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	345132	A. BUILDING _____ B. WING _____	C 12/20/2019

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E 001 SS=E	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop and maintain an Emergency Preparedness (EP) plan that addressed all minimum aspects of an EP plan. The EP plan had not been updated at least annually. or	E 001	Greenhaven Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of	1/27/20

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

Electronically Signed | 01/17/2020

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E 001	Continued From page 1 Based on record review and staff interviews the facility failed to develop an Emergency Preparedness (EP) plan. The EP plan did not address the resident population to include residents at risk, a process for cooperation and collaboration with local, state, regional, tribal and federal officials and the development of an arrangement with other long-term care facilities to receive residents. The facility also failed to develop a communication plan with names and contact information and a method of sharing information with resident's families/representatives regarding the EP plan. The facility failed to develop training and testing exercises for the facility using the EP plan. Findings included: Review of the facility ' s Emergency Preparedness plan materials revealed: A. The LTC facility did not develop and maintain an EP plan that was reviewed and updated at least annually. The EP plan did not address the resident population including at risk residents and the type of services the facility could provide in an emergency. B. The EP plan was not annual updated to include a documented, facility-based risk assessment utilizing an all-hazards approach, including missing residents. Nor comprehensive strategies for addressing emergency events identified by the risk assessment. C. The EP plan did not address a procedure for tracking residents and on-duty staff if evacuated during an emergency.	E 001	residents. The Plan of Correction is submitted as a written allegation of compliance. Greenhaven Health and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenhaven Health and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The Facility has developed and maintains an Emergency Preparedness Plan. This Plan was updated 1/10/20. Table top Drill scheduled for 1/17/20 No residents suffered any negative outcomes. All residents have the potential to be affected. On 1/16/20 The Administrator spoke with Emergency Management Emergency Coordinator. On 1/10/20 the administrator updated the emergency preparedness (EP) plan. A.)On 1/10/20 and 1/13/20 the administrator updated the EP plan signature page to reflect that it was reviewed, signed, and dated annually. B.)On 1/13/20, the administrator updated the EP plan to address the resident population including a risk assessment at risk residents and the type of services the	

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E 001	Continued From page 2 D. The EP plan did not address patient/client population, including, but not limited to, persons at-risk; the type of services the LTC facility could provide in an emergency; and continuity of operations, including delegations of authority and succession plans. E. The EP plan did not include a process for cooperation and collaboration with local, tribal, regional, State, and Federal EP officials' efforts to maintain an integrated response during a disaster or emergency, including documentation of the LTC facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. F. The EP plan did not contain the role of the facility using a waiver declared by the Secretary, in accordance with section 1135 of the Act. G. The EP plan did not address the subsistence needs for staff and residents that included at a minimum, (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. (b) Policies and procedures. LTC facilities must develop and implement EP policies and procedures, based on	E 001	facility could provide in an emergency. C.)On 1/13/20 The Administrator updated the EP plan to address Tracking Residents and on duty staff if evacuated. D.)On 1/13/20 the EP Plan was updated to address persons at risk, types of services, continuity of operations, and delegation of authority. E.)On 1/13/20 the EP plan included a process and contact information on how to include local, regional and state officials in disaster planning and emergency events. F.)The EP Plan contains the facility policy on Waiver utilization. G.)On 1/13/20 the EP plan addressed the subsistence needs for staff and Residents that included: Subsistence needs for staff and Residents whether they evacuate for shelter in place Food, Water, Drugs, Supplies Alternate energy Temperatures to protect Residents and Staff and Safe and sanitary storage. Emergency Lighting Fire detection and sprinkler Operation. Sewage and waste disposal Communications plan. Policies and Procedures updated annually H.)On 1/13/20 the EP plan addressed means to shelter in place. I.)On 1/13/20 the facility planned a Table top drill for 1/17/20 and a full scale exercise in 2020. J.)On 1/13/20 the EP plan addressed medical documentation and preserving Patient information, confidentiality and security of information. K.)On 1/13/20 the EP plan addressed the	

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E 001	Continued From page 3 the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures were not reviewed and updated at least annually. H. The EP plan did not address a means to shelter in place for patients, staff, and volunteers who remain in the LTC facility. I. The EP plan testing exercises did not include a second full-scale exercise that was community or facility based and did not include a tabletop exercise with analysis. J. The EP plan did not address a system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. K. The EP plan did not address the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. L. The EP plan did not address the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. M. The EP plan did not address the LTC facility to develop and maintain an EP communication plan that complies with Federal, State and local	E 001	use of volunteers and other staffing sources. L.)It is the Policy of Greenhaven Health and Rehab to abide by and react as necessary to the implementation of such waivers as is documented in our Compliance with 1135 Waiver declaration E-Tag E-003. M.)On 1/13/20 the EP Plan addressed the communications plan and contacts and updating annually N.)On 1/13/20 the EP Plan addressed training and testing and evaluating annually. Beginning on 1/13/20 Staff was trained and randomly tested. This is to be completed by 1/18/2020. Any nursing staff member, including agency nurses, who have not received the in-service will not be permitted to work until in-service is completed. O.)Staff have been educated on the Emergency Preparedness Plan and will be re-educated annually followed by testing and drills to assess competency. P.)On 1/17/20 the Facility conducted an Emergency Disaster Table top drill. Following the Drill the Administrator reviewed the exercise with Katherine Hughes of the Guilford County Emergency Management Coordinators Office. A second full scale exercise involving community participation that is facility based is to be completed On 1/10/20, the regional vice president of operations provided education to the	

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E 001	Continued From page 4 laws and must be reviewed and updated at least annually. N. The EP plan did not address training and testing. The LTC facility did not develop and maintain an EP training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program were not reviewed and updated at least annually. O. The EP program did not: (ii) Provide EP training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. P. The facility did not conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. Nor did the facility: (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed.	E 001	administrator regarding the requirement for an effective EP plan. The EP plan will be updated by 1/18/20 to reflect all CMS guidelines. The updated EP plan will be reviewed quarterly for four (4) quarters by the Quality Assurance and Performance Improvement (QAPI) Committee to ensure that the EP plan is implemented and EP exercises are completed per regulation.	

