

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <i>Name change</i>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/14/2012
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NAME OF PROVIDER OR SUPPLIER HIGHLAND FARMS INC <i>Givens Highland Farms, LLC</i>	STREET ADDRESS, CITY, STATE, ZIP CODE 200 TABERNACLE RD BLACK MOUNTAIN, NC 28711
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, family interview, staff interview and medical record review that facility failed to make prompt efforts to resolve grievances, involving environmental concerns, that were reported to staff by a resident's family member for 1 of 3 sampled residents who previously voiced grievances with facility staff. (Resident #41)</p> <p>The findings are:</p> <p>Review of Resident #41's medical record revealed the resident had a diagnosis of senile dementia. The resident was assessed on the most recent Minimum Data Set of 11/15/12 as having cognitive deficits and requiring only supervision with no setup assistance for personal hygiene, toileting and dressing.</p> <p>Observations of Resident #41 on 12/13/12 at 7:51 AM revealed the resident was independently ambulating in the hallways without difficulty.</p> <p>On 12/13/12 at 10:45 AM an interview was conducted with a family member of Resident #41. The family member specified that Resident #41 had dementia, but could independently toilet and dress with prompting. The family member voiced</p>	F 166	<p>Givens Highland Farms LLC wishes to have this plan of correction stand as its allegation of compliance. Our date of alleged compliance is January 11, 2013. Preparation and/or execution of this plan of correction does not constitute admissions to, nor agreement with either the existence of or scope and severity of any of the cited deficiencies or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.</p> <p>Corrective Action A grievance form is to be completed on any complaint or repeated complaint or missing item. Resident/Family #41 requested a shelf be put in his bathroom and follow up of drawer sticking in chest was not done. It has been reconciled.</p> <p>Potential to be affected In order to ensure Resident #41's room and surrounding rooms are maintained in the highest working order and family expectations are met, Social Service Director designee will provide education and or in-service on how to handle the grievance process. Social Worker will review all grievance forms to ensure all resident/family needs are satisfied. Social Worker or designee will provide inservice/education to staff on how to handle the grievance process by January 11, 2013.</p> <p>Systemic Changes Any staff member receiving a grievance will submit in writing to Social Services or designee. Then the grievance will be submitted to the appropriate Department Head for resolution and will be signed off by the Department Head and the Administrator. The Social Worker will log it on to the grievance log form and bring to the monthly QA meetings for review.</p>	1/11/13 12/13/12 1/11/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sharon I. Huston</i>	TITLE <i>Administrator</i>	(X6) DATE <i>January 11, 2013</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 166	<p>Continued From page 1</p> <p>concerns that staff were not taking action on issues that were previously brought to their attention. The family member stated that on a number of occasions over the past months she had informed staff, including administrative staff, that bathroom wipes should be kept in the resident's bathroom for personal hygiene use and that the bottom drawer of the resident's dresser would not open, so the resident and staff were unable to access all of the resident's clothing. The family member explained that when she visited Resident #41 the bathroom wipes are often not in the resident's bathroom and the resident's bottom dresser drawer still could not be opened. The family member further stated that it was very frustrating to repeatedly report these issues to staff and to not have the issues resolved as soon as possible.</p> <p>On 12/13/12 from 10:50 AM to 10:55 AM observations were made of Resident #41's room with the resident's family member present. Observations of the resident's bathroom revealed no wipes were stored in the bathroom for the resident's use. Observations of Resident #41's dresser revealed the bottom drawer could not be opened. During this observation Resident #41's family member found the resident's bathroom wipes stored in the resident's closet and stated that the some of the resident's clothing, including pajamas, were stored in the dresser drawer that could not be opened.</p> <p>On 12/13/12 at 11:10 AM an interview was conducted with the facility's administrator. The administrator stated that Resident #41's family member had previously brought issues to the attention of the staff regarding the resident</p>	F 166	<p>This system will be used by the facility for the grievance process. Work orders are now logged in and tracked by number for completion in the Health Care Department.</p> <p>Monitoring All grievances will be reported on in the monthly QA meeting, and all grievances will be monitored for resolution by the QA Committee every month. Housekeeping Director or designee will monitor maintenance work orders for completion. Administrator will oversee process/system.</p>	1/11/13	

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F 166	Continued From page 2 needing more storage space in the bathroom for personal care items and not being able to open the bottom drawer of the resident's dresser. The administrator found a work order dated 11/08/12 that specified Resident #41's family member had requested for two months for a shelf to be installed in Resident #41's bathroom to provide more storage space for personal belongings and that the bottom drawer of resident's dresser would not open. The administrator stated that she thought the facility's maintenance staff had resolved these issues. On 12/13/12 at 11:20 AM observations of Resident #41's room were made with the facility's administrator present. During these observations the administrator confirmed that staff had not taken the needed actions to fix the bottom drawer on the resident's dresser or to install another shelf in the bathroom to provide the resident with more space for personal belongings as requested by the resident's family member during the month November 2012.	F 166			
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff	F 242			

