manager (DM) would have the minutes or notes from the Food Council

An interviews was conducted with the DM on 1/21/18 at 9:05 AM. The DM stated he had only attended the Food Service meeting twice. The DM further stated he had not taken any notes or minutes from the Food Council meetings he had attended. The DM stated the Food Council meeting was mostly related to food preferences of the residents. The DM stated he was unaware of who managed the Food Council meeting but stated there were no notes or minutes from the Food Council meeting.

An interview was conducted with the Administrator on 1/21/18 at 5:21 PM. The Administrator stated it was his expectation when a grievance was spoken in the Resident Council it needed to be forwarded to the department head. In addition the Administrator stated the following

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F 565	Continued From page 8 month the resolution of the grievance needed to be returned to the Resident Council for review.	F 565		
F 584 SS=B	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; §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	F 584		2/16/18

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F 584	Continued From page 9 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 clean and sanitary shower stalls for one of two shower rooms, failed to replace tiles on the sides and floor in one of two shower rooms, failed to maintain clean and homelike rooms (Room 508, 614, 321 and 304) on three of four halls. The findings included: a. Observations on 1/20/18 at 11:00 AM and on 1/21/18 at 12:00 PM revealed a build-up of a thick black substance on the bottom of the shower stall walls in the shower room on the 300 hall. Two of the six shower stalls had missing tiles with the rough plaster exposed. One of the two stalls had a missing tile at the drain in the floor. Interview with the Director of Housekeeping on 1/21/18 at 12:12 PM revealed the shower stalls were due to be deep cleaned on Sundays. The black substance was difficult to remove from the stalls. Further interview revealed the urinal in room 304 was in the floor frequently and had to be replaced by the resident ' s bedside. She had no other explanation for the problems of items not picked up off the floor during regular room cleaning. Follow up with the Housekeeping Director on	F 584	F584 Element 1a: The issues that led up to the deficiencies were no work order had been written for maintenance to repair the missing tiles in the shower room or the bent blinds. Element 1b: The reason for the deficiency in the shower stall with the black build up was because it had not been scrubbed yet. Both shower rooms are scrubbed on Sunday□s s0 we do not interfere with showers being given to the residents. The rooms that had items on the floor were from a new housekeeper not following the cleaning plan properly. Element 1c: The process of cleaning the oxygen concentrator weekly was in place before January 16, 2018. The nursing staff failed to clean oxygen concentrator filter for resident #18 per schedule. Element 2a: 100% audit of all blinds in the facility will be completed by the Maintenance Director	

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F 584	Continued From page 10 1/21/18 at 3:30 PM revealed after the shower room tiles had been cleaned, the black build-up was removed. b. Observations on 1/16/18 at 10:20 AM, 1/19/18 at 1:00 PM and 1/21/18 at 12:10 PM revealed the oxygen concentrator that was in use by Resident #18 had a filter with a large amount of lint build up. Interview on 1/21/18 at 4:10 PM with the Director of Nursing revealed the night shift nurses were responsible for cleaning the oxygen concentrator filters and changing the oxygen tubing. The filter should have been cleaned at the time the tubing was changed. c. Observations on 1/16/18 at 10:49 AM, 1/19/18 at 9:31 AM and 1/21/18 at 11:30 AM of rooms 508 and 614 revealed the window blinds needed to be replaced. The window blind in room 508 had bent slats on the left side and in the middle section. The window blind in room 614 had the bottom metal piece of the blind bent the length of the metal. Interview on 1/21/18 at 12:12 PM with the Administrator revealed the blinds would be replaced by maintenance. d. Observations on 1/16/18 at 10:22 AM, 1:00 PM, and 4:00 PM revealed room 321 had a fork with dried food on the floor beside the resident ' s bed and oxygen tubing with the nasal prongs on the floor. Observations on 1/16/18 at 10:40 AM, and 3:30 PM of room 304 revealed a positioning device and a disposable urinal were under the	F 584	by 2/09/18 to ensure that there are no other blinds that need to be replaced. He will also inspect the shower rooms for any loose or missing tiles. Element 2b: We will continue to scrub the shower rooms on Sunday□s, but will change the time to earlier in the day. If any build up is found during the week, we will clean it immediately when found. The housekeeper will be retrained with the 5-step and 7-step cleaning process. Element 2c: The nurse management team will complete 100% audit of all oxygen concentrators to ensure filters are cleaned and orders for filter cleaning on MAR or TAR by 2/09/18. Element 3a: Maintenance Director is responsible for implementing the plan of correction. There will be training for all staff to write work orders when a broken or bent blind is found and if there are missing tiles in the shower rooms. Element 3b: Environmental Director is responsible for the cleaning of the resident rooms and shower stalls. The housekeeper will be retrained with the proper cleaning procedure and the shower rooms will be monitored.	

