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	345468	A. BUILDING _____ B. WING _____	C 11/21/2019

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E 000	Initial Comments An unannounced Recertification/Complaint Investigation survey was conducted on 11/18/19 through 11/21/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # XW7H11.	E 000		
F 000	INITIAL COMMENTS A recertification/complaint survey was completed on 11/21/19. Two of two complaint allegations were unsubstantiated. Event ID #XW7H11.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		12/19/19

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

Electronically Signed | 12/12/2019

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F 656	Continued From page 1 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 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow a person centered care plan by not placing a Dycem pad (type of non-slip pad) under a resident ' s wheelchair cushion which was put in place as an intervention to prevent falls for 1 of 3 residents (Resident #57) observed for accidents. Findings included: Resident #57 was admitted to the facility on 02/12/18. Diagnoses included, in part, dementia with Lewy bodies, osteoarthritis, Parkinson ' s disease and anxiety. The Minimum Data Set quarterly assessment dated 10/21/19 revealed the resident was cognitively aware. The resident required limited assistance with one staff physical assistance with bed mobility and toileting, supervision with one staff physical assistance with transfers, and	F 656	This Plan of Correction constitutes the facility□s written allegation of compliance for the deficiencies cited in the CMS-2567. However, the submission of this plan is not an admission that a deficiency exists. The Plan of Correction is prepared and executed solely because it is required by federal and state law. This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or conclusion set forth in the Statement of Deficiencies. F656 Actions taken for the residents affected by the alleged deficient practice: On 11/21/2019, DON ensured that dycem was in w/c of resident #57 per plan of care.	

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F 656	Continued From page 2 supervision with set up with dressing and personal hygiene. Resident #57 was frequently incontinent of bowel and bladder, had no impairments and used a walker and wheelchair. Resident #57 had one fall with minor injury during this assessment period. A review of Resident #57 ' s care plan updated on 10/11/19 revealed a plan of care for at risk for falls related to decreased balance. An intervention which was in place included to place a Dycem pad to the seat of resident ' s wheelchair. An interview was conducted with Nursing Assistant (NA) #8 on 11/21/19 at 2:37 PM. NA #8 revealed she was not aware the resident was to use a Dycem pad under her wheelchair cushion. The NA noted the Dycem pad was listed on the tasks to be completed by the nursing assistants in the computer system for Resident #57, but she was not aware of it. NA #8 stated she should have reviewed the tasks to be completed and signed off that she completed the task. NA #8 reported if she needed to know how to take care of a resident, she would look at the nurse ' s report in the nurse's room. NA #8 reviewed the nurse's report sheet that was on the wall and reported it did not indicate Resident #57 was to have the Dycem pad under her wheelchair seat. The NA stated Resident #57 would frequently get out of bed and transfer to her wheelchair without assistance. NA #8 stated she had a history of falls due to sitting on the edge of her wheelchair and keeping personal items tucked behind her back while sitting on the wheelchair. NA #8 stated the Dycem pad would prevent the wheelchair cushion from coming off the wheelchair if the resident should have a fall while	F 656	Identification of other who may be affected by the alleged deficient practice: 100% audit on resident #57 and all residents care planned for dycem completed on 11/21/2019 and no issues were found. This was completed by the DON, Nurse and Central Supply. Systems and measures to ensure that all alleged deficient practice does not occur: All nursing staff in serviced on following care plans related to dycem in W/C. On 11/21/2019, in-service was initiated by the DON for all current full time, part time and PRN, LPN□s, Nursing Assistants and Medication Aides. The in-service included: " Staff to ensure care plans regarding dycem are followed. The SDC will ensure that any clinical staff who does not complete the in-service training by 11/25/2019 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility orientation. Monitoring compliance of the alleged deficient practice: A quality assurance monitor on dycem in W/C audit will be completed by the DON/designee weekly X4 weeks then monthly X3 months. Reports of the suit will be given by the Director of Nursing to the Quality of Life-QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Social Worker, Dietary Manager, Wound	

