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	345331	A. BUILDING _____ B. WING _____	08/03/2017

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F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurately code the Minimum	F 278	Preparation and/or execution of this Plan of Correction does not constitute	8/25/17

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

Electronically Signed | 08/25/2017

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F 278	Continued From page 1 Data Set (MDS) related to prognosis of life (Resident #29), preadmission screening (Resident #53), and active diagnoses (Residents #260 and #323) for 4 of 19 sampled residents who required a MDS. The findings included: 1. Resident #29 was admitted to the facility on 02/18/11 and to hospice care on 08/01/16. Review of Resident #29's hospice certification/recertification statement signed by the physician upon admittance to hospice on 08/01/16 and quarterly thereafter revealed the statement: "I have reviewed the above beneficiary's clinical circumstances and I certify that the beneficiary is terminally ill with a life expectancy of six (6) months or less if the terminal illness runs its normal course." Review of Resident #29's significant change Minimum Data Set (MDS) dated 08/08/16 revealed the MDS indicated Resident #29 received hospice care. The MDS indicated Resident #29 did not have a prognosis of life expectancy of less than 6 months. Review of Resident #29's quarterly MDS dated 11/08/16 revealed the MDS indicated Resident #29 received hospice care. The MDS indicated Resident #29 did not have a prognosis of life expectancy of less than 6 months. Review of Resident #29's quarterly MDS dated 02/08/17 revealed the MDS indicated Resident #29 received hospice care. The MDS indicated Resident #29 did not have a prognosis of life expectancy of less than 6 months.	F 278	admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F 278 On 8/3/17, the surveyor interviewed the MDS Coordinator and determined Resident #29□s MDS indicated that the resident received hospice care. However, the MDS did not indicate that the resident had a prognosis of life expectancy of less than 6 months. In addition, it was determined Resident #53 PASRR was not coded on the MDS. Also, it was determined each of the active diagnosis for Resident #260 and Resident #323, was not coded on the MDS. For Resident #260, PAD/PVD was not coded and for Resident #323, Anxiety was not coded. MDS Modifications were submitted for Resident #29, Resident #53, Resident #260, and Resident #323. MDS Coordinators will be provided education on RAI coding requirements. Director of Nursing or designee will conduct weekly 10% audits of MDS assessment to ensure compliance with coding active diagnosis. Any identified issues will be corrected at that time. In addition, the Director of Nursing or designee will conduct weekly 100% audits of Hospice and PASRR coding to ensure compliance. Any identified issues will be	

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F 278	Continued From page 2 Review of Resident #29's quarterly MDS dated 05/08/17 revealed the MDS indicated Resident #29 received hospice care. The MDS indicated Resident #29 did not have a prognosis of life expectancy of less than 6 months. Interview with the MDS Coordinator on 08/03/17 at 10:14 AM revealed Resident #29 had a prognosis of life expectancy of less than 6 months. The MDS Coordinator explained the physician did not sign Resident #29's hospice certification during the look back period so the MDS did not indicate the correct prognosis. Interview with the Director of Nursing on 08/03/17 at 1:28 PM revealed the MDS should be accurate and reflect Resident #29's prognosis of life. 2. Resident # 53 was readmitted to the facility on 07/06/2017. Review of the medical record dated 08/02/2017 documented diagnosis that included Asperger's, bipolar disorder, and chronic anxiety. Review of the Preadmission Screening Resident Review (PASRR) level II Determination Notification for nursing home applicants and residents documented nursing home placement as appropriate for Resident #53. Review of the annual MDS dated 03/08/2017 PASRR was note coded. Review of the MDS for significant change dated 07/12/2017 revealed PASRR was not coded. An interview on 08/03/2017 at 3:28 PM with the MDS coordinator revealed both the MDS dated	F 278	corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations. The Director of Nursing will be responsible for implementing the acceptable plan of correction.	

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F 278	Continued From page 3 03/08/2017 and 07/12/2017 coding for the PASRR was omitted. She stated it should have been coded. An interview on 08/03/2017 at 3:37 PM with the DON indicated she expected accuracy of the MDS and that PASRR II would be coded. 3. Resident #260 was admitted to the facility on 6/16/17. Diagnoses included peripheral vascular disease (PVD), peripheral arterial disease (PAD), chronic venous hypertension (idiopathic) with ulcers of right and left lower extremities, thrombocytosis, and bilateral lower extremity edema, among others. Medical record review revealed a physician's progress note dated 6/19/17 which documented Resident #260 was admitted to the facility with severe chronic venous stasis ulcers to bilateral lower extremities, and assessed with 1+ edema to both legs and 2 stasis ulcers to both legs. The progress note and physician's order documented to cleanse the wounds, pat dry, apply 30 grams Santyl ointment (debridement) and an oil emulsion gauze to the wound bed daily, cover with an ABD pad, secure with gauze and change every 8 hours/twice daily and as needed. Review of Resident #260's admission Minimum Data Set (MDS) assessment, dated 6/23/17, revealed that in section I0100, the diagnoses of PVD or PAD was not coded as active diagnoses.	F 278		

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F 278	Continued From page 4	F 278		

Review of the June 2017 Treatment Administration Record for Resident #260 revealed the resident received routine treatment to the stasis ulcers per physician's order.

During an interview on 8/03/17 at 1:50 PM, the MDS Coordinator stated that she referred to the physician's/nurse practitioner's progress notes when coding active diagnoses, and if the assessment/plan section of the progress note did not list a diagnoses with current treatment, she did not code the diagnoses as active. The MDS Coordinator further stated that the 6/19/17 physician's progress note for Resident #260 did mention the treatment of the stasis ulcers, but did not specifically mention the diagnoses of PAD/PVD, so she did not code these diagnoses as active.