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F 584	Continued From page 11 resident ' s bed. The floor under the bed appeared to have dried white spills. Interview with housekeeper #1 on 1/21/18 at 11:30 AM revealed on a daily routine, the floors would be swept, items left on the floor would be removed. She had not worked on 1/16/18 and did not know why it was not cleaned and the items removed from rooms 321 and 304. On 1/21/18 at 12:00 PM Administrator and the Director of Housekeeping made rounds with the surveyor. The shower stalls, oxygen concentrator filter and rooms 321, 304, 508 and 614 were observed.	F 584	Element 3c: The Director of Nursing and Nurse Practice Educator re-educated nursing staff to ensure when a resident is ordered oxygen, an order for filter to be cleaned weekly is obtained and processed. Filters to be cleaned weekly along with the tubing change on night shift. Element 4a: Maintenance Director will do a weekly audit for one month, then every 2 weeks for 2 months, and then 1 monthly for 2 months. This process will be added to our environmental rounds. Maintenance Director will submit results of the audits to the monthly QAPI meeting for review. Element 4b: Environmental Director will be responsible for checking the shower stalls for any black build up 2x weekly for 1 month, then 1x weekly for 2 months, then checking 1 monthly for 2 months. This will also be added to our environmental rounds which is done monthly. Environmental Director will submit results of the audit and training to the monthly QAPI meeting for review. Element 4c: Unit Managers will complete audit of 2 random residents with oxygen for clean filters on each unit weekly x 4 weeks, then	

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F 584	Continued From page 12	F 584	bi-weekly x 4 weeks, then monthly x 4 months. 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 to QAPI on a monthly basis x 6 months.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §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 observations, record review and staff interviews, the facility failed to provide a nutritional supplement as ordered by the physician for one of two sampled residents with physician ordered supplements. Resident #18. The findings included: Resident #18 was admitted to the facility on 4/21/15 with diagnosis including Parkinson ' s disease and difficulty swallowing. The quarterly Minimum Data Set (MDS) dated 10/7/17 indicated Resident #18 had mild impairment with long term memory and no impairment with short term memory. Resident #18 required extensive assistance of one person for eating. There was no weight loss documented on this assessment. The care plan dated 10/11/17 included a focus	F 658	F658 Element 1: The process of providing prescribed supplement as ordered to resident that was in place before January 16, 2018. The nurse failed to provide correct supplement as ordered by physician to resident #18. Resident # 18 had supplement orders clarified and is currently receiving supplements per order. Element 2: The nurse management team will completen100% audit of active supplement orders to ensure complete and accurate order by 2-14-18. Element 3: Director of Nursing/Nurse	2/16/18

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F 658	Continued From page 13 Resident #18 was at risk for choking, nutritional and hydrational risk related to the diet consistency downgrade for dysphagia and decline in intake. The interventions included a frozen house supplement cup for weight loss, three times a day as ordered between meals. Review of the physician orders revealed an order dated 10/11/17 for a frozen house supplement to be given three times a day, between meals. Review of the Medication Administration Record (MAR) for the month of January 2018 included an order for frozen house supplement three times a day between meals. The times of administration was at 10:00 AM, 2:00 PM and 8:00 PM. Review of the MAR revealed nurses ' initials for each time from 1/1/18 to 1/20/18. Observations on 1/19/18 at 10:00 AM revealed Resident #18 did not receive the frozen nutritional supplement. An interview was conducted on 1/21/18 at 11:00 AM, with Nurse #1. This nurse was on duty during the day on 1/20/18 for Resident #18. Interview revealed she did not provide a frozen house supplement cup between meals. Nurse #1 explained she gave 90 milliliters (ml) of the liquid supplement on her cart and thickened it. She further explained she knew to give 90 ml because that was what the other residents received. After reviewing the order with her, she explained she did not look at the order on the MAR correctly. She had worked the past 3 weekends and had not given the frozen supplement, but had signed it was given. On 1/20/18 at 11:25 AM an interview was conducted with Nurse #2, who was the usual charge nurse on day shift for Resident #18. Interview revealed Nurse #2 gave the liquid supplement on her cart in the amount of 120 ml.	F 658	Practice Educator re-educated licensed nursing staff. Education included that Nurses will completely read order in its entirety before administering ordered supplement to ensure resident gets appropriate prescribed supplement. If supplement is not available, nurse will notify physician and obtain appropriate order. Element 4: Unit managers will complete audit of 2 residents with orders for supplements to ensure they received as ordered on each unit 2 times weekly X 4 weeks, then weekly X 4 weeks, then monthly X 4 months. 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 to QAPI on a monthly basis X 6 months.	

