

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345285</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN HOME HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE DRIVE HENDERSONVILLE, NC 28739</b>	
(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 637 SS=D	<p>Comprehensive Assessment After Significant Chg CFR(s): 483.20(b)(2)(ii)</p> <p>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to complete the Minimum Data Set (MDS) related to a significant change as required within 14 days for 1 of 1 resident reviewed for hospice (resident #84).</p> <p>The findings included:</p> <p>Resident #84 was admitted to the facility on 02/01/13 with diagnoses that included dementia with behavioral disturbance and Alzheimer's disease.</p> <p>A physician's order dated 01/23/18 indicated a hospice consult related to end stage dementia was ordered for Resident #84.</p> <p>A review of hospice documentation indicated Resident #84 was admitted to hospice care on 01/26/18 and a hospice care agreement between the hospice provider and the facility had been signed on the same day.</p>	F 637	<p>1. A referral was made to hospice on January 26, 2018 for resident # 84. Hospice representative relayed to administrator that she was unable to reach resident's POA to obtain consent for treatment. Consent was obtained at a later date but this information was not relayed to Administrator until after the fourteen day period had passed to do the significant change in condition assessment. The Assistant Director of Nursing had signed the Hospice Contract and the facility was not provided with a copy of the contract until a later date.</p> <p>2. There are no other Residents in the facility currently receiving hospice care.</p> <p>When a Hospice referral is made only the Administrator or Director of Nursing will be authorized to sign the contract. (Four Seasons Hospice and Hospice of the</p>	5/14/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/18/2018

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 637	Continued From page 1  A review of Resident #84's MDS assessments indicated a Significant Change in Status Assessment (SCSA) had not been completed within 14 days of her admission to hospice care on 01/16/18. Instead, a quarterly review assessment MDS dated 01/30/18 was transmitted and it did not indicate Resident #84's enrollment in hospice care.  An SCSA MDS dated 04/02/18 indicated Resident #84 was rarely/never understood and she was unable to complete the brief interview for mental status. She had short term memory problems, long term memory problems, and severely impaired daily decision-making skills. Resident #84 had a prognosis of 6 months or less and was receiving hospice care.  An interview was conducted with the Business Office Manager on 04/25/18 at 09:55 AM. She confirmed Resident #84 was admitted to hospice service on 01/26/18 and the services were ongoing.  An interview was conducted with the MDS Coordinator on 04/25/18 at 10:19 AM. She confirmed she was responsible for coding Section O, O100K hospice status for Resident #84's MDS. She stated she had not been made aware of Resident #84's admission to hospice in a timely manner. When she realized the significant changes, she immediately completed the SCSA MDS on 04/02/18. Normally any significant changes among residents' status would be discussed in the morning meeting. She did not know why this information was missed out. She acknowledged an SCSA should have been completed within 14 days of Resident #84's	F 637	Carolina Foothills have been made aware). A copy of the contract will be given to MDS Coordinator when appropriate signatures have been obtained. A log of all residents who have referrals for hospice care will be maintain to ensure that a significant change assessment is completed within the fourteen day requirement.  3. The MDS coordinator or her designee with utilize a tracking log to ensure that significant change has been completed with fourteen days of the Hospice Contract being signed. The MDS Coordinator will set the ARD date when she receives the signed contract and place residents name on log. The log will be reviewed in morning meeting ensuring that ARD date is met. The Director of Nursing will sign log when Assessment completed.  4. Tracking log will be reviewed by Director of Nursing or Assistant Director of Nursing and results will be reported during Quality Assurance Performance Improvement Committee, consisting of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Social Services Director, Admissions Director, Activity Director, Business Office Manager, Dietary Manager, Human Resources Manager, Maintenance Director, Environmental Services Supervisor, Medical Records, MDS Coordinator, Direct Care Licensed Nurse, and Direct Care CNA, meeting monthly x		

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F 637	Continued From page 2 admission to hospice and it was not done in a timely manner.  An interview was conducted with the Director of Nursing (DON) on 04/25/18 at 10:35 AM. The DON stated the MDS Coordinator was informed in the morning meeting following Resident #84's admission to hospice and it was her oversight for failing to complete the SCSA MDS on time as required. She indicated there was a staffing stability issues in the MDS office and it had affected its performance. She expected the MDS to be completed as required accurately and in timely manner.	F 637	12 months for follow up and/or recommendations.		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g)  §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code 1 of 1 sampled residents reviewed for hospitalization utilizing the Minimum Data Set (MDS) to reflect discharge status (Resident #94), 1 of 5 residents reviewed for accidents (Resident #39), 1of 1 residents reviewed for hospice (Resident #84), 1 of 3 residents reviewed for pain (Resident # 25), and 1 of 5 residents reviewed for unnecessary medication (Resident #74).  Findings included:  1. Resident #94 was admitted to the facility on 11/03/15	F 641	1. American HealthTech program prepopulates the discharge of all residents coded to be discharged as discharged to hospital on MDS section A2100. This has since been corrected through the AHT system. All discharge destinations are now required to be entered manually.  Resident # 94 was scheduled for discharge to another SNF on March 30, 2018. A2100 on the MDS was prepopulated as a hospital discharge. This was corrected to reflect that the resident was discharged to a SNF and resubmitted on April 24, 2018.	5/25/18	