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E 001	Continued From page 5 During an interview with the Administrator on 12/20/2019 at 7:30am He discussed that he had only been here three weeks, he was trying not to put his name on things here at the facility however he called in the Maintenances Director about the training and update the EP book. Administrator indicated he was unaware if the Facility's EP plan contain all of the required information needed. During the interview with the Maintenance Director on 12/20/2019 at 7:40am he stated the only training that we have had was elopement couple of weeks ago. MD indicated he does know everything about the Facility's EP book.	E 001		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/16/19 through 12/20/19. Event ID# FNH411 6 of the 30 complaint allegations were substantiated resulting in deficiencies. Substandard Quality of Care was identified at CFR 483.12 at tag F600 at a scope and severity (H). An extended survey was also conducted.	F 000		
F 600 SS=H	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 600		1/27/20

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F 600	Continued From page 6 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, physician interviews and record review the facility neglected to provide incontinence care for 3 of 5 (Resident #24, Resident #26 and Resident #12) residents observed for incontinence care. Resident #24 expressed that he had to wait 2 and a half hours for incontinence care and felt "embarrassed and angry" about being left in a soiled brief. Resident #26 was not checked for incontinence for over two and a half hours and had a drying brown liquid covering just above his buttocks and down the back of his thighs. Resident #12 stated she had to wait "over an hour" for incontinence care and felt bad and neglected having to remain in a soiled brief. Findings included: 1. Resident #24 was admitted to the facility on 10-5-18 with multiple diagnosis that included lobar pneumonia, hemiplegia and hemiparesis affecting the left side, chronic obstructive pulmonary disease. The annual Minimum Data Set (MDS) dated 10-15-19 revealed Resident #24 was cognitively intact and needed extensive assistance with one person for bed mobility, dressing and personal hygiene and total assistance with one person for	F 600	Residents affected: On 12/16/19, Resident #26 was provided incontinent care. On 12/17/2019, Resident #24 was provided incontinent care. On 12/18/19, Resident #12 was provided incontinent care. No negative outcome identified. Residents with potential to be affected: All Residents have the potential to be affected. On 12/19/2019 all residents were checked by Unit Managers, MDS Coordinator, Staff Development Coordinator and nursing management to determine whether residents were clean and dry using the Resident Monitoring Tool. Any resident who needed incontinence care was immediately provided incontinence care. Plan- systemic changes: On 12/19/2019, the Staff Development Coordinator and Nurse Management initiated in-service training for licensed nurses and C.N.A.□s related to ADL□s, with specific focus on incontinence care.	

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F 600	Continued From page 7 toileting. Resident #24's care plan dated 11-11-19 revealed a goal that personal and activities of daily living care would be completed with staff support and Resident #24 would be neat, clean and odor free. The interventions listed for that goal were; staff to provide total care to include combing the hair, shaving and washing the face, hands and perineum (area below the pelvis and between the legs). During an interview and observation of Resident #24 on 12-17-19 at 8:55am, Resident #24 stated he was "angry" because he had informed Nurse #1 at 7:20am he needed to have incontinence care completed and was told there were no nursing assistants on the floor but when a nursing assistant arrived Nurse #1 would inform them he needed incontinence care. He also stated when he put his call light on around 8:00am "a staff member came in and turned off the light telling me I would have to wait because the breakfast trays were coming out." The resident stated he had not received care and had to eat his breakfast lying in his own feces. Resident #24 was noted to have an odor of feces. The resident also stated "this is an everyday occurrence. I usually have to wait up to 2 hours before they will clean me up." Nurse #1 was interviewed on 12-17-19 at 9:05am. Nurse #1 stated she had been informed at 7:20am by Resident #24 that he needed incontinence care completed but she was the only staff member on the hall and did not feel she could perform incontinence care by herself due to Resident #24 having hemiplegia on his left side. She also stated there were nursing assistants on	F 600	This to be completed by 1/22/20. Any nursing staff member, including agency nurses, who have not received the in-service will not be permitted to work until in-service is completed. Using the Resident Monitoring Tool, starting 12/26/19 Unit Managers, DON, ADON, RN Consultants, MDS Coordinator, and Staff Development Coordinator will audit residents to ensure they are clean and dry. Incontinence care will be provided immediately by nursing staff if identified. Beginning 1/13/2020, the Staff Development Coordinator and Nurse Management initiated in-service training for all staff related to Abuse and Neglect. This to be completed by 1/23/20. Any staff member, including agency staff, who have not received the in-service will not be permitted to work until in-service is completed. Administrator, DON will review staffing patterns and assignments for appropriate coverage during staffing meetings 5 times a week. Nursing Management will be present at each Shift Change and will review that each unit has sufficient staff each shift to meet the Resident Needs. Monitoring: Beginning 1/10/20 Nurse Management will rotate shifts and the assigned Nurse will be present during each shift change daily	