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F 658	Continued From page 14 Nurse #2 explained she had never given him a frozen supplement cup. Nurse #2 had signed the frozen supplement was provided by had given the liquid supplement. Interview with the Director of Nursing on 1/21/18 at 4:00 PM revealed she expected the nurses to read the physician order in its entirety and provide the frozen house supplement as ordered between meals. She further explained it would not be any different than checking the MAR and giving the correct medication. The DON did not know why Resident #18 did not receive the frozen supplement.	F 658		
F 695 SS=G	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, family and staff interviews, the facility failed to secure an oxygen cylinder which resulted in an injury for one of three residents, Resident #79. Resident #79's injury was the result of the facility's failure to secure an oxygen cylinder in the resident's room. The oxygen cylinder size E (4.3 inches in diameter, 25.5 inches in height, and 7.9 pounds in weight empty) fell and resulted in an injury to the resident which necessitated being transported	F 695	Past noncompliance: no plan of correction required.	2/8/18

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to the emergency room (ER) and receiving sutures to her left leg.

The findings included:
Review of the facility policy undated and titled: NSG225 Oxygen: High Pressure Cylinders, revealed the following under Practice Standards: Cylinders must be properly secured to prevent accidental tipping of the tank and possible rupture causing high pressure release of gases. Further review revealed: Cylinders must never be left free standing at any time.

Resident #79 was admitted to the facility on 3/4/16. The resident's diagnoses included, in part, Chronic Obstructive Pulmonary Disease (COPD), arthritis, generalized weakness, dementia, and history of falls.

Review of Resident #79's most recently completed Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 12/10/17. Review of the assessment revealed the following: The resident had moderate cognitive impairment. The resident required limited assistance of one person for transferring (such as from a bed to a chair), walking in the room, walking in the corridor, dressing, toilet use, bed mobility, and personal hygiene. The resident was coded as having had received oxygen therapy.

An interview with a family member of Resident #79's was conducted on 1/21/18 at 12:15 PM. The interview revealed the family member had observed the unsecured oxygen cylinder size E in the resident's room prior to the incident which resulted in the injury to the resident. The family member further stated the resident had utilized

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the oxygen cylinder size E for an outing on Thanksgiving on 11/23/18, which was 5 days prior to the incident.

During an interview conducted with Resident #79 on 1/21/18 12:10 PM she stated the wound felt much better. In regards to how the resident had sustained the injury the resident stated she was walking from her bed over to her closet. The resident moved a chair which had been in front of her closet. The oxygen cylinder size E was between the chair and the wall of the room. The resident stated she moved the chair to get into her closet the oxygen cylinder size E had fallen and hit her lower left leg, which caused the injury to her left leg. The resident stated she was able to ambulate independently in her room without difficulty.

During an interview conducted with Nurse #3 on 1/20/18 at 2:59 PM she stated an oxygen cylinder size E had been left in Resident #79's room and it had fallen on Resident #79's leg which caused an injury to her leg.

A review of the Event Summary Report for Resident #79 for the event which took place on 11/28/17 at 10:35 PM revealed the resident had an unobserved injury of a cut/laceration to the left lower leg, and the location of the incident was in the resident's room. Further information documented in the report detailed the resident was transferred to the hospital on 11/28/17. Review of the report the following under the section of Circumstances of the event and immediate actions taken: Resident was going into her clothing closet and the oxygen cylinder size E, in a fabric sleeve, which was standing in a corner next to the closet, fell on the resident's leg. The

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identified contributing factor to the incident was discovered to be the oxygen cylinder size E was not properly secured on the resident's wheelchair or in a portable oxygen cylinder size E wheeled cart carrier.

A review of the physicians' orders revealed an order dated 2/1/17 in which the resident was ordered to have oxygen via Nasal Cannula (NC) at 2 liters per minute as needed for shortness of breath.

A nursing note dated 11/28/17 and timed 10:54 PM stated Resident #79 had a change in condition and had experienced trauma (injury) and an order had been obtained from the resident's physician to send the resident to the Emergency Room (ER) for sutures.

A phone interview conducted with Nurse #4 on 1/21/18 at 2:00 PM revealed she had been working the evening of 11/28/17 when Resident #79 was sent to the ER. The nurse stated she completed the incident report for Resident #79 from the incident on 11/27/17. The nurse stated the resident had experienced the injury on her left lower leg from the oxygen cylinder size E and the injury was severe enough the resident had to be sent out to the ER.

A review of the physician's orders for Resident #79 revealed an order dated 11/28/17 to send the resident to the ER for evaluation and possible sutures.

A review of the ER report for Resident #79 revealed the resident entered the ER on 11/28/17 and was discharged from the ER on 11/29/17 after receiving sutures.