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F 242	Continued From page 4 preference. The resident stated that even though she tells staff that she preferred to be served grits at breakfast she continued to receive cream of wheat on her breakfast trays every Tuesday, Thursday and Saturday. On 12/13/12 at 8:07 AM Nursing Assistant (NA) #4 was observed to bring Resident #96 a bowl of grits into her room. The resident accepted the grits and informed NA #4 that she wanted to be served grits everyday at breakfast. On 12/14/12 at 8:15 AM an interview was conducted with interview with NA #4. NA #4 stated that Resident #96 had informed her on multiple occasions, including 12/13/12, that she preferred to be served grits at breakfast. NA #4 stated that she informed the dietary staff of this food preference but had not informed the facility's Nutritional Supervisor. On 12/14/12 at 8:30 AM the facility's Nutritional Supervisor (NS) was interviewed. The NS stated that she was not aware that Resident #96 had requested to be served grits at every breakfast meal. The NS confirmed that Resident #96 was only receiving grits at breakfast four days per week. The NS stated that she should have been informed of this known preference by staff, so she could have updated Resident #96's food preferences in the computer to ensure that the resident received grits at every breakfast meal.	F 242			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279	See next page		

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F 279	Continued From page 5 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to develop a care plan that addressed the continued use of antipsychotic medications for 3 of 5 sampled residents receiving antipsychotic medications. (Residents #27, #41 and #66) The findings are: 1. Resident #27 was admitted to the facility on 3/12/12 with diagnoses of dementia with hallucinations. Review of the resident's Physician orders revealed an order written on 03/12/12 for Risperdal (an antipsychotic medication) one milligram at bedtime for agitation. Review of Resident #27's Care Area Assessment	F 279	Continued from page 5 Corrective Action: Personalized care plans have been developed for residents # 27, #41, and # 66. Personalized care plans have been developed for all residents receiving antipsychotic medications. Use of psychotropic medications has previously been addressed as approaches underlying problem(s) (eg., mood, behavior, safety) rather than as a separate problem focusing on systematic dose. Care plans will be updated at quarterly reviews and as changes occur, to include a separate issue to reiterate facility's practice of working with physicians, pharmacists, families and residents to ensure appropriate reductions to psychoactive medications are implemented, to ensure lowest effective dose of medication is ordered / administered. Potential to be Affected: All residents have been assessed for use of psychotic medications. continue on page 7	12/17/12 1/7/13

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F 279	<p>Continued From page 6</p> <p>(CAA) Summary of 03/24/12 revealed the area of "Psychotropic Drug Use" triggered for further review. This CAA specified the area of psychotropic medication use would be addressed on the resident's plan of care.</p> <p>Review of Resident #27's current care plan, reviewed and updated by staff on 09/18/12, revealed it did not address the resident's continued use of antipsychotic medications.</p> <p>Review of Resident #27's monthly Medication Administration Records revealed the resident received Risperdal on a daily basis from March 2012 to December 2012.</p> <p>Interview with the facility's Minimum Data Set/Care Plan Coordinator on 12/14/12 at 1:50 PM confirmed that Resident #27 received Risperdal on a daily basis since her readmission to the facility on 03/12/12, but a care plan was not developed by staff to address the resident's continued use of antipsychotic medications.</p> <p>2. Resident #41 had a diagnosis of senile dementia with delusional features. Review of the resident's physician orders revealed an order for Seroquel (an antipsychotic medication) initiated on 05/21/11.</p> <p>Resident #41's "Psychotropic Drug Use" Care Area Assessment (CAA) of 02/16/12 revealed Seroquel was being administered with positive effects. The resident's CAA Area Summary of 02/16/12 specified the area of psychotropic drug use would be addressed on the resident's plan of care.</p>	F 279	<p>Continued from page 6</p> <p>Each admission will be assessed for antipsychotic medications. If ordered, the nurse will add to the initial care plan.</p> <p>Systematic Changes:</p> <ul style="list-style-type: none"> Care plans will be updated as needed and at quarterly reviews, to include a separate issue to reiterate facility's practice of working with physicians, pharmacists, families and residents to ensure appropriate reductions to psychoactive medications are implemented to ensure lowest effective dose of medication is ordered / administered. Pharmacy will provide nursing with a listing of recommendations monthly. Residents / family members are advised of psychoactive medications being ordered / used and resident will be evaluated regarding stability of underlying mood / behavior for which the medication has been ordered. When a resident is observed to be stable on current dose, physician will be advised to consider a dose reduction. Nursing staff will monitor and document changes and advise MD as appropriate. Supervising Nurse will document in Nurses' Notes and initiate appropriate Therapy referrals, should a decline be noted 	1/11/13

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F 279	<p>Continued From page 7</p> <p>Review of the resident's most recent Minimum Data Set (MDS) assessment of 11/15/12 revealed the use of antipsychotic medication during all of the previous seven days.</p> <p>Review of Resident #41's current care plan, updated and reviewed on by staff 11/20/12, revealed it did not address the resident's continued use of antipsychotic medications.</p> <p>Review of Resident #41's monthly Medication Administration Records (MAR), including the resident's December 2012 MAR, revealed the resident received Seroquel on a daily basis during the past year.</p> <p>Interview with the facility's MDS/Care Plan Coordinator on 12/14/12 at 1:50 PM confirmed that Resident #41 received Seroquel every day on a long term basis, but a care plan was not developed by staff to address the resident's continued use of antipsychotic medications.</p> <p>3. Resident #66 had a diagnosis of senile dementia with persistent episodes of agitation. Review of Resident #66's physician's orders revealed an order written on 01/03/12 for Seroquel (an antipsychotic medication) to be administered each day.</p> <p>Review of Resident #66's Annual Minimum Data Set (MDS) of 10/29/12 revealed the resident received antipsychotic medications six of the past seven days.</p> <p>Review of Resident #66's Psychotropic Drug Use Care Area Assessment (CAA) of 10/29/12 revealed the resident received antipsychotic</p>	F 279	<p>Continued from Page 7</p> <p>Monitoring:</p> <ul style="list-style-type: none"> • DON or designee will audit 6 resident charts to ensure care plans are personalized to reflect the use of psychoactive medications. Weekly audits x 90 days; and then monthly x 9 months. • DON or designee will review the audits at the monthly QA meetings. QA Committee will recommend follow-up as needed. 	1/11/13	