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F 656	Continued From page 3 sitting in her wheelchair. An interview was conducted with Nurse #3 on 11/21/19 at 2:50 PM. Nurse #3 revealed the resident had Parkinson ' s disease and a lot of tremors. Nurse #3 stated the resident was alert and oriented and could make her needs known. She stated the resident was aware she needed to use the call light if she needed assistance to the bathroom or getting out of bed. Nurse #1 stated the resident had a history of falls but was not aware Resident #57 was to have a Dycem pad under her wheelchair cushion. Nurse #3 stated she did not usually work on this floor, but if she wanted to know how to take care of a resident she would look at the care plan. Nurse #3 confirmed the Dycem pad was listed in the care plan as an intervention to prevent falls for Resident #57. An interview was conducted with the Director of Nursing (DON) on 11/21/19 at 3:17 PM. The DON reported she did not observe the Dycem pad under Resident #57 ' s wheelchair cushion, but she later found the Dycem pad in the resident's room in her closet. The DON stated she replaced the pad with a new one under her wheelchair cushion. The DON reported if applying the Dycem pad was listed as a task, the staff should ensure that the Dycem pad was in place under the wheelchair cushion. The DON reported the Dycem pad was put in place in May of 2019 because Resident #57 had a tendency to sit at the edge of the wheelchair and it caused her to slip out of the wheelchair. The DON reported the Dycem pad was put in place as an intervention to prevent falls from her wheelchair and it should be in place as per the care plan.	F 656	Nurse, Minimal Data Assessments Nurse and Support Nurse and Health Information Management and meets monthly. Administrator is responsible for implementing an acceptable plan of correction.	

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F 758	Continued From page 4	F 758		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		12/19/19

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F 758	Continued From page 5 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to respond to pharmacy recommendations made in August 2019 for gradual dose reductions (GDRs) of psychotropic medications for 2 of 5 sampled residents (Resident #38 and #57) reviewed for unnecessary medications. Findings included: 1. Record review revealed Resident #38 was admitted to the facility on 01/04/19. The resident's documented diagnoses included dementia with behavioral disturbances, depression, and cerebrovascular accident (CVA) with hemiplegia/aphasia/dysphagia. A 02/20/19 progress note documented Resident #38 was observed placing her own feces in her mouth, inappropriately laughed about the incident, and admitted that she intentionally did it. "New orders received from (physician assistant) to start Risperdal (antipsychotic) 0.25 mg PO BID (milligrams by mouth twice daily) for diagnosis of dementia with psychotic behaviors." On 03/14/19 "I receive antipsychotic medication related to dx (diagnosis) of dementia with	F 758	F758 Actions taken for the residents affected by the alleged deficient practice: On 11/25/2019, the nursing staff initiated the recommendations for GDR□s on residents # 38 and 57. Initiated new orders from Provider on 11/25/2019. Identification of other who may be affected by the alleged deficient practice: 100% audit on Res #38 and #57 and all other residents with GDR recommendations from pharmacy were reviewed with physician for completion on 11/29/2019 and no issues found. This was completed by the Director of Nursing. Systems and measures to ensure that all alleged deficient practice does not occur: On 11/25/2019, in-service training was initiated by the Director of Nursing for all nursing support staff regarding process completed: The in-service included: " Ensuring pharmacy recommendations	

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F 758	Continued From page 6 psychotic behaviors with risk for adverse side effects" was identified as a problem in Resident #38's care plan. Interventions for this problem included, "Consulting Pharmacist to review my psychotropic meds quarterly and prn (as needed) for possible changes or reductions." A 08/19/19 pharmacy recommendation documented, "She (Resident #38) currently receives Risperdal 0.25 mg BID (since 02/20/19) and Prozac (antidepressant) (since 01/04/19). CMS (Centers for Medicare and Medicaid Services) guidelines require periodic dose reductions of all psychotropic meds unless clinically contraindicated. She is having no behavior documented. Please evaluate to reduce her Risperdal to 0.25 mg QD (daily) and Prozac to 10 mg QD at this time to be in compliance." The resident's 10/01/19 quarterly minimum data set (MDS) documented her cognition was moderately impaired, she exhibited no behaviors including resistance to care, and she was receiving a daily scheduled antipsychotic with no attempted gradual dose reduction (GDR). During an interview with Nurse #1 on 11/21/19 at 12:54 PM she stated Resident #38 was alert and in and out of her room all day. She reported the resident was easy to care for, and did not exhibit any behaviors or anxiety. During an interview with Nursing Assistant (NA) #6 on 11/21/19 at 1:28 PM he stated Resident #38 was easy going, cooperative, and a pleasure to care for. He reported the resident did not exhibit any behaviors at all. After surveyor intervention the physician care	F 758	are addressed within 5 business days. The Staff Development Coordinator will ensure that any clinical staff who does not complete the in-service training by 11/27/2019 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility orientation. Monitoring compliance of the alleged deficient practice: A quality assurance monitor on ensuring timely completion of Pharmacy recommendations audit will be completed by the DON/designee weekly x 4 weeks and then monthly x 3 months.. Reports of the audit will be given by the Director of Nursing to the Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Social Worker, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Support Nurse and Health Information Management and meets monthly. Administrator is responsible for implementing an acceptable plan of correction.	