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Another nursing note dated 11/29/17 and timed 3:51 AM stated Resident #79 returned to the facility at approximately 2:30 AM and had 12 sutures to the laceration to the left leg. In addition there were orders to remove the sutures in 10 days.

A review of the December Treatment Administration Record (TAR) for Resident #79 revealed the following orders related to wound care of the left leg. An order with a start date of 12/4/17 to apply a dry protective dressing to the wound of the left lower leg daily and to change as needed. An order with a start date of 12/12/17 to remove the sutures to the left lower leg on 12/12/17. An order with a start date of 12/13/17 to cleanse the left lower leg wound with normal saline, apply hydrogel dressing, and cover with a boarder gauze daily. Wound therapy to consult on Monday, 12/18/17. An order with a start date of 12/15/17 to cleanse the left lower leg wound with normal saline, apply silver alginate and cover with a dry dressing daily.

An observation of the dressing change to Resident #79's left lower leg wound was conducted along with an interview of the Wound/Treatment Nurse on 1/21/18 at 12:06 PM revealed a wound to the left lower leg approximately 1.5 inches long, 0.5 inches wide, some depth, with yellowish and pink tissue. The wound did not display redness or swelling at the time of the dressing change. The Wound/Treatment Nurse stated the wound looked better and appeared to be healing. There was an oxygen concentrator in the room at the time of the observation and no secured or unsecured oxygen cylinders.

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During an interview with the Director of Nursing (DON) on 1/21/18 at 4:20 PM she stated it was her expectation for oxygen cylinders to be placed in a fabric sleeve holder and secured to the back of a wheelchair or in a wheeled storage cart. The DON further stated it was her expectation when an oxygen cylinder was empty it was to be placed into the empty storage rack. The DON also stated if the resident had an oxygen concentrator, the resident should receive oxygen from the concentrator and the oxygen cylinder should be removed from the room. In addition the DON stated if an unsecured oxygen cylinder was found in a resident's room, the cylinder needed to be removed by the staff member who found the cylinder immediately and placed in the proper storage area.

The corrective action for past non-compliance dated 1/12/18 was as follows:

1. The oxygen cylinder was removed from Resident #79's room and placed in the designated storage closet on 11/28/17. The root cause analysis conducted by the facility determined the oxygen cylinder size E had been removed from the wheelchair by the resident's family and placed in the corner of the room after a family outing.

2. Other residents who were on oxygen had their rooms inspected for unsecured oxygen cylinders on 11/29/17 by the night nurse and no unsecured oxygen cylinders were found. In addition closets and bathrooms were checked in all other resident rooms and no unsecured oxygen cylinders were found. Rounds are conducted with audits to inspect rooms for the presence of unsecured

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oxygen cylinders by the nursing designee, department head, and/or the Manager on Duty (MOD) designee. No unsecured oxygen cylinders have been discovered during the conducted rounds.

3. 100% of nursing staff (licensed and nursing assistants) were in-serviced by the Staff Development Coordinator and Director of Nursing as of 1/12/18. In-services included: Oxygen cylinders are not to be stored in resident rooms without being properly secured and if an unsecured oxygen cylinder was discovered in a resident's room it was to be removed immediately and placed in the appropriate storage area. Nursing staff were taught to ensure all portable cylinders were stored in appropriate holders (bags for w/c, rolling holder, stationary holders on w/c. If bags with oxygen cylinders were to be removed from a wheelchair, the cylinders were to not be left unsecured and ensured that they are stored in the appropriate oxygen storage rooms. Date of completion: 1/12/18.

4. Audits of resident rooms will be conducted by the nursing designee, department head, and/or the Manager on Duty (MOD) designee as instructed by the administrator or DON once per month to ensure oxygen cylinders are not being stored without being properly secured. Audits have been completed on 11/29/17, 12/12/17, 1/10/18, and 1/20/18. Any area of identified concern will be addressed at the time and continued area of concern will be addressed by Quality Assurance (QA) committee for further action plan. The decision to take the matter of unsecured oxygen cylinders to the QA meeting was made on 11/29/17.

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F 695	Continued From page 21 As part of the validation process on 1/16/18 through 1/21/18, the plan of correction was reviewed including the education of staff and observations of resident rooms. Resident #79 did not have secured or unsecured oxygen tanks in her room during the validation period. Observations of other resident rooms through the validation period did not reveal any unsecured oxygen tanks in resident rooms. Interviews with licensed staff and nursing assistants revealed they were trained they were trained unsecured oxygen tanks were not be in resident rooms and if a staff member discovered in a resident room it was to be removed immediately and placed in the designated storage area. A review of the monitoring tools revealed that the facility completed the audit of resident rooms as noted in their POC. 100% of in-servicing of nursing staff was completed on 1/12/18. The final correction date was 1/12/18.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		2/16/18