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F 279	Continued From page 8 medication on a daily basis with positive effect. The resident's CAA summary of 11/08/12 specified the area of psychotropic drug use would be addressed on the resident's care plan. Review of Resident #66's current care plan, updated and reviewed on by staff 09/18/12, revealed it did not address the resident's continued use of antipsychotic medications. Review of Resident #66's monthly Medication Administration Records revealed the resident continued to receive Seroquel on a daily basis from January 2012 to December 2012. Interview with the facility's MDS/Care Plan Coordinator on 12/14/12 at 1:50 PM confirmed that Resident #66 received Seroquel every day on a long term basis, but a care plan was not developed by staff to address the resident's continued use of antipsychotic medications.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, physician interviews and staff interviews the facility failed to obtain clarification from a physician for administration of a medication listed as an allergy for 1 of 4 sampled residents reviewed with medication allergies. (Resident #34).	F 281	Corrective Action: Resident # 39 allergy was discontinued 12/13/12 by the physician. Potential to be Affected: Pharmacy will audit all charts to ensure that all resident medications have been checked against the allergy lists to ensure that there are no drug allergies and potential /adverse reactions. This was completed by the pharmacist consultant on 12/18/12. Systematic Changes: For all new orders, the pharmacy will cross check MD orders with the residents' allergy list and will only send medications that are not	12/13/12 12/18/12

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F 281	<p>Continued From page 9</p> <p>The findings are:</p> <p>Resident # 34 was admitted to the facility on 04/27/12 with diagnoses which included a blood clotting disorder, anemia and rapid heartbeat.</p> <p>The most recent quarterly Minimum Data Set dated 10/25/12 indicated impairment in short and long term memory and moderate impairment in cognition for daily decision making. The MDS further indicated Resident #34 required extensive assistance from staff for activities of daily living.</p> <p>A review of a physician's progress note dated 11/27/12 indicated an allergy list for Resident #34 which included Aspirin.</p> <p>A review of the monthly Physician's orders dated 12/01/12 through 12/31/12 indicated Aspirin 81 milligrams (mg.) by mouth daily.</p> <p>A review of the monthly Medication Administration Records (MAR's) dated 11/01/12 through 11/30/12 and 12/01/12 through 12/13/12 revealed Aspirin 81 mg. was given daily by mouth to Resident #34. A section at the bottom of each MAR listed allergies which included Aspirin.</p> <p>A review of Resident #34's medical record on 12/13/12 had 2 allergy stickers located inside the front cover that indicated an allergy to Aspirin.</p> <p>During an interview on 12/13/12 at 11:29 AM Resident #34's physician explained Resident #34 had an intolerance to Aspirin instead of an allergy and that information should have been documented in the resident's medical record. He explained he treated Resident #34 with a blood</p>	F 281	<p>contraindicated secondary to an allergy unless addressed by the MD.</p> <p>Resident allergies will be listed on the front of the chart, and resident medication intolerances will be listed in the chart under the physician order tab. This will be on a sheet in front of the physician orders. A copy of any resident medication intolerances will be retained in the resident's MARs & TARs.</p> <p>During the 2 person check for end of the month MAR change-over, resident allergies will be crosschecked against the residents' medication list. Any discrepancies will be noted and followed up with the MD.</p> <p>Monitoring: The DON or designee will audit 6 residents every week x 4 weeks and then every month x 2 months. If noncompliance is found, auditing will continue monthly for 3 more months. The DON or designee will report the results of the audits to the monthly and quarterly QA meeting.</p>	1/11/13
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F 281	<p>Continued From page 10</p> <p>thinner several months ago but switched her to a daily dose of Aspirin because she had a rapid heartbeat and needed a low dose blood thinner. He further stated the Aspirin was not harmful to her but she was at risk for bleeding and had a history of anemia. The physician verified Resident #34's last hemoglobin dated 12/05/12 was low at 9.1 grams per deciliter of blood (gm/dl) (normal range between 11.5 gm/dl -16.5 gm/dl) and her last hematocrit dated 12/05/12 was low at 28.0 percent (normal range 36.6 percent - 50.2 percent). He further stated there should have been documentation to clarify for the nursing staff that it was acceptable to give the Aspirin.</p> <p>During an interview on 12/13/12 at 11:40 AM Nurse #1 explained nurses were expected to look in the resident's chart for documentation when there was a discrepancy between an allergy and a medication that was ordered. She further stated the information should be documented where they could easily find it and the clarification was usually documented in the nurse's notes or placed in the front of the chart where the allergies were listed.</p> <p>During an interview on 12/13/12 at 12:47 PM Nurse # 2 stated resident allergies were listed on the bottom of the MAR. She verified Resident #34 had an allergy listed for Aspirin on the MAR and the resident received Aspirin 81 mg. daily by mouth. She stated she had not noticed the allergy for Aspirin but she would expect to see something documented from the physician so she would know it was okay to give it.</p> <p>During an interview on 12/14/12 at 8:13 AM the Director of Nursing stated it was her expectation</p>	F 281		