During an interview on 8/03/17 at 2:35 PM, the director of nursing (DON) revealed that she expected the MDS to be completed accurately. The DON further stated that due to the current treatment Resident #260 received for the stasis ulcers, the diagnoses of PAD/PVD should have been recorded as an active diagnoses on the MDS or the MDS Coordinator should have clarified the active diagnoses with the physician.
4. Resident # 323 was admitted to the facility on 7/14/17 with diagnoses that included dementia and hypertension. The admission Minimum Data Set (MDS) dated 7/20/17 indicated Resident # 323 received 7 days of an antianxiety medication. The MDS did not have anxiety coded as an active diagnosis in the last 7 days.

Record review revealed a medication administration record dated July 2017, indicated

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F 278	Continued From page 5 Resident # 323 received Xanax 0.5 mg daily from 7/14/17 to 7/20/17. Record review revealed a hospital summary of care document dated 7/14/17, indicated anxiety as an active diagnosis for Resident # 323. Record review also revealed a hospital summary of care document dated 7/16/17, revealed anxiety as an active diagnosis for Resident # 323. During an interview on 8/3/17 at 10:15 AM with the MDS nurse stated information for the MDS was supposed to be gathered from the residents, staff, therapy, hospital records, and information from the resident's chart. The MDS nurse indicated the admission MDS dated 7/20/17 for Resident # 323 was coded as received 7 days of antianxiety medication. The MDS nurse also stated the MDS was not coded for diagnosis of anxiety. The MDS nurse further indicated the diagnoses on the documents from the hospital dated 7/14/17 and 7/16/17 would not be included on the MDS because the diagnoses were not from the medical director of the facility. On 8/3/17 at 4:16 PM, the Director of Nursing (DON) indicated she reviewed Resident's # 323 chart and the diagnosis of anxiety was listed on the discharge papers from the hospital and should have been coded on the MDS. The DON stated her expectations were for the MDS to be coded correctly for the resident to show the active diagnoses.	F 278		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that	F 309		8/30/17

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F 309	Continued From page 6 applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to implement a bowel program for constipation to 2 of 4 sampled residents reviewed who had no indication of a bowel movement for greater than 72 hours	F 309	F 309 Surveyor□s review of Resident #260 and Resident #323 nurse□s notes, bowel and bladder reports, and staff interviews	

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F 309	Continued From page 7 (Residents #260 and #323). 1. Resident #260 was admitted to the facility on 6/16/17. Diagnoses included cognitive impairment, chronic pain, peripheral vascular disease, thrombocytosis, right leg pain, peripheral artery disease, and adult failure to thrive, among others. Medical record review for Resident #260 revealed a physician's progress note dated 6/19/17 which documented "constipation has been an issue" for this Resident. Review of Resident #260's admission Minimum Data Set (MDS) assessment, dated 6/23/17, revealed that Resident #260 was rarely/never understood, had impaired cognition, and was always incontinent of bowel with no constipation. Review of the facility's "Physician Standing Orders, Bowel Program for Constipation", dated March 2016, revealed instructions to "Implement one of the following medications if resident complains of constipation or no bowel movement (BM) in 72 hours: · Check for impaction · Senekot-S one by mouth twice a day for 48 hours · Miralax 17 grams by mouth mixed with fluid everyday as needed (hold for loose bowels) · Dulcolax suppository one rectally every other day as needed for 48 hours Review of nurse's notes and a July 2017 bowel and bladder report for Resident #260 revealed no documentation of a BM or check for impaction related to constipation from 7/8/17 through	F 309	determined that the bowel protocol was not implemented after consecutive days each resident did not have documentation of bowel movements. Resident #260 was assessed on 8/3/17 for bowel movement and did not require prn medication for bowel movement. Resident #323 was assessed on 8/1/17 for bowel movement and standing order was implemented on 8/1/17. Nurses will be inserviced on implementing the □Physician Standing Orders, Bowel Program for Constipation□ for triggered residents. CNAs will be inserviced on the importance of accurate documentation in CareTracker of bowel movements, to ensure triggered residents receive care in accordance with the bowel program. Unit Supervisors will run a daily CareTracker report to identify residents that did not have documentation of bowel movement within 72 hours. The Unit Supervisor will alert the assigned nurse to implement the bowel program. Director of Nursing or designee will monitor the report weekly, to identify residents that did not have documentation of a bowel movement within 72 to ensure compliance with the bowel program implementation. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat	

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F 309	Continued From page 8 7/16/17 (9 consecutive days) and 7/20/17 through 7/26/17 (7 consecutive days). Review of the July 2017 Medication Administration Record (MAR) for Resident #260 also revealed no administration of medication for constipation for the same dates per the facility's Physician Standing Orders/Bowel Program for Constipation. Continued review of the July 2017 MAR revealed Resident #260 routinely received the following medications that include constipation as a side effect: · Norco 7.5-325 miligrams 1 tablet orally every 12 hours · Transdermal Fentanyl Patch, 12 micrograms, apply one patch every 72 hours An interview with nurse aide (NA) #4 on 8/03/17 at 10:45 AM revealed she routinely provided care to Resident #260 and that the resident was incontinent of bowel. NA #4 stated that she could not recall if Resident #260 had a bowel movement on dates that she provided care if it was not documented. An interview with NA #5 on 8/03/17 at 10:47 AM revealed she worked with Resident #260 regularly, the resident was incontinent of bowel, but she could not recall if Resident #260 had any additional bowel movements that were not documented. During an interview with nurse #1 on 8/03/17 at 2:33 PM, the nurse stated that she remembered reminding one of the NA to document a bowel movement for Resident #260, but she could not recall the date. Nurse #1 further stated that she expected the NAs to advise the nurse if a resident	F 309	citations. The Director of Nursing will be responsible for implementing the acceptable plan of correction	

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did not have a bowel movement in 72 hours, so that the nurse could implement the bowel protocol. Nurse #1 also stated that if the resident did not void after the protocol was implemented, she would notify the physician.