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F 761	Continued From page 22 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired medications, date multi-dose vials when opened and maintain a clean medication refrigerator for storage for two of two medication rooms. The findings included: Observations on 1/20/18 at 11:34 AM of the medication room for the 200 and 300 halls revealed the following stock medications were expired: 2 boxes of ear drop earwax removal aid one box expired 9/17 and the other box expired 10/17; 1 bottle of Pink Bismuth regular strength that expired 11/17; and one bottle of Aspirin 325 milligrams (mg) expired 11/17. The medication refrigerator had 1 multi-dose vial of tuberculin purified protein derivative diluted Apilisol opened and not dated; 2 multi-dose vials of influenza vaccine afluria quadrivalent opened. One multi-dose vial was dated 12/1/17 and the second multi-dose vial was dated 12/15/17, which expired 30 days after opening; and 1multi-dose vial of the influenza that was opened and not dated. Observations on 1/20/18 at 12:35 PM of the	F 761	F761 Element 1: The process of checking and removing expired medications from Medication rooms before January 16, 2018. The nursing staff failed to inspect and remove all medications that had expired, all multi-dose vials that were past 30 days once opened, any/all undated opened multi-dose vials. Nursing staff also failed to date multidose vials upon opening. Element 2: The nurse management team will complete 100% audit of both medication rooms and medication carts for expired medications/biologicals, dated open multi-dose vials by 2-9-2018. Element 3: The Director of Nursing/Nurse Practice Educator re-educated licensed nursing staff that each nurse is to ensure all medications are in date, all multi-dose vials are dated when opened, and discard/remove dated open multi-dose vials greater than allowed number of days	

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F 761	Continued From page 23 medication room for the 500 and 600 halls revealed the medication refrigerator had 1 multi-dose vial of tuberculin purified protein derivative diluted Apilisol opened and not dated. The following medications were expired in the refrigerator: 3 phenergan 25 mg suppositories expired 12/17; one multi-dose vial of influenza vaccine afluria quadrivalent, opened and dated 10/15/17 which expired 30 days after opening. The medication refrigerator in this medication room had dried yellow spills on the two shelves in the main part of the refrigerator and on the side shelves of the door. Interview with the Director of Nursing on 1/21/18 at 4:00 PM revealed the nurses were responsible for removing expired medications and cleaning the medication refrigerator. The task was assigned to the 11-7 nurses to perform. She was not aware there were expired medications in the medication rooms.	F 761	once opened. If medication expired, remove/discard appropriately and ensure medication available according to order. If opened multi-dose vials found without date opened and/or dated greater than allowed amount of days, remove/discard appropriately and ensure medication is ordered/available as ordered. Night shift will complete medication room/cart checks nightly for expired medications and labeling/dating of medications/biologicals. Element 4: Unit managers will complete audits of medication rooms/carts weekly X 4 weeks, then bi-weekly X 4 weeks, then monthly X 4 months. 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 2-16-2018. Director of Nursing will bring to QAPI on a monthly basis X 6 months.	
F 812 SS=F	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, 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	F 812		2/16/18

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	345286	A. BUILDING _____ B. WING _____	C 01/21/2018

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F 812	Continued From page 24 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 record reviews, observation and staff interviews, the facility failed to perform cleaning in food preparation areas on 3 of 4 cold air returns, 5 of 12 heating vents in the ceiling, pipes running from the ceiling to the floor beside the handwashing sink and on a plugged in robot coupe cord that was wrapped around a clean utensil rack, the heating unit above the coffee and tea serving area, dry serving trays prior to storage and use, and ensure the correct mix of sanitizer in the three-compartment sink. Findings included: 1. A review of the property management cleaning accountability form indicated the ceiling vents, tiles and lights were the responsibility of the maintenance department and should be cleaned quarterly. A review of work orders completed on 1/16/2018 revealed a repair requisition for "air vents at storage door are dirty" was filled out, but no date completed information was on the work order. An observation of the kitchen was made on 1/16/2018 at 10:14 AM revealed a light grey, fluffy material noted on cold air returns and heating vents on the ceiling. The kitchen was observed 1/20/2018 at 12:05 PM and a light grey, fluffy material was noted to remain on three of four cold air returns and five of twelve heating vents in the ceiling.	F 812	F812 #1 Element 1. Maintenance and dietary staff failed to identify 3 of 4 cold air returns, 5 of 12 heating vents in the ceiling needed cleaning. Element 2. The 3 of 4 cold air returns, 5 of 12 heating vents in the ceiling were cleaned by Maintenance staff on 1/20/18. Element 3. Administrator will re-educate the Maintenance Director and Dietary Manager on audit tool as well as expectation of cleanliness of all cold air returns, heating vents by 2/9/18. Maintenance/Director/designee and Dietary Manager/designee will complete an audit of all cold air returns, heating vents every 2 weeks x 12 weeks to ensure regulatory compliance. Element 4. Maintenance Director and Dietary Manager will be responsible for implementing cleaning audits to ensure acceptable Plan of Correction. Date of compliance will be 2/16/18. Maintenance	