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F 281	Continued From page 11 when there was a discrepancy between a resident's medications and their allergies the nurses should call the physician for clarification and write the clarification in the resident's medical record.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to follow the care plan for one of three residents reviewed for rehabilitation. (Resident #58). The findings are: Resident #58 was admitted to the facility 10/01/12 with diagnoses that included debility and Parkinson's disease. Physician orders dated 10/01/12, 11/01/12 and 12/01/12 revealed Resident #58 had aspiration precautions with no straws to be used. The admission Minimum Data Set dated 10/09/12 assessed the resident as being severely impaired in cognition. The resident required supervision with eating after set up. The CAAS (Care Area Assessment Summary) for nutrition dated 10/09/12 revealed Resident #58	F 282	Corrective Action: Resident #58 order for "No Straw" was discontinued in consultation with the Speech Therapist on 12/14/12 as she presented with no signs or symptoms of aspiration. Potential to be Affected: All residents with "No Straw" orders were verified to have no water pitchers in their rooms but to have only water bottles or appropriate adaptive drinking equipment in their rooms. Systematic Changes: Dietary will be notified of "No Straw" order by Nursing via duplicate dietary communication slip. Dietary will then give the resident a red placemat on their trays. DON or designee will put a red paper in the resident's chart, MARs, TARs, and CNA flow books to alert staff on "No Straw" status. The resident is not to have water pitchers in the room, but is to only have water bottles or appropriate adaptive drinking equipment in the room. Therapy will meet once a week with Dietary & Nursing to review diet changes and diet information for new admissions. Staff was inserviced on 12/26/12.	12/17/12 1/9/13

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F 282	<p>Continued From page 12</p> <p>had a mechanical soft diet with ground meat and no straws were to be used due to aspiration precautions. The CAAS further documented the resident had no problems on current diet with swallowing.</p> <p>A care plan for nutrition dated 10/09/12 revealed a focus on mechanical soft diet with ground meat and no straws with a goal to have no signs or symptoms of aspiration with interventions that included monitoring for signs of aspiration.</p> <p>Review of a Speech Therapy (ST) screening done on 10/16/12 revealed the Resident presented with mild oral dysphagia (difficulty swallowing) likely related to missing teeth and Parkinson's disease which may be progressing, precautions for aspiration risk. The ST note documented the resident had a swallow study while in the hospital on 9/27/12 which showed mild oral dysphagia that had improved during hospital stay.</p> <p>Observation on 12/14/12 at 8:30 AM revealed an empty drinking glass containing a straw sitting on the Resident's over bed table.</p> <p>The Restorative Nurse Aide (NA) #1 was interviewed on 12/14/12 at 9:00 AM. NA #1 stated the resident was on a mechanical soft with ground meats and was not supposed to use straws.</p> <p>The direct care staff Nurse Aide #2 (who was caring for Resident #58) was interviewed on 12/14/12 at 9:15 AM. NA #2 stated she was not aware of any restrictions regarding the resident's diet orders or drinking ability. NA #2 also stated</p>	F 282	<p>Monitoring: Residents with orders for "No Straws" will be audited by RN Supervisor or designee every week x4 weeks and then every month x 2 months. The DON or designee will review the results of the audits at the monthly and quarterly QA meetings.</p>	1/11/13

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F 282	Continued From page 13 she was not aware of the order for no straws and could not confirm who gave the resident the straw. NA#2 reported the resident had eaten breakfast in the restorative dining area. The Speech Therapist (ST) was interviewed on 12/14/12 at 10:50 AM and stated during Resident's hospitalization in September of 2012, she was placed on no straws because of mild oral dysphagia. The ST stated Resident #58 received speech therapy for two weeks in October and did not see any signs of aspirations during therapy. The ST stated the resident had used a straw during therapy and had no problems and believed the order for "no straws" had carried over from the hospital orders. During an interview on 12/14/12 at 12:15 PM the Minimum Data Set (MDS) coordinator stated the order for "no straws" was a recommendation from the hospital and was placed as a focus area on the care plan. The MDS coordinator further stated she did not think drinking from a straw was a problem for Resident #58 based on observations and speech therapy. The Director of Nursing (DON) was interviewed on 12/14/12 at 2:00 PM and stated her expectations were for all staff to be informed of any orders regarding any diet restrictions. The DON further stated chart audits were done daily and the order for no straws had been missed. The DON stated she expected staff to follow care plans as written.	F 282		
F 310 SS=D	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a	F 310		