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team responded for the first time to the Consultant Pharmacist's 08/09/19 recommendation for Resident #38 on 11/21/19, documenting to reduce the resident's Risperdal to 0.25 mg QD but to keep the resident on 20 mg Prozac QD.

During an interview with the Director of Nursing (DON) on 11/21/19 at 2:12 PM she stated the current physician care team had not seen the Consultant Pharmacist's 08/09/19 recommendation for Resident #38 until presently, probably because there was a Nurse Practitioner (NP) who was stacking paperwork to the side and not addressing resident needs timely. The DON explained she had requested that this NP not return to the building. She commented Resident #38 was a good candidate for a Risperdal GDR because she was very psychologically stable and exhibiting no behaviors without a true psychiatric diagnosis other than dementia with behaviors. The DON also remarked that the resident was not being followed by psychiatric services.

2. Resident #57 was admitted to the facility on 02/12/18. Diagnoses included, in part, dementia with Lewy bodies, osteoarthritis, Parkinson ' s disease, depression and anxiety.

The Minimum Data Set quarterly assessment dated 10/21/19 revealed the resident was cognitively aware. The resident received 7 days of antipsychotics, antidepressants and opioids.

A pharmacy medication regimen review (MRR) on 08/08/19 revealed a recommendation for a

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gradual dose reduction (GDR) of Zoloft (antidepressant medication) 150 milligrams (mg).

A pharmacy medication regimen review (MRR) on 09/10/19 revealed under recommendation "no response to 08/08/19 Zoloft consult."

A pharmacy medication regimen review (MRR) on 10/08/19 revealed a recommendation for a response to the Zoloft GDR. The MRR revealed there was no response noted for the 08/08/19 Zoloft consult.

A review of the pharmacy medication regimen review (MRR) on 11/13/19 revealed, in part, recommendation for Zoloft GDR.

A review of the November Medication Administration Record (MAR) revealed the resident was receiving Zoloft 150 mg daily as ordered.

An interview was conducted with the Director of Nursing (DON) on 11/21/19 at 3:07 PM. The DON reported the process for implementing pharmacy recommendations was that the pharmacist would email the MRR to her each month. The DON would give the medication recommendations to the physician or the Nurse Practioner (NP) to review. The DON stated if the physician or NP made changes to the medication, they would give it to the Unit Manager to make the changes and update the physician orders. The DON realized the pharmacy recommendations were made to consider a GDR for Resident #57 ' s Zoloft medication since August, 2019. She was unable to provide a response as to why those recommendations were not addressed and believed it was related to a

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F 758	Continued From page 9 previous Nurse Practioner who had not handled the recommendations as they were given to her. The DON stated she recognized that there was a systems problem as it pertained to reviewing and following up on pharmacy recommendations.	F 758		
F 761 SS=D	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 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 date 2 opened insulin pens for 2 residents (Resident #26 and Resident #44) that	F 761	F761 Actions taken for the residents affected by	12/19/19

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were found in 2 of 2 medication carts observed on the 200/300 hall, and failed to discard several loose pills that were identified in the medication cart draws for 2 of 2 medication carts observed on the 200/300 hall. Findings included:

1 a. An observation of medication cart #1 on the 300 hall on 11/21/19 at 1:50 PM revealed an opened Lantus (insulin) pen for Resident #44, but had no date as to when it was opened.

An interview with Nurse #3 on 11/21/19 at 1:50 PM revealed she was not sure when the Lantus insulin pen was opened, but when it was opened, it should have been dated because the medication expired after 28 days and without an open date, you would not be able to determine which date it expired.

1 b. An observation of medication cart #1 on the 300 hall on 11/21/19 at 1:50 PM revealed in the second draw of the medication cart there were noted to be a significant amount of loose pills in 3 of 3 compartments where the medication cards for the residents were stored.

An interview with Nurse #3 revealed she could not identify what each of the pills were but stated the nurses were responsible for checking and cleaning their carts before each shift. Nurse #3 stated she did not usually work on this cart (300 hall) and she did not check the cart for expired medications and ensure that all opened medications were dated nor did she clean the cart before her shift.