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F 812	Continued From page 25 An interview was conducted with the Dietary Manager (DM) on 1/20/2018 at 3:21 PM. He reported that he had been instructed to clean areas in the kitchen he could reach and any areas above that would be cleaned by maintenance. The Executive Chef (EC) #2 was interviewed on 1/21/2018 at 11:36 AM. She reported she had filled out the repair requisition/work orders on 1/16/2018, but because the copy machine was broken, she did not submit to the maintenance department. She further reported she had shown the work orders to the Maintenance Director, but was not certain if he completed the repairs. An interview was conducted with the Maintenance Director (MD) on 1/21/2018 at 2:24 PM. He reported that the ceiling vents and air filters in the cold air returns were cleaned quarterly, but he did not have a record of the kitchen cleaning that had been completed. He reported he did not recall the EC#2 showing him the work orders. An interview was conducted with the Administrator on 1/21/2018 at 4:46 PM. He reported it was his expectation that cleaning of the kitchen would be completed correctly. 2. A review of the property management cleaning accountability form did not indicate which department should clean the pipes in the kitchen. An observation of the kitchen was made on 1/16/2018 at 10:14 AM. There was a light grey, fluffy material noted on the copper pipes beside the handwashing sink. These pipes extended from the ceiling to the floor and were noted to be covered with a light grey, fluffy particles from ceiling to floor. The kitchen was observed on 1/20/2018 at 12:05 PM. The light grey, fluffy material was noted to be	F 812	Director and Dietary Manager will bring these audits to QAPI on a monthly basis for 3 months. #2 Element 1. Maintenance and dietary staff failed to identify the pipes beside handwashing sink needed cleaning. Element 2. The pipes beside handwashing sink were cleaned by Maintenance staff on 1/20/18. Element 3. Administrator will re-educate the Maintenance Director and Dietary Manager on audit tool as well as expectation of cleanliness of pipes beside the handwashing sink by 2/9/18. Maintenance/Director/designee and Dietary Manager/designee will complete an audit of pipes beside the handwashing sink every 2 weeks x 12 weeks to ensure regulatory compliance. Element 4. Maintenance Director and Dietary Manager will be responsible for implementing cleaning audits to ensure acceptable Plan of Correction. Date of compliance will be 2/16/18. Maintenance Director and Dietary Manager will bring these audits to QAPI on a monthly basis for 3 months.	

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F 812	Continued From page 26 covering the pipes beside the handwashing sink, from ceiling to floor. An interview was conducted with the DM on 1/20/2018 at 3:21 PM. He reported that he had been instructed to clean areas in the kitchen he could reach and any areas above that would be cleaned by maintenance. He reached up to demonstrate on the pipes and he could reach approximately 75 to 80 inches from the floor. An interview was conducted with the MD on 1/21/2018 at 2:24 PM. He did not have a record of cleaning the pipes beside the handwashing sink and reported it was his understanding the kitchen would clean them to the point where they could not reach and the maintenance department would clean above that point. An interview was conducted with the Administrator on 1/21/2018 at 4:46 PM. He reported it was his expectation that cleaning of the kitchen would be completed correctly. 3. An observation of the serving line was completed on 1/20/2018 from 12:05 PM until 1:25 PM. The Dietary Aide (DA) #1 was preparing trays by adding silverware and the hot plate bottom to the tray. The trays were noted to be dripping wet and the DA #1 wiped them down with a towel. The DA #1 was interviewed on 1/20/2018 at 12:05 PM and she reported that the trays were very wet today. The Dietary Manager was interviewed at the same time and he reported the trays should have been air dried prior to use and storage. An interview was conducted with the Administrator on 1/21/2018 at 4:46 PM. He reported it was his expectation that trays were air dried prior to use. 4. A review of the property management	F 812	#3 Element 1. Dietary aides failed to dry serving trays prior to storage and use. Element 2. All serving trays were pulled, washed and set out to air dry before being stored and used on 1/20/18. Element 3. Administrator re-educated Dietary Manager on new serving tray inspection sheet by 2/9/18. Dietary Manager/designee will re-train employees on proper drying and storing of serving trays by 2/16/18 to ensure compliance Dietary Manager/designee will inspect serving trays 1 x daily x 2 weeks, then 1 x weekly x 2 months to ensure that trays are being dried prior to storage and use Element 4. Dietary Manager will be responsible for implementing tray checks to ensure acceptable Plan of Correction. Date of compliance will be 2/16/18. Dietary Manager will bring these checks to QAPI on a monthly basis for 3 months. #4 Element 1. Maintenance and dietary staff failed to identify cord running from robot coupe to ceiling needed cleaning.	