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F 310	<p>Continued From page 15</p> <p>feed self. The approaches indicated to encourage and assist Resident #63 with meals as needed, offer alternative foods to uneaten foods and to provide preferred fluids and encourage resident to promote hydration. The care plan did not list specific interventions regarding how staff were to encourage or assist Resident #63 during meals.</p> <p>A review of physician's orders dated 12/01/12 through 12/31/12 indicated a regular diet, small portions at meals per resident's request and encourage resident to feed self.</p> <p>During continuous observations on 12/13/12 starting at 7:37 AM Resident #63 was seated in her wheelchair at a table in the restorative dining room. A plate was directly in front of her with a fork and spoon on the (R) side of the plate and a cup of orange juice, a cup of water and a cup of coffee were placed next to the top of the plate. Resident #63 picked up a fork in her (R) hand and fed herself gravy and biscuit. Nurse #1 picked up a cup of orange juice and held it to Resident #63's mouth to drink without providing an opportunity for Resident #63 to drink independently. Resident #63 then asked for coffee and Nurse #1 picked up a coffee cup and held it for the resident to drink without providing an opportunity for Resident #63 to drink independently. Resident #63 continued to feed herself gravy and biscuit with the fork in her (R) hand. At 8:21 AM Nurse #1 held a cup of orange juice to Resident #63's mouth for the resident to drink and then started feeding Resident #63 cereal with milk. Resident #63 was still holding the fork in her (R) hand. At 8:27 AM Nurse #1 asked Resident #63 if she wanted more coffee</p>	F 310		

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F 310	<p>Continued From page 16</p> <p>and Resident #63 laid her fork down on the table and attempted to reach for her coffee cup. Nurse #1 picked up the coffee cup and held it to the resident's mouth to drink without providing an opportunity for Resident #63 to drink independently. At 8:36 AM Nurse #1 fed Resident #63 cereal then bacon and eggs. Resident #63 made no further attempts to pick up her fork or any of the drink cups to feed herself.</p> <p>During an interview on 12/13/12 at 9:05 AM Resident #63 stated she could use her (R) hand to feed herself and she could hold a cup and drink from it. She further stated she liked to feed herself because that was about all she could do for herself anymore.</p> <p>During an observation on 12/13/12 at 11:49 AM Resident #63 was transported in her wheelchair into the restorative dining room and was placed at a table. At 11:53 AM Nurse #4 placed a clothing protector around Resident #63's neck and Resident #63 kept her hands folded in her lap under the clothing protector. Nurse #4 opened Resident #63's meal tray and put salad dressing on a salad and cut the salad in smaller pieces. Nurse #4 fed Resident #63 salad, bites of chicken, rice and mixed vegetables without providing an opportunity for Resident #63 to feed herself. Resident #63 stated she wanted bread and Nurse #4 cut up pieces of cornbread and fed it to the resident with a fork. Resident #63 then stated she wanted coffee and Nurse #4 picked up the coffee cup and held it to Resident #63's mouth to drink without providing Resident #63 an opportunity to drink independently. Resident #63 made no attempts to pick up her fork, spoon or cups and kept her hands in her lap under the</p>	F 310		

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F 310	Continued From page 17 clothing protector for the entire meal service. During an interview on 12/13/12 at 2:50 PM Nurse #4 stated she was recently hired in the facility and she had been told to feed Resident #63 earlier today during lunch. She further stated she did not know if Resident #63 could feed herself or hold a cup to drink from it. She explained she fed Resident #63 because that was what she had been told to do but she should have found out what Resident #63 could do for herself and should have encouraged Resident #63 to feed herself and drink from her cup as she was able. During an interview on 12/14/12 at 10:32 AM Nurse #1 stated staff fed Resident #63 according to how alert she was. She further stated she usually told Resident #63 that her food was in front of her and would wait and see if the resident would try to feed herself. She stated if Resident #63 attempted to feed herself they were supposed to encourage her and she should have encouraged Resident #63 to hold her cups when she wanted something to drink. During an interview on 12/14/12 at 10:57 AM the Director of Nursing stated it was her expectation for nursing staff to assist residents in the restorative dining room at meals and encourage residents to feed themselves to prevent further decline of their independence. She further stated staff should adapt their strategies as needed while assisting residents to prevent further decline of their ADL's and Resident #63's care plan should include specific interventions for her to maintain independence as long as possible.	F 310		
F 311	483.25(a)(2) TREATMENT/SERVICES TO	F 311		

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F 311	<p>Continued From page 19 of care specified; "encourage/assist with meals."</p> <p>Review of Resident #15's care conference notes of 11/27/12 specified that the resident was eating meals in the restorative dining room with positive results.</p> <p>During the survey observations of Resident #15 eating two meals in the facility's restorative dining room revealed the following:</p> <p>On 12/11/12 from 12:05 PM to 12:30 PM Resident #15 was observed in a restorative dining room eating her lunch meal while seated in a wheel chair. The resident was seated at the end of the table with one of her wheel chair foot rests positioned directly against one of the table's legs. The resident was approximately a foot away from her meal and needed staff assistance to reach the foods and beverages served to her at this meal. The staff member, who assisted Resident #15 at this meal, was observed at times to feed the resident bites of food and bring beverages to the resident's mouth. When foods and beverages were placed within the resident's reach the resident was able to eat and drink independently, but was observed to spill foods onto her lap as she brought them from the plate to her mouth.</p> <p>On 12/12/12 from 8:10 AM to 8:20 AM Resident #15 was observed in a restorative dining room eating her breakfast meal while seated in her wheel chair. The resident had eggs spilled on her lap and was positioned approximately one foot away from her meal. The arm rests of the resident's wheel chair were observed positioned directly against the edge of the dining room table which prevented Resident #15 from being</p>	F 311		