The director of nursing (DON) was interviewed on 8/03/17 at 2:35 PM and stated that she expected the NAs to communicate with the nurse if a resident did not have a BM in 72 hours, the nurse should implement standing orders for the bowel management protocol, document on MAR and if not successful notify the physician. The DON reviewed the MAR, nurse's notes and bowel records for Resident #260 during the interview and confirmed that there was no documentation of BMs and no implementation of the bowel protocol.

On 8/3/17 at 3:04 PM an interview with the administrator indicated he expected for the bowel management protocol to be followed by the nurses.

An interview on 8/03/17 at 4:10 PM with nurse #3 revealed she recalled Resident #260 told staff at times, "I went a little", but that nurse #3 did not stay to observe whether or not Resident #260 had a BM and that she could not recall the dates.
2. Resident # 323 was admitted to the facility on 7/14/17 with diagnoses that included dementia and hypertension. The admission Minimum Data Set (MDS) dated 7/20/17 indicated Resident # 323 was rarely or never understood and required extensive assistance with activities of daily living. The MDS also indicated Resident # 323 was frequently incontinent of bowel with no constipation.

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Record review revealed a standing order for constipation that read in part: Implement one of the following medications if Resident complains of constipation or no bowel movement (BM) in 72 hours.

1. Check for impaction
2. Senekot-S one by mouth twice a day for 48 hours or
3. Miralax 17 grams by mouth mixed with fluid everyday as needed or
4. Dulcolax suppository one rectally every other day as needed x 48 hours.

Record review for Resident # 323 revealed nursing notes and a bowel and bladder report that indicated no BM from 7/16/17 to 7/23/17. The record review did not indicate Resident # 323 was checked for an impaction from 7/16/17 to 7/23/17.

Record review further revealed a Medication Administration Record (MAR) dated July 2017 that revealed no medication was given to Resident # 323 for no BM in 72 hours.

On 8/3/17 at 2:22 PM Nurse # 3 indicated the nurse aides were supposed to document the BMs in the computer and notify the nurse of no BM. Nurse # 3 stated a BM report was ran nightly and if the resident did not have a BM then the bowel protocol should be followed. Nurse # 3 further stated she did not recall Resident # 323 having problems with constipation or being on the list for no BM in 3 days. Nurse # 3 indicated she had not given Resident # 323 any medication for constipation.

On 8/3/17 at 2:36 PM an interview with Nurse Aide # 3 stated, the nurse aides documented when a resident had a BM in the computer and

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F 309	Continued From page 11 they were supposed to notify the nurse on that shift if the resident did not have a BM and the nurse would give the resident medication. Nurse Aide # 3 then stated she had notified the nurse before of Resident # 323 not having a BM. Nurse Aide # 3 indicated she notified the nurse last night of the resident not having a BM but she could not recall the other dates. On 8/3/17 at 2:56 PM the Director of Nursing (DON) indicated the nurse aides documented the residents' BM in the care tracker and were supposed to notify the nurse on that shift if no BM. The DON then stated the nurse was supposed to administer medication if needed. The DON went on to say if the residents did not have a BM every three days then the bowel protocol was supposed to be followed. The DON stated Resident # 323 had a BM on 7/15/17, 7/24/17, 7/26/17, and 7/30/17. The DON confirmed that Resident # 323 did not have a BM from 7/16/17 to 7/23/17. The DON stated there was no documentation on the July 2017 MAR for Resident # 323 to have received medication for no BM. The DON further stated her expectations were for the nurse aide to notify the nurse when no BM in 3 days and for the nurse to implement the bowel protocol. On 8/3/17 at 3:04 PM an interview with the Administrator indicated he expected for the BM protocol to be followed by the nurses.	F 309		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission	F 315		8/30/17

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F 315	Continued From page 12 receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to change an indwelling urinary catheter monthly and follow an order for voiding trial for 1 of 3 residents sampled for urinary catheter. (Resident # 211).	F 315	F 315 Surveyor□s review of Resident #211□s physician□s orders, Medication Administration Record and staff interviews	