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F 812	Continued From page 27 cleaning accountability form revealed the robot coupe blender was the responsibility of the dietary department for daily cleaning. The kitchen was observed on 1/20/2018 at 12:05 PM. There was noted to be a robot coupe blender sitting on a table. The table had an attached rack for hanging clean utensils. The electric cord from the robot coupe was wrapped around the rack and plugged into the ceiling. The electric cord was covered in fluffy grey material. An interview was conducted with the Dietary Manager (DM) on 1/20/2018 at 3:21 PM. He reported that he had been instructed to clean areas in the kitchen he could reach and any areas above that would be cleaned by maintenance. He was not certain why the cord to the robot coupe had not been cleaned. An interview was conducted with the MD on 1/21/2018 at 2:24 PM. He did not have a record for kitchen cleaning and did not know which department should clean the cord that extended from the robot coupe to the ceiling, but reported he felt that the kitchen should care for the base and the cord to the point where they could not reach and then maintenance would clean above that spot. An interview was conducted with the Administrator on 1/21/2018 at 4:46 PM. He reported it was his expectation that cleaning of the kitchen would be completed correctly.	F 812	Element 2. The cord running from robot coupe to ceiling was cleaned by Maintenance staff on 1/20/18. Element 3. Administrator will re-educate the Maintenance Director and Dietary Manager on audit tool as well as expectation of cleanliness of cord running from robot coupe to ceiling by 2/9/18. Maintenance/Director/designee and Dietary Manager/designee will complete an audit of /cord running from robot coupe to ceiling every 2 weeks x 12 weeks to ensure regulatory compliance. Element 4. Maintenance Director and Dietary Manager will be responsible for implementing cleaning audits to ensure acceptable Plan of Correction. Date of compliance will be 2/16/18. Maintenance Director and Dietary Manager will bring these audits to QAPI on a monthly basis for 3 months.	
	5. The property management cleaning accountability form was reviewed and no cleaning schedule was noted for the heater in the kitchen. A review of work orders completed on 1/16/2018 were reviewed and it was noted a repair requisition for "heating unit dirt build-up" was filled out, but no date completed information was on		#5 Element 1. Maintenance and dietary staff failed to identify the heating unit above the coffee and tea serving area needed cleaning. Element 2. The heating unit above the	

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F 812	Continued From page 28 the work order. An observation of the kitchen was made on 1/16/2018 at 10:14 AM. There was a light grey, fluffy material noted on heater above the coffee and tea serving center. The kitchen was observed 1/20/2018 at 12:05 PM and a light grey, fluffy material was noted to remain on heater above the coffee and tea serving center. An interview was conducted with the DM on 1/20/2018 at 3:21 PM. He reported that he had been instructed to clean areas in the kitchen he could reach and any areas above that would be cleaned by maintenance. He was not certain why the heater in the kitchen had not been cleaned. The EC #2 was interviewed on 1/21/2018 at 11:36 AM. She reported she had filled out the repair requisition/work orders on 1/16/2018, but because the copy machine was broken, she did not submit to the maintenance department. She further reported she had shown the work orders to the Maintenance Director, but was not certain if he completed the repairs. An interview was conducted with the MD on 1/21/2018 at 2:24 PM. He reported he did not have a record of the kitchen cleaning that had been completed. He reported he did not recall the EC#2 showing him the work orders. An interview was conducted with the Administrator on 1/21/2018 at 4:46 PM. He reported it was his expectation that cleaning of the kitchen would be completed correctly. 6. The dishwashing room was observed on 1/20/2018 at 3:21 PM. The Multi-quat sanitizer was noted to be in the 3-compartment sink. The DM tested the parts per million (PPM) and discovered the Multi-quat was diluted and did not register on the tape. The DM drained the sink and	F 812	coffee and tea serving area were cleaned by Maintenance staff on 1/20/18. Element 3. Administrator will re-educate the Maintenance Director and Dietary Manager on audit tool as well as expectation of cleanliness of heating unit by 2/9/18. Maintenance/Director/designee and Dietary Manager/designee will complete an audit of heating unit every 2 weeks x 12 weeks to ensure regulatory compliance. Element 4. Maintenance Director and Dietary Manager will be responsible for implementing cleaning audits to ensure acceptable Plan of Correction. Date of compliance will be 2/16/18. Maintenance Director and Dietary Manager will bring these audits to QAPI on a monthly basis for 3 months. #6 Element 1. Diet aide failed to have 3 compartment sink sanitizer at an acceptable range between 150-400. Element 2. 3 compartment sink was drained and refilled with sanitizer at an acceptable range between 150-400 on 1/20/18. Element 3. Dietary Manager/designee will train all employees on manual ware washing. All employees will take the Food	