2 a. An observation of medication cart #2 on the 200 hall on 11/21/19 at 2:00 PM revealed an opened Levemir (insulin) pen for Resident #26,

the alleged deficient practice:
(a.) On 11/21/19 the staff nurse replaced the insulin pens and dated insulin pens for residents #26 and #44.
(b.) On 11/21/19 the staff nurse cleaned all medication carts from loose pills.

Identification of other who may be affected by the alleged deficient practice:
(a). 100% audit of residents #26 and #44 and all other residents on insulin pens were dated with open dates to ensure insulin pens were dated. No additional issues found and completed on 11/21/2019. This was completed by the Director of Nursing.
(b). 100% of all med carts were audited for loose pills on 11/21/2019 and/or corrected with no further issues noted. This was completed by the Director of Nursing.

Systems and measures to ensure that all alleged deficient practice does not occur:
On 11/29/2019, in-service training was initiated by the Director of Nursing and Staff Development Coordinator for all current full time, part time and PRN RN□s, LPN□s, Nursing Assistants and Medication Aides.
The in-service included:
" Importance of dating new insulin pens when opened.
" Ensuring medication carts are free of loose pills.
The Staff Development Coordinator will ensure that any clinical staff who does not complete the in-service training by 11/25/2019 will not be allowed to work

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F 761	Continued From page 11 but had no date as to when it was opened. An interview with Med Aide #1 on 11/21/19 at 2:00 PM revealed she was not sure when the Levemir insulin pen was opened, but that when it was opened the process was to document the date it was opened on the pen. The Med aide was not certain of when the Levemir expired, but thought it was 28 days. (Levemir expires 42 days after opening). 2 b. An observation of medication cart #2 on the 200 hall on 11/21/19 at 2:00 PM revealed in the second draw of the medication cart there were noted to be a significant amount of loose pills in 3 of 3 compartments where the medication cards for the residents were stored. An interview with Med Aide #1 on 11/21/19 at 2:00 PM revealed she did not usually work on the 200 hall medication cart and that she usually just cleaned and checked her cart in assisted living unit. The Med Aide reported she did not check medication cart #2 on the 200 hall prior to her shift. An interview with the Director of Nursing (DON) was conducted on 11/21/19 at 3:20 PM. The DON reported she expected her nurses and medication aides, at the beginning of their shift, to clean their carts to ensure there were no loose pills or spillage from liquid medications, to dispose of any expired medications and to ensure insulin pens were dated upon opening. The DON stated the night shift nurses should also be checking and cleaning the medication carts since they usually have more down time to complete this task.	F 761	until the training is completed. This in-service was incorporated into the new employee facility orientation. Monitoring compliance of the alleged deficient practice: A quality assurance monitor on auditing med carts for dated open insulin pens and loose pills in W/C audit will be completed by the DON/designee weekly x 4 weeks and then monthly x 3 months. Reports of the audit will be given by the Director of Nursing to the Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Social Worker, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Support Nurse and Health Information Management and meets monthly. Administrator is responsible for implementing an acceptable plan of correction.	

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	345468	A. BUILDING _____ B. WING _____	C 11/21/2019

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F 812	Continued From page 12	F 812		
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 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 interview the facility failed to remove a pink slimy film from the back panel of the ice machine, failed to remove dust and dirt from 6 of 13 fluorescent light fixtures, failed to remove food debris from the deep fryer, and failed to clean the interior top of the microwave. The facility also failed to cover and label and date food items in storage areas. Findings included: 1. During initial tour of the kitchen, beginning at 10:48 AM on 11/18/19, there was a pink slimy film across the back panel of the ice machine. The ice was not touching this panel, but there was moisture running down the back panel into the	F 812	F812 Actions taken for the residents affected by the alleged deficient practice: On 11/18/2019, the Dietary Manager immediately cleaned and disinfected the ice machine, microwave and deep fryer, all light panels identified were cleaned in the kitchen, and the noodle bags were stored and labeled correctly. There was no indication of residents directly affected by the concerns identified. Identification of other who may be affected by the alleged deficient practice:	12/19/19