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F 311	Continued From page 20 positioned closer to her meal. Continued observations of Resident #15 revealed she spilled her eggs onto her lap as she used a fork to bring them from her plate to her mouth. On 12/14/12 at 12:45 PM an interview was conducted with restorative aide (RA) #1. Interview with RA #1 revealed that Resident #15 always sat in her wheel chair when she ate meals in the restorative dining room and was capable of feeding herself with cueing and prompting. RA #1 stated that Resident #15 should be positioned as close to her meal as possible to enable her to independently eat without spilling foods onto herself and requiring extra assistance. RA #1 further explained that at meals Resident #15 could not be positioned closer to her foods and beverages because the tables in this restorative dining room could not be adjusted to a higher level to allow the resident's wheel chair to fit completely underneath the table.	F 311			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:	F 315	See next page		

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F 315	<p>Continued From page 21</p> <p>Based on resident interviews, staff interviews and record reviews the facility staff failed to toilet a resident regularly to promote continence for 1 of 1 resident observed with incontinence (Resident #7).</p> <p>The findings are:</p> <p>Resident #7 was re-admitted to the facility on 09/28/11 with diagnoses which included Parkinson's disease and ataxia (a neurological condition consisting of the lack of voluntary coordination of muscles).</p> <p>The most recent annual Minimum Data Set (MDS) dated 09/27/12 indicated Resident #7 was cognitively intact and required extensive assistance from staff for activities of daily living (ADL's) which included toileting. The MDS further indicated Resident #7 was frequently incontinent of bladder and always continent of bowel; was not steady moving on or off toilet and was only able to stabilize with staff assistance.</p> <p>A review of a Care Area Assessment Summary (CAA's) dated 09/27/12 indicated urinary incontinence was an area of concern based on a review of nurse's notes and nurse aide flowsheets. The CAA's further indicated Resident #7 was continent of bladder and bowel, needed extensive staff assistance for hygiene and transfers, wore absorbent undergarments due to a history of urgency, and was frequently incontinent of bladder during night time hours. The CAA's also indicated to assist Resident #7 as needed and maintain scheduled toileting program.</p>	F 315	<p>Corrective Action: Resident # 7 was assessed by the Care Plan team and placed on a formalized toileting program. Staff was inserviced on 01/07/13. Resident # 7 care plan was individualized to meet her needs.</p> <p>Potential to be Affected: All residents have the potential to not be toileted on a regular basis, to promote continence. The CNA's are expected to give input to update the care plan as the residents condition changes.</p> <p>Systematic Changes: Every resident as their care plan review approaches or when there is a change in condition will be assessed for an individualized toileting program. There will be a 3 day bowel and bladder monitoring done to trend patterns. CNA's will be informed of which residents are placed on Bowel and Bladder retraining or toileting programs.</p> <p>Monitoring: The DON or Designee will audit 6 charts every week x4 weeks and then every month x 2 months. The DON will report the audit results to the monthly and quarterly QA Meeting.</p>	1/7/13 1/7/13 1/11/13

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F 315	<p>Continued From page 22</p> <p>A review of a care plan titled ADL's and dated 10/02/12 indicated a self-care deficit attributed to weakness and progression of Parkinson's disease, with frequent significant tremors noted which required extensive, weight bearing assist of 1-2 staff to maintain hygiene and ADL's, with night time incontinence noted. The goals indicated Resident #7 would be clean, dry, appropriately dressed and odor free daily with moderate staff assistance and would participate in her care daily, as able, and remain free of skin breakdown/urinary tract infections; and continent during waking hours. The approaches listed were to assist Resident #7 with ADL's as necessary and assist with absorbent undergarments, as needed to maintain hygiene. The approaches further indicated to toilet Resident #7 regularly especially after getting up; before lying down and before and after meals.</p> <p>A review of an undated facility document titled Nurse Aide Resident Care Summary indicated in a section titled Toileting Needs that Resident #7 was continent of bowel and bladder and used the toilet. A handwritten note on the back of the form dated 11/12/12 indicated to use the rest of resident's pads with tabs then start to use pull-ups instead. The Nurse Aide Resident Care Summary did not include any documentation related to a scheduled toileting program or list specific interventions under the section for toileting regarding when staff were expected to take Resident #7 to the bathroom.</p> <p>During an interview on 12/12/12 at 09:06 AM Resident #7 stated she had a bladder that didn't like to wait and when she needed to go to the bathroom she needed to go as soon as possible.</p>	F 315			

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F 315	Continued From page 23 During an interview on 12/13/12 at 9:51 AM Nurse Aide (NA) #8 explained Resident #7 wore pull ups during the day and a brief at night. She stated Resident #7 was alert and oriented and could ring her call bell and called out to staff when she saw them walk by her door. NA #8 explained sometimes Resident #7 had to get to the bathroom fast and sometimes she didn't quite make it. She stated Resident #7 was not on a scheduled bladder program that she was aware of and they took her to the bathroom when the resident asked them to. During an interview on 12/13/12 at 3:51 PM a Nursing Supervisor stated Resident #7 needed extensive assist by staff and needed assistance with toileting. She further stated the expectation was for staff to respond within 5 minutes to take Resident #7 to the bathroom or get another staff member to assist her if they were unable to respond quickly. During an interview on 12/14/12 at 10:01 AM Resident #7 stated the facility wanted her to wear pull-ups because they were more convenient if staff didn't get there in time to take her to the bathroom. She further stated they had decided for her to wear the pull-ups during the day and briefs at night. She stated she was aware when she needed to go to the bathroom and felt if staff assisted her on a regular basis and in a timely manner she would not have incontinent episodes. Resident #7 stated it was the normal routine for staff to toilet her when she called for them and they did not come in and take her on any specific schedule to the bathroom.	F 315		