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F 315	Continued From page 13 Findings included: Resident # 211 was originally admitted to the facility on 4/14/16 with diagnoses that included neurogenic bladder with Foley catheter, and chronic kidney disease. Review of the significant change Minimum Data Set (MDS) dated 4/20/17 indicated Resident # 211 was cognitively intact, required limited assistance with activities of daily living (ADL), and had an indwelling catheter in place during the 7 day look back period. The care area assessment indicated Resident # 211 had an indwelling catheter since admission, had 2 failed voiding trials, and had routine urology appointments. Record review revealed a doctor order for Resident # 211 dated 5/3/17 that read in part: patient to have Foley catheter removed for voiding trial and repeat again one month later. A care plan dated 5/4/17 indicated Resident # 211 had an indwelling catheter due to hypertonia and decreased bladder compliance. The care plan goal was to minimize risk for complications of catheter use. The care plan interventions included to provide catheter care every shift, and to refer to the urologist as needed. Record review revealed a Medication Administration Record (MAR) for Resident # 211 revealed the indwelling catheter was removed on 5/31/17 for a voiding trial and the Foley catheter was changed. Record review revealed a doctor order for Resident # 211 dated 6/15/17 indicated to change	F 315	determined that the physician□s orders to remove the resident□s catheter for a voiding trial and to change the catheter in June, was not followed. On 8/2/17 resident was assessed and determined not to have adverse effects from voiding trial not being initiated and the catheter not being changed in June. Nursing staff will be educated on implementing physician orders for catheter care. Unit Supervisor or designee will conduct weekly 10% audits of residents with catheters to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. The Director of Nursing will be responsible for implementing the acceptable plan of correction.	

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F 315	Continued From page 14	F 315		

Foley catheter every month.

Record review did not reveal a Foley catheter change for Resident # 211 in June 2017.

Record review did not reveal a voiding trial for Resident # 211 in June 2017.

Record review revealed a MAR for Resident # 211 revealed the indwelling catheter was removed on 7/28/17 for a voiding trial and the Foley catheter was changed.

On 8/1/17 at 4:53 PM an interview with Nurse # 2 revealed the catheter for Resident # 211 was supposed to be changed monthly by the nurse. Nurse # 2 stated Resident # 211 had a recent failed voiding trial and his catheter had to be reinserted. Nurse # 2 further indicated she did not change the catheter for Resident # 211 because in the facility catheters were supposed to be changed on another shift.

On 8/2/17 at 12:08 PM the Director of Nursing (DON) stated Resident # 211 had an order to change the catheter every month written on 6/15/17. The DON also stated the catheter for Resident # 211 was changed on 5/31/17 after a failed voiding trial. The DON then indicated there was no documentation that the catheter for Resident # 211 was changed in June 2017 or a voiding trial was completed. The DON went on to say that the catheter for Resident # 211 was changed on 7/28/17 after a failed voiding trial. The DON also stated that Resident # 211 catheter was supposed to been changed around 6/30/17. The DON further stated her expectations were for the nursing staff to follow the doctor's orders.

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F 315	Continued From page 15 On 8/2/17 at 1:14 PM an interview with the Medical Director (MD) revealed Resident # 211 was supposed to have a voiding trial a month after the 5/31/17 date as ordered. The MD also stated the facility was supposed to complete monthly catheter changes for Resident # 211 because that was the current recommendation. The MD further stated there was no adverse effects from the catheter not being changed for Resident # 211. On 8/2/17 at 2:53 PM an interview with the Administrator revealed his expectations were for the doctor orders to be followed as written.	F 315		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 323		8/30/17

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F 323	Continued From page 16 (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews (Resident # 219), and record review the facility failed to maintain hot water temperatures below 120 degrees Fahrenheit (F) for 1 of 4 sampled hallways. (Hall 300). Findings included: A review of the water temperature logs for July 5-7, 2017 revealed hot water temperatures at room randomly selected from each hallway were with the range of 103-116 degrees Fahrenheit. (F.) A review of the incident report log for May-July 2017 revealed no incidents related to water in residents' room being too hot. A review of the Resident Council Minutes May-July 2017 revealed no resident concerns about hot water temperatures in their rooms being too hot. Observations of hot water temperatures in residents' rooms revealed hot water temperatures that were too hot to touch by running water on one's hand: 08/01/2017 at 08:54 AM room 313	F 323	F 323 Surveyor□s review of the water temperature logs, observation of hot water temperatures and staff interviews determined that water temperatures in four rooms were above 120 degrees Fahrenheit. The onsite Maintenance Mechanic assessed the situation and determined that debris in the mixing valve pipe caused these temperatures to rise. On 8/1/17, the onsite Maintenance Mechanic flushed the valve of debris and retested the water temperatures. Temperatures were below 116 degrees Fahrenheit and remained in compliance. On 8/2/17, an outside maintenance team checked the mixing valve again, flushed any remaining debris and changed the gasket. The water temperatures were retested and temperatures were below 116 degrees Fahrenheit and remained in compliance. The outside maintenance team cleaning schedule to check the mixing valve and flush any debris will be increased from quarterly to monthly. The Hot Water	

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F 323	Continued From page 17 08/01/2017 at 08:57 AM room 306 08/01/2017 at 09:39 AM room 311 08/01/2017 at 11:28 AM room 312 An interview on 08/01/2017 at 11:28 AM with Resident # 219 (who resided on the 300 Hall) revealed he used the sink in his room and he stated the water was too hot. (Resident #219's Minimum Data Set (MDS) dated 05/10/2017 assessed him as able to participate in daily decision making.) Observations of hot water temperatures on 08/01/2017 at 4:19 PM on the 300 hallway taken by maintenance staff (MS) #1 with the Administrator present revealed: Room 313 hot water temperature 124 degrees F. Room 312 hot water temperature 123 degrees F. Room 311 hot water temperature 122 degrees F. Room 306 hot water temperature 123 degrees F. While the water temperatures were being taken, the administrator requested that hot water temperature observations be discontinued in 4 additional resident rooms where hot water temperature had been too hot to touch. (Rooms 300, 302, 308, 310). An interview on 08/01/2017 at 5:07 PM with MS #1 revealed he randomly tests water temperatures around the building. He stated he had used the same infrared thermostat	F 323	Temperature Check Log to test water temps was updated from five observations per week to twenty observations per week. The Hot Water Temperature Check Log will be monitored for compliance by the Administrator and/or designee weekly. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. The onsite Maintenance Mechanic will be responsible for implementing the acceptable plan of correction.	