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F 600	Continued From page 8 the hall and she had informed them of Resident #24's need for incontinence care at 7:45am. Nurse #1 stated she was unaware Resident #24 had not received incontinence care and she would remind staff. Resident #24 was interviewed on 12-17-19 at 9:25am. Resident #24 stated no one had come to provide incontinence care and he was still lying in his urine and feces "I'm sorry if I smell but I can't help it when they won't come and clean me up". On 12-17-19 at 9:26am, Nurse #1 was observed to attempt to locate the nursing assistants but was unable to find them on the hall. Nurse #1 was noted to request the medication nurse to provide incontinence care to Resident #24. Incontinence care was observed on 12-17-19 at 9:30am. Resident #24 was noted to have crusted dried feces on his buttocks and his brief was noted to have a dried dark yellow ring. The resident's skin was intact with no redness noted. Nursing assistant #2 was interviewed on 12-17-19 at 10:00am. The nursing assistant stated she was the assigned nursing assistant for Resident #24 and had not been informed Resident #24 needed incontinence care when she arrived to work at 7:40am. She stated Resident #24 had put his call light on for incontinence care "around 8:00am" but stated she could not perform care at that time due to the arrival of the breakfast trays. Nursing assistant #2 stated she had planned to attend to Resident #24 after breakfast but there were only 2 nursing assistants on the hall, and she had been requested to help the other nursing assistant first.	F 600	x one month then 3 x week each shift x one month then weekly each shift x 1 month. Beginning 12/26/19 The Director of Nursing, Assistant Director of Nursing, MDS nurses, RN Nurse Consultant, and Unit Managers will complete an audit on all residents using the Resident Monitoring Tool daily x 2 weeks, then 4 times a week x 1 week, then 2 times a week for 1 week, then weekly x 2 months. The Director of Nursing will take the completed audits to the monthly QAPI committee for discussion and review to assure continued compliance for three months.	

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During an interview with the facility's physician on 12-18-19 at 12:55pm, the physician stated Resident #24 could not perform most of his activities of daily living care by himself due to his hemiparesis but that the resident was cognitively intact. The physician stated she expected staff to respond to any resident's needs within minutes and allowing feces or urine to dry on the resident's skin could cause infection and skin breakdown.

An interview on 12/20/19 at 4:07 pm with the Administrator revealed he felt the primary reason the residents did not receive care in a timely manner was related to the need to improve the quality of care the staff provided and recruit additional staff for the facility.

2. Resident #26 was admitted to the facility on 10-3-18 with multiple diagnosis that included congestive heart failure, dementia and a stroke.

The annual Minimum Data Set (MDS) dated 10-15-19 revealed Resident #26 was moderately cognitively impaired and needed extensive assistance with one person for toileting and personal hygiene.

Resident #26's care plan dated 11-11-19 revealed a goal of activities of daily living and personal care would be completed with the support of staff. The interventions listed for the goal were; assist with frequent incontinence and provide supervision and physical assistance.

An observation and interview were conducted with Resident #26 on 12-16-19 at 1:30pm. Resident #26 was noted to be laying on his left side covered with a white sheet that was noted to

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have a brown liquid substance covering the sheet from the back of Resident #26's thighs to just above his buttocks. The brown liquid was noted to be drying around the edges and there was a foul odor in the resident's room. The resident stated he last received incontinence care "before lunch" but was not able to provide an exact time. It was also noted Resident #26 did not have his call light in reach. The call light was noted to be wrapped around the right bed rail which was down below the mattress. The resident attempted to reach his call light but was unable. Once the call light was handed to Resident #26, he was able to turn it on for assistance.

An observation made on 12-16-19 at 1:35pm revealed Resident #26 was in bed laying on his left side covered by a white sheet with his call light turned on. A large area of the resident's white sheet was observed to be soiled with a brown liquid substance that was easily visible to anyone who entered the resident's room. The activities director (AD) was observed to enter Resident #26's room, turned off his call light and asked the resident what he needed but then quickly stated "oh you're ok." The AD was observed to leave the residents room without giving the resident a chance to respond to why his call light was activated.

During an interview with the AD on 12-16-19 at 1:36pm, the AD stated she did not notice Resident #26 was soiled or the foul odor in the resident's room. The AD stated, "I was just looking at his face." The AD stated she would have a nursing assistant check on the resident.

Incontinence care was observed with Resident #26 on 12-16-19 at 1:50pm. Nursing assistant #2

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GREENHAVEN HEALTH AND REHABILITATION CENTER	801 GREENHAVEN DRIVE GREENSBORO, NC 27406

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was observed providing the care and when NA #2 removed the sheet covering Resident #26, it was noted the brown liquid was partially dry on the back of his thighs and above his buttocks. The resident's skin was noted to be intact with no redness.

During an interview with nursing assistant (NA) #2 on 12-16-19 at 2:05pm, the nursing assistant stated she could not remember the last time she provided Resident #26 with incontinence care but "believed" it was before lunch between 10:30am and 11:00am. She also stated the resident ate in the dining room, so she did not know if Resident #26 had been soiled during lunch and was unaware he was back in his room. The NA stated residents should have their call bell within reach and "whoever put him in the bed should have checked to make sure he could reach it." She also stated she tried to check on her residents every 2 hours for incontinence "but sometimes there is not enough help and it takes a little longer." NA #2 stated she had not checked Resident #26 for incontinence for "over 2 hours" and stated she felt it was neglectful "because we are supposed to do our rounds at least every 2 hours."

During an interview with the facility physician on 12-18-19 at 12:55pm, the physician stated she expected staff to respond to any resident's needs within minutes and allowing feces or urine to dry on the resident's skin could cause infection and skin breakdown.

An interview on 12/20/19 at 4:07 pm with the Administrator revealed he felt the primary reason the residents did not receive care in a timely manner was related to the need to improve the

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quality of care the staff provided and recruit additional staff for the facility.