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F 315	<p>Continued From page 24</p> <p>During an interview on 12/14/12 at 12:20 PM the MDS Director/Coordinator verified Resident #7's MDS indicated she was frequently incontinent due to night time incontinence. She stated Resident #7 was supposed to be on a scheduled toileting program especially when they woke her up and before or after meals and at bedtime. She explained Resident #7 wore a pull-up during the day and a brief during the night because her incontinence occurred primarily during the night. She explained when the care plan was updated by nursing the Nurse Aide Resident Care Summary should also be updated so the nurse aides would know specifically what to do for the resident.</p> <p>During an interview on 12/14/12 at 2:06 PM Nurse #5 explained when residents were admitted they were monitored daily for several days to determine their level of continence. She stated for the most part Resident #7 had been continent but staff should take her to the bathroom when she first got up, after each meal and when she requested it if she needed to go more often. She explained she had written the note on the Nurse Aide Resident Care Summary sheet on 11/12/12 to use the rest of resident's pads with tabs then start to use pull-ups instead. She stated the Nurse Aide Resident Care Summary was the care plan the NA's used so they would know specifically what care to provide to the resident and it should be updated as resident's needs changed.</p> <p>During an interview on 12/14/12 at 2:20 PM with NA #9 she stated Resident #7 was usually continent and they took her to the bathroom when she rang her call bell. She further stated she was</p>	F 315		

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F 315	Continued From page 25 not aware of any scheduled toileting program for Resident #7. During an interview on 12/14/12 at 2:29 PM the Director of Nursing stated it was her expectation for staff to assist resident's to the bathroom. She stated toileting should be individualized for each resident and documented in the care plan and the Nurse Aide Resident Care Summary should have included specific interventions regarding scheduled toileting for Resident #7 so the NA's would know how to care for the resident.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	Corrective Action: Resident #41 Seroquel dosage was reduced from 25mg qHS to 12.5mg qHS on 12/27/12 per MD order in consultation with the pharmacist. See next page	12/27/12

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F 329	<p>Continued From page 27</p> <p>that on 07/31/12 and in November 2012 the resident's physician specified that a gradual dose reduction attempt of the resident's Seroquel would be contraindicated, but did not provide any reasons why a GDR would be contraindicated.</p> <p>Review of Resident #41's medical record did not reflect that a gradual dose reduction for the resident's Seroquel was attempted during the past year.</p> <p>Review of Resident #41's Minimum Data Set assessment of 11/15/12 revealed the use of antipsychotic medications during the prior seven day period.</p> <p>On 12/14/12 at 9:05 AM an interview was conducted with the facility's Director of Nursing (DON). The DON stated that she could not find where a gradual dose reduction was attempted during the past year for Resident #41's continued use of Seroquel. The DON explained that the facility's consultant pharmacist had made recommendations to the physician for a gradual dose reduction for Resident #41's Seroquel to be attempted, but the physician replied that a dose reduction would be contraindicated. The DON was unaware of any specific reasons why a gradual dose reduction attempt of Resident #41's Seroquel would be contraindicated.</p> <p>On 12/14/12 at 2:30 PM an interview was conducted with the facility's consultant pharmacist. The pharmacist stated that he recommend to the physicians in his monthly reports when a gradual dose reduction for an antipsychotic medication was needed or required. The pharmacist further stated that he submitted</p>	F 329		

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F 329	Continued From page 28 his monthly reports to the facility's DON and the DON was to inform the physicians of his recommendations and to follow-up with them regarding the need for gradual dose reductions of antipsychotic medications. On 12/14/12 at 2:45 PM an interview with the facility's administrator revealed that the DON was responsible to follow up with the physicians on any gradual dose reductions that were recommended by the consultant pharmacist. The administrator stated that Resident #41's physician was very receptive to perform gradual dose reductions and to discontinue antipsychotic medications whenever possible.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to keep food preparation and food storage equipment clean and failed to cover, label and date stored foods. The findings are:	F 371	Corrective Action: A. A deep clean of the kitchen was performed on Wednesday Dec. 19 th , 2012. The kitchen stove was broken down and cleaned, including the splash guard. This as well as other kitchen equipment was placed on a three times a week cleaning schedule and supervised by the chef and Dietary Manager. B. Twelve food preparation trays were purchased and put into use on Dec. 17, 2012, replacing the twelve trays with grease build up and residue. C. An inservice was held on 12/13 and 12/26/2012 about sanitation in the kitchen. Included in this training was the issue of wet rags in contact with items ready for use. D. Wet pans – An additional drying rack for metal pans was purchased on 12/19/2012 and put into service. The dish room and pot sink staff were instructed on placing pans on this rack for complete drying.	12/26/12