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F 812	Continued From page 13 cubes of ice below. Part of the pink build-up was removed when a paper towel was used to wipe across a section of the back panel. During an interview with the Dietary Manager (DM) on 11/21/19 at 2:18 PM she stated the ice machine needed to be cleaned more frequently, and she would be transferring the responsibility from the maintenance to the dietary department. She reported a sanitizing solution should be used to wipe down the back panel weekly and as needed. She commented allowing a build-up of a pink residue on the back panel of the ice machine could contaminate the ice placed in resident beverages. During an interview with Dietary Employee #1 on 11/21/19 at 2:31 PM she stated the back panel of the ice machine should remain free of residue all the time, and if allowed to form, the residue could introduce bacteria and mold into the ice supply. 2. During initial tour of the kitchen, beginning at 10:48 AM on 11/18/19, 6 of 13 fluorescent light panels had dust and dirt on them. During an interview with the Dietary Manager (DM) on 11/21/19 at 2:18 PM she stated lights and vents in the kitchen were cleaned monthly by the maintenance department, but when dust and dirt built up on them between months someone should immediately make sure the dust and dirt were removed from them. She reported if dust and dirt were allowed to collect on light fixtures these contaminates could fall into the food which was being prepared and served off the steam table. During an interview with Dietary Employee #1 on	F 812	The Dietary Manager corrected all deficiencies noted above and in-serviced staff on 11/21/2019 regarding: 1. Thoroughly cleaning the ice machine weekly. 2. If dust or buildup is noted on lights, vents and fixtures prior to the scheduled cleaning, maintenance will be notified to clean. 3. Fryer oil being filtered after each use. 4. Daily cleaning of the microwave. 5. Dating and labeling of open food items. No other areas were identified. Systems and measures to ensure that all alleged deficient practice does not occur: The Dietary Manager implemented a QA tracking tool on 12-1-2019 that will audit food items stored, to ensure proper labeling and storage practices are being used. Logs were also implemented on 12-1-2019 to monitor the cleaning of the ice machine, microwave and ceilings. This will be completed daily by the Dietary Manager. The Dietary Manager will review and report any identified concerns to the NHA. Monitoring compliance of the alleged deficient practice: A quality assurance monitor on auditing the kitchen and sanitary processes will be completed by the Dietary Manger/designee weekly x 4 weeks and then monthly x 3 months. Reports of the audit will be given by the Dietary Manager to the Quality of Life- QA committee and corrective action initiated as appropriate.	

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F 812	Continued From page 14 11/21/19 at 2:31 PM she stated lights and vents in the kitchen should be kept free of dust and dirt which could fall into the food being prepared for residents and make them sick. 3. During initial tour of the kitchen, beginning at 10:48 AM on 11/18/19, the oil in the deep fryer was murky and there was food debris floating in the oil. There was also a build-up of old food debris resembling French fries on the inner ledge of the deep fryer. During an interview with the Dietary Manager (DM) on 11/21/19 at 2:18 PM she stated oil in the deep fryer was supposed to be filtered after each use. She remarked that fresh foods cooked in unfiltered oil that still had food debris in it would make the fresh foods taste bad, and old food debris posed the risk of causing pest infestation. During an interview with Dietary Employee #1 on 11/21/19 at 2:31 PM she stated the oil in the deep fryer should be filtered to remove food debris after each use. She reported the cooks who used the fryer was responsible for making sure the oil in it remained clean. She commented old, unclean oil could give foods a rancid taste and possibly make residents sick. 4. During initial tour of the kitchen, beginning at 10:48 AM on 11/18/19, there was a large amount of dried food caked on the interior top of the microwave. During an interview with the Dietary Manager (DM) on 11/21/19 at 2:18 PM she stated the dietary staff was supposed to clean all interior surfaces of the microwave after each shift or twice a day. She reported food that wasn't	F 812	The Quality of Life committee consists of the Director of Nursing, Administrator, Social Worker, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Support Nurse and Health Information Management and meets monthly. Administrator is responsible for implementing an acceptable plan of correction.	

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F 812	Continued From page 15	F 812		

cleaned off the top of the microwave could burn or fall into fresh food which was being heated.

During an interview with Dietary Employee #1 on 11/21/19 at 2:31 PM she stated it was important not to overlook cleaning the interior top of the microwave because heat could loosen dried food particles which could contaminate fresh foods and make residents sick.

5. During initial tour of the kitchen, beginning at 10:48 AM on 11/18/19, two bags of egg noodles below a preparation counter had been opened but were not labeled and dated. A four-pound box of cheese cake mix in the dry storage room had been opened but was not labeled and dated. Four dessert bowls of peaches were uncovered in the reach-in refrigerator. Eleven bowls of tossed salad on a baking pan, a styrofoam plate containing lettuce/tomato/cheese, and a home-made pie in the walk-in refrigerator did not have labels and dates on them. A pack of Swiss cheese slices, a bag of shredded mozzarella cheese, a bag of shredded cheddar cheese, a gallon container of heavy duty mayonnaise, and a package of corned beef had been opened but were without labels and dates.