3. Resident #12 was admitted to the facility on 10/8/18 and diagnoses included chronic kidney disease, diabetes, polyneuropathy, depression and anxiety.

An annual minimum data set (MDS) dated 10/16/19 for Resident #12 identified she was always incontinent of bowel / bladder and required extensive two-person assist with toilet use. She required extensive one-person assist with personal hygiene, her cognition was intact, and no behaviors were identified for the look-back period.

A care plan for Resident #12 with a revision date of 11/19/19 stated activities of daily living and personal care would be completed with staff support as appropriate to maintain or achieve the highest practical level of functioning. An additional care plan, also with a revision date of 11/19/19 stated problematic manner in which resident acts characterized by inappropriate behavior, resistive to treatment / care by certain staff members which resulted in missed treatments.

An interview with Resident #12 on 12/18/19 at 9:30 am revealed her primary concern was she had to sit in stool and urine for an hour or more before being changed. She stated this made her feel bad and neglected by the staff. Resident #12 stated this was an ongoing problem and she had gone an entire shift without being changed. She explained she had not reported this directly to the facility staff, but she had submitted 2 complaints to the state. Resident #12 expressed she didn ' t know if she had to wait so long to be changed

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because of a lack of staff or that the staff just didn ' t bother to check on her. Resident #12 stated she had a cell phone and that was how she know how long it took to respond to her call bell. She added frequently the staff would come in and turn her call light off and tell her they would be right back and not return.

An interview with Resident #12 on 12/19/19 at 9:15 am revealed she had urinated in her brief, but it had not been very long, and she hadn ' t called for assistance yet.

An observation on 12/19/19 of the 300-hall revealed Resident #12 ' s call light came on at 9:35 am. A continuous observation revealed a staff member entered Resident #12 ' s room and the call light went off at 9:40 am.

An interview on 12/19/19 at 9:41 am with the Activity Director (AD), who answered Resident #12 ' s call light, revealed the resident needed to be changed. She stated she had turned the residents call light off and notified Resident #12 ' s nurse (Nurse #5) the resident needed to be changed.

An interview on 12/19/19 at 9:42 am with Nurse #5 revealed the AD had notified her that Resident #12 needed to be changed and she would let a Nursing Assistant (NA) know.

A follow-up interview with Resident #12 on 12/19/19 at 10:05 am revealed she had not been changed yet and she had urine in her brief.

A follow-up interview with Resident #12 on 12/19/19 at 10:44 am revealed no staff had come in to clean her up yet. She stated her brief was

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F 600	Continued From page 14 wet and her gown was soaked. She added she had not put her call light back on since the AD had turned it off. During an interview with Nurse #5 on 12/19/19 at 10:45 am she stated she was going to get someone to change Resident #12 and she would get right on it after she gave the medications she had already pulled out. An observation on 12/19/19 at 10:47am identified Resident #12 ' s call light was on. NA #3 entered Resident #12 ' s room at 10:48 am and the call light went off. NA #3 left the room and was observed entering another residents room. At 10:49 am NA #3 was observed speaking to Nurse #5 in the hallway. At 10:53 am NA #3 was observed entering Resident #12 ' s room with wash clothes and left the room again. An interview and observation of Resident #12 on 12/19/19 at 10:56 am revealed she was tearful upon entering the room. The resident stated she was "okay and didn ' t want to talk about it". An observation on 12/19/19 at 11:00 am of Resident #12 during incontinence care revealed the bottom of her gown was wet and her brief was soaked with urine that had leaked onto the incontinence pad. An interview on 12/20/19 at 4:07 pm with the Administrator revealed he felt the primary reason the residents did not receive care in a timely manner was related to the need to improve the quality of care the staff provided and recruit additional staff for the facility.	F 600		
F 658	Services Provided Meet Professional Standards	F 658		1/27/20

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F 658 SS=D	Continued From page 15 CFR(s): 483.21(b)(3)(i)	F 658		

§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, resident and staff interview the facility failed to monitor and treat Resident #18's skin condition according to the care plan and physician's orders. This was evident for 1 of 3 residents reviewed for general skin condition (Resident #18).

Findings Included:

Resident #18 was admitted to the facility on 10/4/19 and diagnoses included peripheral vascular disease, diabetes and fracture of left pubis.

An admission skin assessment dated 10/4/19 for Resident #18 identified her skin was intact.

A care plan with an initiation date of 10/7/19 for Resident #18 stated she was at risk for actual infection related to diabetes and chronic cellulitis to bilateral lower extremities. Interventions included treatment as ordered by the physician and monitor for infection.

An admission minimum data set (MDS) dated 10/17/19 for Resident #18 revealed no current pressure ulcers and her cognition was intact.

A physician's order for Resident #18 with a start date of 11/5/19 stated silver sulfadiazine cream

Resident affected:

On 12/20/2019 the wound supplies were removed from Resident #18□s room and the rationale for removal of wound supplies was explained to the resident and that the nurse responsible for wound care will complete the wound treatments; the resident agreed to this plan of care.

On 12/30/19, the physician observed the resident and new orders were received. The TAR was updated to reflect the new treatment.

Residents with potential to be affected:

On 1/13/2020, the RN consultant completed an audit on all residents with skin conditions (non-pressure related) to assure physician□s order in place, transcribed onto the TAR, and appropriate care plan in place using the Care plan and skin condition audit form.