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F 323	Continued From page 18 thermometer for the past four years. He stated he did calibrate it. An interview on 08/02/2017 at 09:16 AM with the Safety Officer (SO) for the facility revealed she has had no concerns about hot water on her regular rounding or at the bimonthly safety meetings for the past year. She stated she randomly tested the water temperatures. There were safety committee meetings every other month and no hot water temperature issues had been brought to the committee. An interview on 08/03/2017 at 12:06 PM with the Administrator revealed he expected the hot water temperature in the residents' room to be between 100-116 degrees F.	F 323		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food	F 371		8/30/17

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F 371	Continued From page 19 service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to sanitize dishes with the correct sanitizer concentration. The facility failed to store opened frozen foods in the freezer with labels including the name, date opened and date to use by on the items. (Pancakes, chicken, peas, omelets), and a small dish of diced pears and a thickened beverage in the refrigerator. Findings included: 1. A review of the facility's food services policies and procedures regarding low temperature dish machine procedure dated 02/16/2016 revealed the chlorine concentration should be 50-100 parts per million (ppm). A review of the sanitizer log record dated July 28-31, 2017 revealed the tests strip registered 75 ppm. On 07/31/2017 at 09:59 AM Dietary Aide (DA) #2 stated she had tested the chlorine solution that morning and it registered 75 ppm. She stated the 75 ppm registered a purple color on the test key on the bottle of strips between the 50 ppm and the 100 ppm colors on the bottle. DA #1 revealed they run the dishes through the dish machine and then let them rest. They tested the sanitizing cycle three times a day and recorded it on the log.	F 371	F 371 On 7/31/17, the surveyor observed DA #1, checking the concentration of chlorine solution following the sanitizing cycle. The test strip did not register 50 parts per million (PPM). The facility replaced the sanitizer bucket and primed the sanitizer pump. Afterwards, the Food Service Director tested the sanitizer at the dish machine and the sanitizer test strip was registering between 50 ppm □ 100 ppm for the sanitizing cycle. All the breakfast dishes were then run through the dish machine again, to be sanitized. On 8/2/17, the surveyor observed the following items in the freezer that were opened with no label including name of the item, date opened and use by date: 6 omelets; 6 pancakes; peas; 10 chicken breasts. Kitchen staff were able to identify with certainty that the omelets, pancakes, peas, and chicken breasts were opened on 8/1/17. Each of these items were then properly labeled with the name of the item, date opened and use by date. In addition, the surveyor observed the following items in the refrigerator that were opened with no label including name of the item, date prepared and use by	

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F 371	Continued From page 20 It was tested before they had started washing the breakfast dishes today and was recorded at 75ppm. At 09:59 AM DA #1 was observed checking the concentration of the chlorine solution following the sanitizing cycle. The test strip did not register 50 parts per million (ppm). The cycle was repeated two more times and each time the test strip did not indicate 50 ppm. The sanitizer concentration was tested in the dish machine after the sanitizing cycle was finished. On 07/31/2017 at 10:01 AM, DA #2 pressed the button on the chemical flow machine on top of the dishwasher and ran the dish machine again. The sanitizer concentration was tested in the rinse water in the dish machine after the sanitizing cycle. It appeared to register 10 ppm. On 07/31/2017 at 10:08 AM, DA #3 tested the sanitizer concentration with a new bottle of chlorine tests strips. It did not register 50 ppm. It appeared to register 10 ppm. On 07/31/2017 at 10:11 AM the chemical drum was replaced with a new one for the dish machine sanitizing cycle. An observation on 07/31/2017 at 10:27 AM the dish machine technician from the vendor checked the machine. He stated the sanitizing cycle should register 50 ppm on the tests strips for this machine. He stated the probe was not inserted correctly. He stated the facility has replaced the sanitizer bucket and primed the sanitizer pump. He stated the dish machine was sanitizing upon his arrival at the facility. On 07/31/2017 at 10:29 AM the Food Service Director tested the sanitizer at the dish machine and the sanitizer test strip was registering	F 371	date: dish of fruit and a glass of thickened beverage. Each of these items were discarded. All dishwashing staff will be educated to test the sanitizer before sanitizing dishes for each meal and again after completion of dish sanitizing. In addition, Ecolab will install an alarm that will sound when the chemical is low, alerting staff to change out the 5-gallon premixed bucket of sanitizer. The dish machine daily PPM checklist will be completed before and after each meal and will be monitored for compliance by the Administrator and/or designee weekly. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations. Dietary staff will be inserviced on food sanitation policy which will include labeling requirements. The daily labeling and dating checklist, which defines locations of food items, times, initials, and corrective action, will be utilized twice per day by the General Manager and/or designee. The Administrator and/or designee, will monitor for compliance weekly. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly.	