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F 812	Continued From page 29 refilled with Multi-quat sanitizer and retested the solution and found it to be 400 PPM, within the acceptable range. The DM questioned DA #2 and he reported he had filled the 3-compartment sink with both hot water and Multi-quat. He reported he was not aware that the Multi-quat was already mixed with water and reported he did not know how to fill the 3-compartment sink. An interview was conducted with the executive chef (EC) #2 on 1/21/2018 at 11:36 AM. She reported that she had trained DA #2, but did not keep a record of the areas he was trained. She reported she did not remember specifically training DA #2 with the 3-compartment sink, but felt that it had been covered in his training. The DM was interviewed on 1/20/2018 at 3:21 PM. He reported that because the DA#2 had stated he knew how to fill the 3-compartment sink, he had not observed him completing the task and further reported that training a dietary aide was the job of the Executive Chef. An interview was conducted with the Administrator on 1/21/2018 at 4:46 PM. He reported it was his expectation that training of the kitchen staff was completed.	F 812	& Nutrition Competency validation for manual ware washing. All competency will be completed by 2/16/18 to ensure compliance. Dietary Manager/designee will inspect Dish Machine Temp logs daily x 3 months to ensure that sanitizer is in an acceptable range of 150-400 thus meeting regulatory compliance. Element 4. Dietary Manager will be responsible for checking dish area logs to ensure acceptable Plan of Correction. Date of compliance will be 2/16/18. Dietary Manager will bring these logs to QAPI on a monthly basis for 3 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	F 865		2/16/18

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F 865	Continued From page 30 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 record review, observations, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 11/3/16 recertification survey and the 1/26/17 complaint investigation. This was for one deficiency in the area of: Resident Rights/Exercise of Rights. The deficiency was recited again on the current recertification survey of 1/21/18. The continued failure of the facility during multiple federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: 483.10- Based on record review, observation and staff interview the facility failed to treat Resident #16, 1 of 2 residents reviewed, with dignity. Resident #16's bed linen (fitted sheet and mattress cover) were observed to have dried, dark yellowish, brown stains and had a strong odor of urine. During the recertification survey of 11/3/16 the	F 865	F865 Element 1. The repeat deficiencies were in the area of resident Rights/Dignity (F550) Element 2. The administrator re-educated QAPI (Quality Assurance Performance Improvement) Committee on the QAPI process to include implementation of action plans, monitoring tools and the evaluation process to ensure sustainability for identified areas. Members of the QAPI Committee include CRC (Clinical Reimbursement Coordinator) nurses, Director Nursing, Environmental, Maintenance, Dietary, Social Services, Activities, Unit Mangers, NPE (Nurse Practice Educator), Admissions. Element 3. Administrator met with the facility Medical Director to review the current survey outcomes and reviewed preliminary Plan of Correction for this survey. Element 4. The Administrator will review weekly x 4 weeks the audits for deficiencies to ensure compliance with the	

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F 865	Continued From page 31 facility was cited for failing to provide meals concurrently for residents in the same room for 2 of 2 dining rooms allowing a resident to sit and wait for her meal tray while her roommate was eating. During a complaint investigation dated 1/26/17 the facility was cited for failing to treat a resident in a respectful manner by not honoring his right to refuse a shower resulting in the resident feeling humiliated for 1 of 3 sampled residents. An interview was conducted with the Administrator on 1/21/18 at 4:58 PM. The Administrator stated that the facility had a Quality Assurance (QA) Committee. The QA Committee consisted of the Administrator, Director of Nursing (DON), Medical Director, Business Office Manager, Admissions Coordinator, Maintenance Director, Dietary Manager, Human Resources (HR) Benefits Coordinator, Social Work Coordinator, Minimum Data Set (MDS) Coordinator, Housekeeping Services Director and the Activities Director. In addition the Registered Dietitian (RD) and the pharmacist attend the QA Committee meeting quarterly. The Administrator stated the QA Committee met monthly and discussed identified deficiencies and had put into place a Quality Assurance Process Improvement program as part of the QA process. The Administrator further stated the identified deficient practices from the recertification survey and the complaint investigation regarding dignity had been resolved. The Administrator stated due to the deficient practice of dignity having been resolved there was no longer a need for it to be reviewed in the QA Committee meetings. The Administrator stated dignity would be discussed and reviewed in upcoming QA Committee meetings as well as other identified deficiencies.	F 865	intended regulation. Then 1 x monthly x 3 monthly to ensure compliance. Date of compliance will be 2/16/18	

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