Plan- systemic changes:

An in-service was initiated on 01/09/2020 by the Staff Development Coordinator and nursing management for all licensed

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F 658	Continued From page 16 1%, apply to bilateral lower extremities, wrap with Kerlix and change once daily. A care plan with an initiation date of 11/7/19 for Resident #18 identified she had peripheral vascular disease related to diabetes. Interventions included to monitor for signs / symptoms of redness, edema, blistering, itching, bruising, cuts, ulcers, infection, etc., to lower extremities. Review of the most recent skin checks for Resident #18 revealed on 12/6/19 a skin check identified an open area to the front of her left lower leg and interventions stated to clean, apply silver sulfadiazine cream 1% (a topical antimicrobial drug used with other treatments to help prevent wound infections) and wrap. The right leg was noted to be healed and leave open to the air. A skin check on 12/7/19 identified bilateral lower extremities had redness and interventions stated moisturizer at bedside and Triamcinolone cream (an anti-inflammatory cream used to treat a variety of skin conditions). There were no skin checks completed for the week of 12/9/19 and 12/16/19. An observation and interview on 12/17/19 at 11:54 am with Resident #18 revealed a bandage was present on her left lower ankle. She stated she took care of the area on the ankle herself. She stated she had the supplies, a spray and some bandages. Resident #18 added the nurses had looked at the area and had measured it in the past. Review of the December 2019 treatment administration record (TAR) for Resident #18 revealed a treatment order for silver sulfadiazine	F 658	nurses. The in-service included obtaining a physician□s order for wound care, transcribing the order onto the TAR, documenting on the TAR treatment was completed, following the care plan, and updating the care plan as needed. This to be completed 1/23/20. Any licensed nursing staff member, including agency nurses, who have not received the in-service will not be permitted to work until in-service is completed. Beginning 1/13/20 Audits on residents with skin conditions (non-pressure related) will be completed using the Care Plan and Skin Condition Audit tool by the R.N. consultant, Assistant Director of Nurses, and Director of Nursing. Monitoring: Beginning 1/20/20 Audits regarding the residents□ skin condition and accompanying care plan will be completed weekly by the R.N. consultant, Assistant Director of Nurses and Director of Nurses, using the Care plan and skin condition Audit tool weekly x 3 months. Beginning 1/21/20 Audits regarding TAR sign-off will be completed by the DON, ADON, Unit Managers, MDS coordinators and R.N. consultant using the TAR audit tool 5 times a week x 1 month, then 3 x a week x 1 month then 1 x a week for 1 month. The Director of Nursing will take the audits to the monthly QAPI committee for	

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cream 1% apply to bilateral lower extremities. The bilateral lower extremities had been crossed off and left lower extremity had been handwritten in. Wrap with Kerlix and change once daily on the 7-3 shift. The TAR had not been signed off as completed on 12/1/19, 12/2/19, 12/4/19, 12/9/19, 12/11/19, 12/13/19 and 12/14/19. The TAR had another treatment order that stated to apply silver sulfadiazine cream 1% to bilateral lower extremities, wrap with Kerlix and change as needed. This had been initialed as completed one day, 12/6/19.

A physician note dated 12/16/19 for Resident #18 stated the resident had a chronic left leg sore. The plan stated "open wound of lower extremity, unspecified, unclear etiology; currently being treated with silver sulfadiazine cream 1% initiated last week. Re-assess after reasonable treatment course by wound consultant and provider team."

A review of the physician's orders for Resident #18 did not include any orders for the resident to treat her own wounds.

An observation of Resident #18 on 12/20/19 at 12:21 pm was conducted with Nurse #4 and the corporate wound consultant. The resident had a bandage present on her left lower leg that was dated 12/19/19 at 5:30 pm. Resident #18 stated a nurse had treated her ankle yesterday. She also stated she (the resident) had found a blister on her right big toe last night and she covered it with a band aid. Resident #18 confirmed that she did do her own treatment to the left leg on occasion. She showed us the supplies she had in her room which included small individualized packed bleach wipes, a container of silver sulfadiazine cream, a cleansing spray, band aids and a pair of

review and discussion to monitor ongoing compliance for 3 months.

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scissors. Nurse #4 stated she was not aware the resident had these items in her room. A skin observation revealed a blister on the right medial great toe. This was measured by Nurse #4 and was 3 centimeters (cm) in length by 2 cm in width; the blister was open with a slight amount of light-yellow drainage. Nurse #4 applied silver sulfadiazine cream 1% and a foam dressing to the right great toe. The dressing was removed from her left lower leg and was noted to have a small amount of yellow drainage on the dressing. This area was approximately the size of a quarter and Nurse #4 treated with silver sulfadiazine cream 1% and wrapped in Kerlix. She did not measure the area. A blister was also noted above the open area on her left leg approximately the size of a quarter and was intact.

An interview with the corporate wound consultant on 12/20/19 at 12:50 pm revealed the skin areas for Resident #18 appeared to be vascular in nature, but this was the first time she had seen the resident. She stated the skin areas should be monitored and measured routinely. The corporate wound consultant added she didn't know why there was a discrepancy between the physician's order for silver sulfadiazine cream 1% to both legs and just applying to her left leg. She was observed to tell Nurse #4 she should provide all of this new information about Resident #18's legs to the Nurse Practitioner (NP) and clarify the treatment orders for her legs.