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F 371	Continued From page 21 between 50 ppm - 100 ppm for the sanitizing cycle. The FSD tested the sanitizer by dipping the strip into the rinse water in the dish machine after the sanitizing cycle. On 07/31/2017 at 10:30 AM the FSD stated all breakfast dishes would be run through the dish machine again to be sanitized. If all of them could not be washed again by lunchtime, they would use paper products at lunch. Interview with the FSD on 07/31/2017 at 10:48 AM revealed his expectation was that the sanitizing cycle would have the correct amount of the chlorine chemical at 50 ppm of the during the sanitizing part of the dish washing cycle. During an interview on 08/03/2017 at 12:06 PM with the Administrator he stated he expected the sanitizing solution for the dish machine was in the pH range that was required to sanitize the dishes and that regular testing was going on to assure the dishes and other items were sanitized when they had gone through the dish machine. 2. Observations on 08/02/2017 at 04:17 PM revealed concerns with food storage: Freezer: A plastic bag with 6 omelets, a plastic with 6 pancakes, a large bag approximately half full of peas and a plastic bag with 10 chicken breasts were opened with no label including name of the item, date opened and use by date. Refrigerator #1: A dish of fruit (diced pears) and a glass of thickened beverage had no label with item name,	F 371	QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations. The General Manager will be responsible for implementing the acceptable plan of correction.	

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F 371	Continued From page 22 date prepared or used by date. An interview on 08/03/2017 at 12:06 PM with the Administrator revealed he expected that all food items are labeled with what it is, the date it was opened and the date to use it by. An interview on 08/03/2017 at 3:30 PM with the FSD revealed he expected all foods that are in the refrigerators and freezer to be labeled, dated and have a use by date on them. He stated all staff were responsible for labeling items in the storage areas including freezer, refrigerators and dry storage.	F 371		
F 490 SS=E	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility record review, the facility's administration failed to monitor implemented procedures put into place by the facility's Quality Assessment and Assurance committee to maintain compliance and sustain an effective system to manage resident care and services (Residents #29, #53, #260, and #323). The findings included: 1a. Cross reference - F278	F 490	F 490 The facility will be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Corrective Action Plan and plan for the facility's administration to monitor implemented procedures put into place by the facility's Quality Assessment and	8/30/17

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F 490	Continued From page 23 Based on staff interviews and record review, the facility failed to accurately code the Minimum Data Set (MDS) related to prognosis of life (Resident #29), preadmission screening (Resident #53), and active diagnoses (Resident #260 and Resident #323) for 4 of 19 sampled residents who required an MDS. 1b. Cross reference - F309 Based on staff interviews and medical record review, the facility failed to implement a bowel program for constipation to 2 of 4 sampled residents reviewed who had no indication of a bowel movement for greater than 72 hours (Residents #260 and #323). 1c. Cross reference - F371 Based on observations, staff interviews and record review, the facility failed to sanitize the dishes with the correct sanitizer concentration. The facility failed to store opened frozen foods in the freezer with labels including the name, date opened and date to use by on the items. (Pancakes, chicken, peas omelets), and a small dish of diced pears and a thickened beverage in the refrigerator. 1d. Cross reference - F520 Based on observations, staff interviews and review of medical and facility records, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in July 2016. This was for 3 recited deficiency that was originally cited in June 2016 on a Recertification/Complaint	F 490	Assurance Committee to maintain compliance and sustain an effective system to manage resident care and services, to be reviewed with the Quality Assurance and Performance Improvement (QAPI) Committee. Corrective Action: F520 The facility will maintain a Quality Assessment and Assurance committee with members including the Director of Nursing Services, the Medical Director or his/her designee, and at least three other members of the facility's staff. Corrective Action Plan and plan for monitoring to sustain an effective Quality Assessment and Assurance Program, to be reviewed with the Quality Assurance and Performance Improvement (QAPI) Committee. We feel what led to this deficiency was a monitoring period through the QAPI committee that was too brief. Our 90 day monitoring resulted in 100% compliance in these areas, as tracked by our QAPI committee. However, had we lengthened the monitoring period for these deficient areas from 90 days to 6 months or 1 year, perhaps we would not have had repeat issues. As a result, our Plan of Correction for our repeat citations F278, F309, F371 and F520 is to continue monitoring through QAPI the audit processes and operational compliance until our next annual	

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F 490	Continued From page 24 survey and subsequently recited on the facility's current Recertification survey. The deficiencies were in the areas of resident assessments, maintain well-being, and dietary services. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. An interview on 8/3/17 at 4:37 PM with the administrator revealed that he managed the facility's QAA committee which met at least quarterly to assess the needs of the facility. The administrator stated that during the quarterly QAA meetings, participants reviewed trending/tracking reports/data to identify resident concerns that required a plan for correction and monitoring. He stated that resident assessments related to MDS accuracy remained a QAA agenda item for 90 days until the facility achieved 100% accuracy and then it was removed from the QAA's agenda. He attributed continued concerns in the dietary department to staff turnover and the need for continued monitoring. The administrator stated that perhaps the areas of resident assessment, well-being, dietary services and QAA should have remained on the agenda for continued monitoring.	F 490	recertification survey (roughly one year from now). Provided this annual recertification survey results in no repeat citations for F278, F309, F371 and F520, we would then discontinue monitoring through our QAPI Committee. Corrective Action: F278 On 8/3/17, the surveyor interviewed the MDS Coordinator and determined Resident #29□s MDS indicated that the resident received hospice care. However, the MDS did not indicate that the resident had a prognosis of life expectancy of less than 6 months. In addition, it was determined Resident #53 PASRR was not coded on the MDS. Also, it was determined each of the active diagnosis for Resident #260 and Resident #323, was not coded on the MDS. For Resident #260, PAD/PVD was not coded and for Resident #323, Anxiety was not coded. MDS Modifications were submitted for Resident #29, Resident #53, Resident #260, and Resident #323. MDS Coordinators will be provided education on RAI coding requirements. Director of Nursing or designee will conduct weekly 10% audits of MDS assessment to ensure compliance with coding active diagnosis. Any identified issues will be corrected at that time. In addition, the Director of Nursing or designee will conduct weekly 100% audits of Hospice and PASRR coding to ensure compliance. Any identified issues will be	

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F 490	Continued From page 25	F 490		

corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations.