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F 371	Continued From page 31 On 12/14/12 at 12:52 PM the facility's administrator was interviewed. The Administrator stated kitchen equipment should always be kept clean and foods stored properly. The Administrator explained that internal audits should have been performed by the dietary staff on a weekly to identify problems with kitchen sanitation issues that needed to be corrected and monitored for compliance, but these audits were not completed by staff. 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 371	Monitoring: Weekly sanitation audits will be performed by management staff including the Executive Chef, Dining Room Manager, Health Care Supervisor, or Dietary Manager. RD Consultant will audit weekly behind dietary management staff. RD will work with the Dietary Manager and Chef when inservicing is identified or non-compliance. The Dietary Manager will review the results of the audits at the monthly and quarterly QA meeting. The QA committee will take the appropriate steps to monitor kitchen sanitation practices and systems to keep food preparation and equipment clean. Administrator and Executive Director will monitor overall compliance.	1/11/13
F 520 SS=F	A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520	Quality Assessment and Assurance Committee: Corrective Action: 1. A "deep clean" of the kitchen was done December 19, 2012. The kitchen stove was broken down and cleaned, including the metal splash guard. 2. Twelve food preparation trays were purchased and put in use December 17, 2012; replacing the previous 12 trays with grease build up. 3. An inservice was held on Dec. 13 and 26, 2012 about sanitation expectations for the kitchen. This training included unclean and wet rags next to bowls. 4. An additional drying rack for metal pans was purchased on Dec. 19, 2012 and put into service. Staff has been trained on how to use for complete drying.	12/26/12

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F 520	<p>Continued From page 32</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to have an effective Quality Assurance program to monitor kitchen sanitation practices and systems to keep food preparation and storage equipment clean.</p> <p>The findings are:</p> <p>1. Observations of the facility's kitchen on 12/11/12 from 8:00 AM to 8:15 AM revealed the following problems with stored food preparation equipment:</p> <p>A. One of the kitchen's stoves was unclean with a thick greasy residue that had accumulated around the stove's burners and cooking grates. The metal splash guard behind the stove was also very unclean with a heavy grease build up and accumulated dried food splatters.</p> <p>B. Twelve shallow food preparation metal trays, that were stacked together and ready for use, were unclean with a greasy residue.</p> <p>C. Unclean and wet rags were observed in direct contact with two large plastic serving bowls that were air drying on a metal rack.</p> <p>D. Thirty six metal food preparation pans and two plastic pans, stacked on top of each other and ready for use were not dry.</p> <p>Interview with the Dietary Manager (DM) on 12/12/12 at 4:05 PM revealed food preparation</p>	F 520	<p>Potential to be affected: Kitchen sanitation expectations training was held on Dec. 13 and 26, 2012 to the dietary staff. Training was held to the QA Committee on expectations covering F520 on Dec. 17, 2012. New systems and follow-up monitoring to ensure kitchen environment, food preparation and storage equipment is clean has been developed for dietary.</p> <p>Systemic Changes: The Dietary Manager will review monthly the results of dietary audits at the QA meeting. The QA Committee will follow up on any unacceptable results. Action Plans will be developed as necessary by the Dietary Manager to ensure compliance. The consultant RD will audit weekly following the staff audits to ensure sanitary compliance. This will continue as long as it is determined is needed, by the QA Committee for compliance.</p> <p>Monitoring: Sanitation audits will be done weekly by management staff to include Executive Chef, Dining Room Manager, Health Care Supervisor, or Dietary Manager. These audits will be followed by an audit done weekly by the RD Consultant. The RD will work with the Dietary Manager and Chef when inservicing or noncompliance needs are identified. The Dietary Manager will review the results of the audits at the monthly and quarterly QA meeting. The QA Committee will take the appropriate steps to monitor kitchen sanitation practices and systems to keep food preparation and equipment clean. The Administrator and Executive Director will monitor overall compliance.</p>	<p>12/26/12</p> <p>01/11/13</p>
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F 520	<p>Continued From page 33</p> <p>equipment should be clean and dry when stored for use by staff and that staff should not store dirty rags in close proximity to clean dishware. The DM further explained that the kitchen's food preparation equipment was on the schedule to be cleaned three times per week and after each use, but staff had failed to implement the kitchen's cleaning schedule as planned which resulted in kitchen equipment becoming unclean.</p> <p>2. Observations of the facility's kitchen on 12/11/12 from 8:37 AM to 9:05 AM revealed the following problems with food storage equipment:</p> <p>A. Two reach-in refrigerators had a build up of a sticky residue that had accumulated on both of the refrigerator's handles and metal slates.</p> <p>B. One of the kitchen's ice scoops was stored inside a plastic container that contained approximately one fourth inch of water and a black residue on the bottom of the container. The ice scoop was observed to be in direct contact with the black residue.</p> <p>C. Two large storage containers, that contained food products, were unclean with accumulated dried spills and splatters</p> <p>D. The kitchen's juice dispenser and the dispenser's knobs were unclean with accumulated sticky substances.</p> <p>On 12/12/12 at 4:30 PM an interview was conducted with the Dietary Manager (DM). The DM further stated that he expected staff to keep food storage equipment clean.</p>	F 520		

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F 520	Continued From page 34 On 12/14/12 at 10:00 AM an interview was conducted with the facility's Administrator. The administrator stated that during the facility's previous recertification survey completed on 01/12/12 the facility was cited for failing to keep kitchen equipment clean. The administrator stated in response to this citation the facility developed a Plan of Correction that directed staff to perform weekly audits to monitor the cleanliness of the kitchen equipment that were to be reviewed at the facility's monthly and quarterly Quality Assurance (QA) meetings. The administrator explained that these weekly audits were not completed by staff as planned and no follow up was performed by facility's QA committee. The administrator stated the facility's QA committee was not effective during the past year to monitor the kitchen environment to ensure kitchen equipment was kept clean on an ongoing basis.	F 520			