An interview on 12/20/19 at 12:45 pm with the Director of Nursing (DON) revealed skin assessments should be completed and documented weekly on the skin check sheets for all residents. He stated the nurses should be completing treatments as ordered by the

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F 658	Continued From page 19 physician and they should initial the TAR when the treatment was completed. The DON explained he was not aware Resident #18 had her own wound supplies in her room. He added if a resident wanted to complete their own treatments, they would need to be evaluated for their ability to do so and have a physician's order. The DON stated currently various nurses were providing skin care. An interview on 12/20/19 at 1:17 pm with the NP revealed she had provided care for Resident #18 and she did recall the resident had some open areas to both lower legs that were being treated with silver sulfadiazine cream 1%. She stated she was not aware the resident had blisters on both legs, and she thought the area to her right leg had healed. The NP indicated she was not aware the resident had some wound supplies in her room, and she did not feel Resident #18 should be completing her own treatments. She added the nurses should have been applying the silver sulfadiazine cream 1% as ordered to both legs, not just the left leg and the areas on the resident's legs should be measured weekly to monitor their status. An interview with the Administrator on 12/20/19 at 4:17 pm revealed the breakdown in the system had to do with the lack of consistency of staff providing the wound care and he did expect physicians' orders would be followed.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686		1/27/20

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F 686	Continued From page 20 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, records review, and interviews with the nurse practitioner (NP) and staff, the facility failed to discontinue one treatment and initiate a new treatment for a pressure ulcer as ordered by the physician for 1 of 3 residents reviewed for pressure ulcers (Resident #47). Findings included: Resident #47 was admitted to the facility on 10/15/19 and diagnoses included adult failure to thrive and contractures of multiple sites. An annual minimum data set (MDS) dated 10/23/19 revealed Resident #47 had severely impaired cognition. A physician's order dated 11/20/19 for Resident #47 stated to clean sacrum with normal saline, pack with calcium alginate and cover with dry dressing every Monday and Thursday. A care plan with a revision date of 12/13/19 for Resident #47 stated she was admitted with a stage 4 sacrum ulceration or interference with	F 686	Resident affected: On 12/20/2019, the correct physician□s order for Resident #47 was transcribed onto the TAR and the treatment was rendered as per physician□s order. No negative outcome was identified. Resident with potential to be affected: On 12/20/19 the R.N. consultant began and completed audits using the Pressure Ulcer Audit tool on all residents with pressure ulcers to assure all treatments were as per physician□s order. Plan- systemic changes: In-service was initiated on 01/09/2020 by Staff Development Coordinator and nursing management for all licensed nurses. The in-service included obtaining physician□s order, transcribing onto the TAR, and document on the TAR that treatment was completed. Completed by	

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F 686	Continued From page 21 structural integrity of layers of skin caused by pressure related to cognitive impairment, incontinence of bowel and / or bladder and immobility. Interventions included to provide treatment as ordered by physician. A physician order dated 12/13/19 for Resident #47 stated to discontinue current treatment to sacral wound. Cleanse with normal saline, pat dry, apply skin prep to peri-wound, gently pack wound with hydrogel impregnated gauze, cover foam / dry dressing daily and as needed. A skin assessment dated 12/13/19 for Resident #47 identified she had a stage 4 pressure ulcer on her sacrum. It measured 1.0 centimeters (cm) by 0.5 cm by 0.2 cm. The December 2019 treatment administration record (TAR) for Resident #47 revealed an order dated 11/20/19 to clean sacrum with normal saline, pack with calcium alginate and cover with dry dressing every Monday and Thursday. The treatment was initialed as being completed on 12/2/19, 12/5/19, 12/11/19, 12/16/19 and 12/19/19. An observation on 12/20/19 at 2:20 pm of wound care for Resident #47 was conducted with Nurse #4 and the corporate wound consultant. Nurse #4 cleaned the wound with normal saline, packed with calcium alginate and covered with a foam dressing. The wound was slightly red around the wound opening; there was no sign of infection, drainage or odor. An interview on 12/20/19 at 3:05 pm with Nurse #4 and the corporate wound consultant revealed they had followed the treatment order that was on	F 686	1/23/20 Any licensed nursing staff member, including agency nurses, who have not received the in-service will not be permitted to work until in-service is completed. The R.N. consultant completed an audit on 12/20/19 using the Pressure Ulcer Audit tool for all residents with pressure ulcers to assure all treatments were completed per physician order. Monitor: Beginning 12/27/19,the Director of Nursing and/or ADON, Unit Managers, R.N. consultant will complete an audit using the Pressure Ulcer Audit tool to review all residents with pressure ulcers to assure all treatments transcribed per physician□s order weekly x 3 months. Beginning 1/21/20 Audits regarding TAR sign-off will be completed by the DON, ADON, Unit Managers, MDS coordinators and R.N. consultant using the TAR audit tool 5 times a week x 1 month, then 3 x a week x 1 month, then 1 x a week for 1 month. The Director of Nursing will take the audits to the monthly QAPI meeting for review and discussion to monitor ongoing compliance for 3 months.	

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F 686	Continued From page 22	F 686		

the TAR. They were not aware the order had been changed and they were not sure who was supposed to have transcribed to current order onto the TAR.

An interview on 12/20/19 at 3:19 pm with the Director of Nursing (DON) indicated the facility was responsible for transcribing new treatment orders to the TAR. He stated there was not a fail-safe process in place to double check that orders were transcribed correctly.

An interview on 12/20/19 at 3:40 pm with Nurse #5 revealed she had written the telephone order for the dressing change on 12/13/19 for the hydrogel impregnated gauze. Nurse #5 explained she was new to the facility and thought the floor nurse would process the order by making the change on the TAR and faxing the new order to the pharmacy.

An interview on 12/20/19 at 3:46 pm with the Nurse Practitioner (NP) revealed if the wound was draining the calcium alginate would help to dry up the wound. She added when the order was changed to the hydrogel this would provide moisture to the wound, so they served different functions in treating the wound. The NP stated the order for the hydrogel should have been carried out to the TAR, so the correct wound treatment was provided for the current condition of the wound.