The Director of Nursing will be responsible for implementing the acceptable plan of correction.

8/30/17

Corrective Action: F309

Surveyor□s review of Resident #260 and Resident #323 nurse□s notes, bowel and bladder reports, and staff interviews determined that the bowel protocol was not implemented after consecutive days each resident did not have documentation of bowel movements. Resident #260 was assessed on 8/3/17 for bowel movement and did not require prn medication for bowel movement. Resident #323 was assessed on 8/1/17 for bowel movement and standing order was implemented on 8/1/17.

Nurses will be inserviced on implementing the □Physician Standing Orders, Bowel Program for Constipation□ for triggered residents. CNAs will be inserviced on the importance of accurate documentation in CareTracker of bowel movements, to ensure triggered residents receive care in accordance with the bowel program.

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F 490	Continued From page 26	F 490	Unit Supervisors will run a daily CareTracker report to identify residents that did not have documentation of bowel movement within 72 hours. The Unit Supervisor will alert the assigned nurse to implement the bowel program. Director of Nursing or designee will monitor the report weekly, to identify residents that did not have documentation of a bowel movement within 72 to ensure compliance with the bowel program implementation. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations. The Director of Nursing will be responsible for implementing the acceptable plan of correction. 8/30/17 Corrective Action: F371 On 7/31/17, the surveyor observed DA #1, checking the concentration of chlorine solution following the sanitizing cycle. The test strip did not register 50 parts per million (PPM). The facility replaced the sanitizer bucket and primed the sanitizer pump. Afterwards, the Food Service Director tested the sanitizer at the dish machine and the sanitizer test strip was	

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F 490	Continued From page 27	F 490		

registering between 50 ppm □ 100 ppm for the sanitizing cycle. All the breakfast dishes were then run through the dish machine again, to be sanitized.

On 8/2/17, the surveyor observed the following items in the freezer that were opened with no label including name of the item, date opened and use by date: 6 omelets; 6 pancakes; peas; 10 chicken breasts. Kitchen staff were able to identify with certainty that the omelets, pancakes, peas, and chicken breasts were opened on 8/1/17. Each of these items were then properly labeled with the name of the item, date opened and use by date. In addition, the surveyor observed the following items in the refrigerator that were opened with no label including name of the item, date prepared and use by date: dish of fruit and a glass of thickened beverage. Each of these items were discarded.

All dishwashing staff will be educated to test the sanitizer before sanitizing dishes for each meal and again after completion of dish sanitizing. In addition, Ecolab will install an alarm that will sound when the chemical is low, alerting staff to change out the 5-gallon premixed bucket of sanitizer. The dish machine daily PPM checklist will be completed before and after each meal and will be monitored for compliance by the Administrator and/or designee weekly. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a

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F 490	Continued From page 28	F 490	weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations. Dietary staff will be inserviced on food sanitation policy which will include labeling requirements. The daily labeling and dating checklist, which defines locations of food items, times, initials, and corrective action, will be utilized twice per day by the General Manager and/or designee. The Administrator and/or designee, will monitor for compliance weekly. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations. The General Manager will be responsible for implementing the acceptable plan of correction. 8/30/17	
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a	F 520		8/30/17

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F 520	Continued From page 29 minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of medical and facility records, the facility's Quality Assessment and Assurance (QAA)	F 520	F 520 The facility will maintain a Quality	

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F 520	Continued From page 30 committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in July 2016. This was for 3 recited deficiency that was originally cited June 2016 on a Recertification/Complaint survey and subsequently recited on the facility's current Recertification survey. The deficiencies were in the areas of resident assessments, maintain well-being, and dietary services. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1a. Cross reference - F 278 Based on staff interviews and record review, the facility failed to accurately code the Minimum Data Set (MDS) related to prognosis of life (Resident #29), preadmission screening (Resident #53), and active diagnoses (Resident #260 and Resident #323) for 4 of 19 sampled residents who required an MDS. The facility was originally cited in June 2016 for accuracy of resident assessments related to hearing and speech and recited for accuracy of resident assessments on the current survey regarding the prognosis of life, preadmission screening and active diagnoses. 1b. Cross reference - F 309 Based on staff interviews and medical record review, the facility failed to implement a bowel	F 520	Assessment and Assurance committee with members including the Director of Nursing Services, the Medical Director or his/her designee, and at least three other members of the facility's staff. Corrective Action Plan and plan for monitoring to sustain an effective Quality Assessment and Assurance Program, to be reviewed with the Quality Assurance and Performance Improvement (QAPI) Committee. We feel what led to this deficiency was a monitoring period through the QAPI committee that was too brief. Our 90 day monitoring resulted in 100% compliance in these areas, as tracked by our QAPI committee. However, had we lengthened the monitoring period for these deficient areas from 90 days to 6 months or 1 year, perhaps we would not have had repeat issues. As a result, our Plan of Correction for our repeat citations F278, F309, F371 and F520 is to continue monitoring through QAPI the audit processes and operational compliance until our next annual recertification survey (roughly one year from now). Provided this annual recertification survey results in no repeat citations for F278, F309, F371 and F520, we would then discontinue monitoring through our QAPI Committee. Corrective Action: F278	