During an interview with the Dietary Manager (DM) on 11/21/19 at 2:18 PM she stated she checked the storage areas each morning to make sure there were labels and dates on all opened food items, repackaged food items, and left overs. She reported food items kept in refrigerated storage should be kept covered to prevent cross contamination. She commented the labeling and dating program helped reduce spoilage and promoted residents getting the freshest foods possible.

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F 812	Continued From page 16 During an interview with Dietary Employee #1 on 11/21/19 at 2:31 PM she stated all dietary employees were responsible for monitoring storage areas to make sure opened food items were labeled and dated, food items were not past their use-by dates, and foods were covered and packaged to protect against pests. She reported labeling and dating helped make sure old foods were disposed of and fresh foods were served to the residents.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842		12/19/19

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(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic

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F 842	Continued From page 18 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to include lab results and consults in the paper and electronic medical records of 2 of 20 sampled residents (Resident #40 and Resident #46) whose medical records were reviewed. Findings included: 1. Record review revealed Resident #40 was admitted to the facility on 04/30/09. Her documented diagnoses included Alzheimer's dementia with behavioral disturbances, cerebrovascular accident (CVA) with hemiplegia/aphasia/dysphagia, hypertension, hypercholesterolemia, depression, and anxiety disorder. A 08/17/17 physician order documented every six month (in April and October) the resident was to have a complete blood count (CBC) with differential, basic metabolic panel (BMP), thyroid stimulating hormone (TSH), lipid panel, and liver function test (LFT) drawn. Record review revealed there were no October 2019 lab results for Resident #40 in her paper or electronic medical records. During an interview with the Director of Nursing (DON) on 11/21/19 at 11:30 AM she provided a copy of 10/08/19 lab results for Resident #40 (which included a CBC with differential, BMP, TSH, lipid panel, and liver function panel). She stated these lab results should have been scanned into the resident's electronic medical record, but the facility was behind in scanning lab results and consults because medical records	F 842	F842 Actions taken for the residents affected by the alleged deficient practice: On 12/11/2019 the Health Information Manager uploaded residents #40 lab results and #46 psychotherapy notes into their electronic medical record. Identification of other who may be affected by the alleged deficient practice: On 12/11/2019, the Health Information Manager performed a 100% audit on all active residents in the skilled nursing portion of the building to assess if all lab results and notes are scanned into the medical chart. The Administrator educated the facility HIM of the importance of timely scanning of lab orders and notes. This education was completed by the Administrator on 12/10/2019. Systems and measures to ensure that all alleged deficient practice does not occur: On 12/11/2019 a validation log was implemented to track when documents are uploaded into the resident□s electronic medical record. Monitoring compliance of the alleged deficient practice: A quality assurance monitor on electronic medical record will be completed by the Health Information Manager/designee weekly x 4 weeks and then monthly x 3	

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F 842	Continued From page 19 had lost a part time worker. 2. Record review revealed Resident #46 was admitted to the facility on 10/14/19. His documented diagnoses included dementia with Lewy bodies, cancer, diabetes, depression, and insomnia. Review of the resident's progress notes from 10/21/19 through 10/31/19 documented the resident was experiencing intermittent anxiety, behaviors, and confusion. During an interview with Resident #46's primary physician on 11/20/19 at 2:46 PM she stated she thought the resident was being followed by psychiatric services. During a 11/21/19 11:00 AM interview with the Unit Manager on Resident #46's hall she stated all residents in the rehabilitation unit only had electronic medical records, and paper charts had been done away with. Record review revealed there were no psychiatric consults in Resident #46's electronic medical record. During an interview with the Director of Nursing (DON) on 11/21/19 at 11:30 AM she provided copies of a 10/24/19 psychotherapy note and a 10/29/19 psychiatry note for Resident #46. She stated these consults should have been scanned into the resident's electronic medical record, but the facility was behind in scanning lab results and consults because medical records had lost a part time worker.	F 842	months. Reports of the audit will be given by the Dietary Manager to the Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Social Worker, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Support Nurse and Health Information Management and meets monthly. Administrator is responsible for implementing an acceptable plan of correction.	