An interview with the Administrator on 12/20/19 at 4:17 pm revealed the breakdown in the system had to do with the consistency of staff providing the wound care and he did expect physicians' orders would be followed.

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F 725	Continued From page 23	F 725		
F 725 SS=H	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and physician interviews the facility failed to provide sufficient nursing staff to prevent resident neglect and provide incontinence care for 3 of 5 sampled residents (Resident #24, Resident #26 and Resident #12) reviewed for activities of daily living. The residents had to lay in	F 725	Residents affected: On 12/16/19, Resident #26 was provided incontinent care. On 12/17/2019, Resident #24 was provided incontinent care. On 12/18/19, Resident #12 was provided incontinent care. No negative outcome	1/27/20

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F 725	Continued From page 24 urine and feces while waiting for staff to provide incontinence care. Findings included: This tag was crossed referenced to: 1. F600: Based on observation, staff and resident interviews, physician interviews and record review the facility neglected to provide incontinence care for 3 of 5 (Resident #24, Resident #26 and Resident #12) residents observed for incontinence care. Resident #24 expressed that he had to wait 2 and a half hours for incontinence care and felt "embarrassed and angry" about being left in a soiled brief. Resident #26 was not checked for incontinence for over two and a half hours and had a drying brown liquid covering just above his buttocks and down the back of his thighs. Resident #12 stated she had to wait "over an hour" for incontinence care and felt bad and neglected having to remain in a soiled brief. During an interview with nurse #1 on 12-17-19 at 9:00am, the nurse stated she was the only employee working on hall 300 on 12-17-19 from 7:00am until "about 7:40am because the nursing assistants were late coming to work." She also stated she had been aware residents' needed incontinence care, but she was not able to perform the care on her own due to the acuity of the residents "so they just had to wait until more staff arrived." Nurse #1 stated on hall 300 there were 2 nursing assistants scheduled on 12-17-19 for the 7:00am to 3:00pm shift and there were 24 residents on hall 300. The Assistant Director of Nursing (ADON) was interviewed on 12-19-19 at 3:00pm. The ADON	F 725	identified. Residents with potential to be affected: On 12/19/2019 all residents were checked by Unit Managers, MDS Coordinator, Staff Development Coordinator and nursing management to determine whether residents were clean and dry using the Resident Monitoring Tool. Any resident who needed incontinence care was immediately provided incontinence care. On 12/19/2019, the Director of Nursing validated the staff assigned to the hall were in the facility on their assignment. Plan- Systemic Changes: On 12/19/2019, the Staff Development Coordinator and nursing management initiated an in-service for Nursing Staff. Nursing staff are not to leave their assignment unless there is someone to relieve them. This to be completed by 1/23/2020. Any nursing staff member, including agency nurses, who have not received the in-service will not be permitted to work until in-service is completed. The Administrator, Director of Nursing, Staff Development Coordinator and scheduler will review staffing patterns and shift assignments for appropriate coverage during the staffing meeting held 5 times per week.	

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F 725	Continued From page 25 was made aware on 12-17-19 "around 7:15am" that there were no nursing assistants present on hall 300. She stated she informed the Director of Nursing (DON) and they checked the schedule to see who was supposed to be working and then the ADON stated she returned to the dining room to help feed residents. She stated she was aware the 11:00pm to 7:00am nursing assistants had left and there were no nursing assistants working on hall 300. An interview with the DON occurred on 12-19-19 at 3:10pm. The DON stated he arrived at the facility at 6:59am on 12-17-19, checked the schedule to see who was supposed to be working and "about 15 minutes later" he heard the call lights on hall 300 that were not being answered. So he went to see what was happening and that was when he was made aware the two nursing assistants who were scheduled to work the 7:00am to 3:00pm shift, had not reported to work. The DON stated he had expected the ADON to call the staff that was scheduled and the scheduler to find out what was going on "but I guess she did not do that." He also stated he saw the staffing issue as a safety factor for the residents. During an interview with nurse #2 on 12-19-19 at 7:58am, the nurse stated on 12-19-19 there were no nursing assistants working on hall 300 "except NA #8". Nurse #2 also stated she was agency and was asked to work that morning (12-19-19). Nurse #2 stated it was not safe for the residents to have one nursing assistant on the hall. Nurse #2 also stated "we need some help down here." The facility's scheduler was interviewed on 12-19-19 at 8:20am regarding the lack of staff on	F 725	Through discussion in our twice a day Interdisciplinary Team Meeting, Staffing adjustments will be made as necessary when Resident needs and/or acuity require additional support or attention. Additional Staff will be called in/scheduled. Administrative Nursing staff will support other staff members until additional help arrives. Beginning 1/10/20 Nursing management will review that each unit has sufficient nursing staff each shift to meet the needs of the residents by being present during each shift change daily. Monitoring: Beginning 12/26/19 The Director of Nursing, Assistant Director of Nursing, MDS nurses, RN Nurse Consultant, and Unit Managers will complete an audit on all residents using the Resident Monitoring Tool daily x 2 weeks, then 4 times a week x 1 week, then 2 times a week for 1 week, then weekly x 2 months. Using the Shift Change monitoring calendar, the DON, ADON, Staff Development Coordinator, RN Consultant, Unit Managers, and MDS coordinators will rotate shifts and the assigned nurse will be present during each shift change daily for 1 month, then 3 times a week each shift x 1 month, then weekly each shift x 1 month.	