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F 520	Continued From page 31 program for constipation to 2 of 4 sampled residents reviewed who had no indication of a bowel movement for greater than 72 hours (Residents #260 and #323). The facility was originally cited in June 2016 for well-being related to implementing a physical therapy recommendation for respiratory services and recited for well-being on the current survey regarding implementation of a bowel management program. 1c. Cross reference - F 371 Based on observations, staff interviews and record review, the facility failed to sanitize the dishes with the correct sanitizer concentration. The facility failed to store opened frozen foods in the freezer with labels including the name, date opened and date to use by on the items. (Pancakes, chicken, peas, omelets), and a small dish of diced pears and a thickened beverage in the refrigerator. The facility was originally cited in June 2016 for dietary services related to labeling/dating opened foods and discarding expired foods and recited for dietary services on the current survey regarding dish sanitation and labeling/dating opened foods. An interview on 8/3/17 at 4:37 PM with the administrator revealed that he managed the facility's QAA committee which met at least quarterly to assess the needs of the facility. The administrator stated that during the quarterly QAA meetings, participants reviewed trending/tracking reports/data to identify resident concerns that required a plan for correction and monitoring. He	F 520	On 8/3/17, the surveyor interviewed the MDS Coordinator and determined Resident #29□s MDS indicated that the resident received hospice care. However, the MDS did not indicate that the resident had a prognosis of life expectancy of less than 6 months. In addition, it was determined Resident #53 PASRR was not coded on the MDS. Also, it was determined each of the active diagnosis for Resident #260 and Resident #323, was not coded on the MDS. For Resident #260, PAD/PVD was not coded and for Resident #323, Anxiety was not coded. MDS Modifications were submitted for Resident #29, Resident #53, Resident #260, and Resident #323. MDS Coordinators will be provided education on RAI coding requirements. Director of Nursing or designee will conduct weekly 10% audits of MDS assessment to ensure compliance with coding active diagnosis. Any identified issues will be corrected at that time. In addition, the Director of Nursing or designee will conduct weekly 100% audits of Hospice and PASRR coding to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations. The Director of Nursing will be	

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F 520	Continued From page 32 stated that resident assessments related to MDS accuracy remained a QAA agenda item for 90 days until the facility achieved 100% accuracy and then it was removed from the QAA's agenda. He attributed continued concerns in the dietary department to staff turnover and the need for continued monitoring. The administrator stated that perhaps the areas of resident assessment, well-being, dietary services and QAA should have remained on the agenda for continued monitoring.	F 520	responsible for implementing the acceptable plan of correction. 8/30/17 Corrective Action: F309 Surveyor□s review of Resident #260 and Resident #323 nurse□s notes, bowel and bladder reports, and staff interviews determined that the bowel protocol was not implemented after consecutive days each resident did not have documentation of bowel movements. Resident #260 was assessed on 8/3/17 for bowel movement and did not require prn medication for bowel movement. Resident #323 was assessed on 8/1/17 for bowel movement and standing order was implemented on 8/1/17. Nurses will be inserviced on implementing the □Physician Standing Orders, Bowel Program for Constipation□ for triggered residents. CNAs will be inserviced on the importance of accurate documentation in CareTracker of bowel movements, to ensure triggered residents receive care in accordance with the bowel program. Unit Supervisors will run a daily CareTracker report to identify residents that did not have documentation of bowel movement within 72 hours. The Unit Supervisor will alert the assigned nurse to implement the bowel program. Director of Nursing or designee will monitor the report weekly, to identify residents that did not have documentation of a bowel	

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F 520	Continued From page 33	F 520		

movement within 72 to ensure compliance with the bowel program implementation. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations.

The Director of Nursing will be responsible for implementing the acceptable plan of correction.

8/30/17

Corrective Action: F371

On 7/31/17, the surveyor observed DA #1, checking the concentration of chlorine solution following the sanitizing cycle. The test strip did not register 50 parts per million (PPM). The facility replaced the sanitizer bucket and primed the sanitizer pump. Afterwards, the Food Service Director tested the sanitizer at the dish machine and the sanitizer test strip was registering between 50 ppm □ 100 ppm for the sanitizing cycle. All the breakfast dishes were then run through the dish machine again, to be sanitized.

On 8/2/17, the surveyor observed the following items in the freezer that were opened with no label including name of the item, date opened and use by date: 6 omelets; 6 pancakes; peas; 10 chicken

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F 520	Continued From page 34	F 520	breasts. Kitchen staff were able to identify with certainty that the omelets, pancakes, peas, and chicken breasts were opened on 8/1/17. Each of these items were then properly labeled with the name of the item, date opened and use by date. In addition, the surveyor observed the following items in the refrigerator that were opened with no label including name of the item, date prepared and use by date: dish of fruit and a glass of thickened beverage. Each of these items were discarded. All dishwashing staff will be educated to test the sanitizer before sanitizing dishes for each meal and again after completion of dish sanitizing. In addition, Ecolab will install an alarm that will sound when the chemical is low, alerting staff to change out the 5-gallon premixed bucket of sanitizer. The dish machine daily PPM checklist will be completed before and after each meal and will be monitored for compliance by the Administrator and/or designee weekly. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations. Dietary staff will be inserviced on food sanitation policy which will include labeling requirements. The daily labeling and dating checklist, which defines locations	

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F 520	Continued From page 35	F 520	of food items, times, initials, and corrective action, will be utilized twice per day by the General Manager and/or designee. The Administrator and/or designee, will monitor for compliance weekly. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations. The General Manager will be responsible for implementing the acceptable plan of correction. 8/30/17	