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F 725	Continued From page 26 hall 300 for the 7:00am to 3:00pm shift on 12-19-19. The scheduler stated there were normally 2-3 nursing assistants assigned to hall 300 and was not made aware there were no nursing assistants on hall 300 "until I walked in the door 5 minutes ago." She stated it was the facility's policy that the previous shift (11:00pm to 7:00am) could leave "as long as there was one person on the hall." The scheduler stated there were usually just two nursing assistants assigned to hall 300. The scheduler also stated she was "not sure" how the residents would be cared for if there was an emergency "I guess we would ask for help from the other halls." An interview with nurse #2 occurred on 12-19-19 at 8:15am. Nurse #2 stated she felt frustrated when she worked at the facility because she was not able to provide the best care due to the lack of staff "I have to stop giving medications which makes medication pass late or rush a resident taking the medication because I have to answer call lights." She also stated there were 2 nursing assistants for hall 300 and she would often have to help the nursing assistants with activities of daily living care and answering call lights which "takes away from me spending quality time with the residents." NA #8 was interviewed on 12-19-19 at 8:15am. The NA stated she was frustrated that she could not provide "high quality" care for the residents because there were not enough staff. She also stated she had been the only nursing assistant on hall 300 "for the last hour" for 24 residents "I can't get to all the call lights or provide the incontinence care they need when they need it." During an interview with NA #9 on 12-19-19 at	F 725	The Director of Nursing will take the audits to the monthly QAPI meeting for review and discussion to monitor ongoing compliance for 3 months.	

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F 725	Continued From page 27	F 725		

2:50pm, the NA stated she felt she could not provide timely incontinence care to the residents due to having only 2 nursing assistants working on hall 300. She also stated there were only 2 nursing assistance working on hall 300 "the majority of the time like every day."

NA #5 was interviewed on 12-19-19 at 3:32pm: The NA stated she resigned in December 2019 "because the work load was to much." She stated she worked hall 300 and would "typically" have 14 to 15 residents to care for and "there were days I was the only nursing assistant." The NA stated she could not provide quality care to the residents with 2 nursing assistants because the residents on hall 300 required total care. NA #5 further stated "all I could do was apologize to the residents for having to wait so long to answer their call bell or change them."

A phone interview was conducted on 12/20/19 at 8:42 am with NA #6. She stated she worked at the facility for a year and usually was assigned to the hall 300. NA #6 revealed there were typically 2 NAs scheduled for the 300 hall and it was difficult to provide activities of daily living or incontinence care when the residents requested the care to be done because the residents on that hall were heavy care. She added "they really needed 3 NAs on hall 300 to provide the care the residents needed."

During a phone interview with NA #7 on 12/20/19 at 10:59 am she stated she had worked at the facility for about a year and was scheduled for both first and third shifts. NA #7 revealed she typically had 15 residents when she worked on third shift. She added she felt hall 300 required more staff than scheduled because there were

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F 725	Continued From page 28 residents that had behaviors and that could take up a lot of your time if they were "acting out". NA #7 stated, because there was not enough staff working on hall 300, she was not able to provide the residents incontinence care when it was needed or answer the residents call lights timely. The Administrator was interviewed on 12-19-19 at 11:55am. The Administrator stated the facility had a shortage of staff and the facility was trying to hire more staff by advertising and offering sign on bonuses. He also stated until more staff could be hired, the facility was using agency nurses. The Administrator was interviewed on 12-20-19 at 3:55pm. The Administrator stated the system failure was due to the change in leadership and staff making changes to when they arrive to work without informing management. He also stated he expected staff to remain at work until their relief arrived and he had started the process to correct the situation by verbal counseling with staff members.	F 725		
F 812 SS=E	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.	F 812		1/27/20

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F 812	Continued From page 29 (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 discard out of date food items and clean the refrigerator in 1 of 1 nourishment room. Findings Included: An observation of the nourishment room on 12/20/19 at 8:46 am revealed the following: · A 16-ounce can of corned beef hash approximately half full dated 11/14/19 · A 46-ounce container of applesauce approximately a quarter full dated 11/27/19 · A plate of leftover food in a plastic bag dated 12/11/19 · The top shelf of the refrigerator had sticky substances on approximately half of the shelf · The inner shelf of the freezer had a brown, sticky substance An interview on 12/20/19 at 9:00 am with the Dietary Manager (DM) revealed the dietary staff were responsible for checking the refrigerator in the nourishment room. She explained they were supposed to dispose of outdated or undated food items. The DM confirmed that the items found in the refrigerator should have been discarded. She added the staff should also clean up any spills in the refrigerator. The DM stated this was the only nourishment room for the facility.	F 812	The nourishment room refrigerator was cleaned and contents disposed on 12/20/2019. The refrigerator was restocked on 12/20/2019. Nursing and Dietary staff will be educated on the following by the Administrator/Staff Dev. Coordinator/designee by 1/18/2020: Dietary staff will be responsible for the nourishment refrigerators and the following: Rotate stock and check for expiration/best used by date. Add or take away stock as needed. Check that refrigerator is clean. Check dates on Residents' open items. Any nursing/dietary staff member, including agency nurses, who have not received the in-service will not be permitted to work until in-service is completed. Beginning 1/18/20 Dietary Manager or designee will audit utilizing the "Nourishment Room Audit Tool" , five times a week for 4 weeks, then 3 times a week for 4 weeks, then 1 time a week for 4 weeks.	

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F 812	Continued From page 30 An interview on 12/20/19 at 4:28 pm with the Administrator revealed the dietary department was responsible for maintaining the refrigerator in the nourishment room. He explained they should keep the refrigerator clean, rotate the food items and record the temperature. The Administrator added the housekeeping department was responsible for the rest of the room.	F 812	Dietary Manager will report Audit results to the QAPI committee monthly or as needed for three months.	