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F 641	<p>Continued From page 3</p> <p>A review of a physician's order dated 03/29/18 indicated staff were to discharge Resident #94 to another nursing home on 03/30/18.</p> <p>A review of the Social Worker ' s discharge summary indicated Resident #94 was discharged on 03/30/18 to another nursing home.</p> <p>A review of a nurse's note dated 03/30/18 indicated Resident #94 was discharged from the facility with family on 03/30/18.</p> <p>A review of the discharge MDS assessment dated 03/30/18 indicated under Section A, A2100 Discharge Status that Resident #94 was coded as discharged to an acute hospital and not coded as discharged to another nursing home.</p> <p>On 04/24/18 at 2:05 PM an interview was conducted with the MDS Coordinator who stated she was responsible for coding Section A, A2100 Discharge Status on Resident #94's discharge MDS assessment dated 03/30/18. The MDS Coordinator stated she miscoded that Resident #94 was discharged to an acute hospital on 03/30/18. The MDS Coordinator stated she knew that Resident #94 had a planned discharge to another nursing home on 03/30/18 and miscoded the discharge status. The MDS Coordinator stated she would need to modify the discharge MDS assessment dated 03/30/18 to reflect Resident #94 was discharged to another nursing home on 03/30/18 and transmit.</p> <p>On 04/24/18 at 3:03 PM an interview was conducted with the DON who stated her expectation was that the MDS Coordinator would have coded the discharge MDS assessment dated 03/30/18 accurately to reflect Resident #94</p>	F 641	<p>Resident #39 was to the Emergency Room on November 16, 2017 after a fall that resulted in multiple displaced pelvic fractures. Section J1900B was coded that resident had a fall without injury. This corrected and MDS resubmitted on April 25, 2018.</p> <p>Resident #84 was referred to hospices services and due to a lack of communication between nursing staff and the hospice representative as well as the family member, the significant change assessment was not completed in a timely manner. This was corrected and resubmitted on April 24, 2018.</p> <p>Resident # 25 was prescribed antidepressant medication and the MDS nurse failed to code MDS as resident having received the medication. The MDS was corrected and resubmitted on April 25, 2018.</p> <p>Resident # 74 was coded as having received antidepressant medication seven days out the seven day lookback period, however the MDS did not include the diagnosis of depression. MDS was corrected and resubmitted on April 26, 2018.</p> <p>2. An MDS audit of all residents who receive antidepressant medications will be completed. This audit will include documentation of medication administration as well as ensuring proper diagnosis documentation. This audit will</p>		

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F 641	<p>Continued From page 4</p> <p>was discharged to another nursing home on 03/30/18. The DON stated Resident #94 had a planned discharge therefore the MDS Coordinator should have accurately coded the discharge MDS assessment dated 03/30/18 to reflect discharge status was to another nursing home. The DON stated her expectation was that the MDS Coordinator would modify and transmit the discharge MDS assessment dated 03/30/18 to reflect Resident #94 was discharged to another nursing home on 3/30/18.</p> <p>On 04/24/18 at 3:21 PM an interview was conducted with the Administrator who stated her expectation was that the MDS Coordinator would have accurately coded the discharge MDS assessment to reflect that Resident #94 was discharged to another nursing home on 03/30/18. The Administrator stated Resident #94 had a planned discharge therefore the MDS Coordinator should have accurately coded the discharge MDS assessment dated 03/30/18 to reflect discharge status was to another nursing home. The Administrator stated her expectation was that the MDS Coordinator would modify and transmit the discharge MDS assessment dated 03/30/18 to reflect Resident #94 was discharged to another nursing home on 03/30/17.</p> <p>2. Resident #39 was admitted to the facility on 08/31/17.</p> <p>A review of an emergency room record dated 11/16/17 indicated Resident #39 presented to the emergency room with hip pain and was determined to have multiple displaced pelvic fractures.</p> <p>A review of an occupational therapy note dated</p>	F 641	<p>be completed by May 25, 2018.</p> <p>3. AHT has been reprogramed to no longer prepopulate discharge destination.</p> <p>Records of residents returning from Emergency room will be reviewed at the next morning meeting after their return. If a diagnosis was not documented by emergency room MD, Medical records will call and obtain them. In the absence of the Medical Records employee the Admissions Coordinator will be responsible for obtaining these records. These records will be reviewed by the IDT the next morning meeting after the residents return. A log of these residents will kept by the DON/ ADON to ensure information is being obtained in a timely manner. The IDT team consist of:</p> <p>All hospice referrals will be reviewed during weekday morning meeting to ensure that MDS coordinator is aware.</p> <p>A tracking log will be initiated by the DON/ ADON of all current residents receiving antidepressants to review diagnosis coding and medication documentation. Residents who receive new orders for antidepressants will be added to the log for monitoring of the same. The log will be reviewed by the IDT team on a weekly basis x4 weeks then monthly x 6 months.</p> <p>A random line by line audit of MDS assessments for proper coding will be performed by Director of Nursing and/or Regional VP of Clinical Services will be</p>		

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F 641	<p>Continued From page 5</p> <p>11/20/17 indicated Resident #39 began therapy care on 11/20/17 related to a fall in her room which resulted in multiple pelvic fractures.</p> <p>A review of a physician note dated 03/29/18 indicated Resident #39 sustained a pelvic fracture in the facility on 11/16/17.</p> <p>A review of the significant change Minimum Data Set (MDS) assessment dated 11/28/17 indicated under Section J, 1900B that Resident #39 was coded as having 2 or more falls without major injury.</p> <p>On 04/25/18 at 9:28 AM an interview was conducted with the MDS Coordinator who stated she was responsible for coding Section J of the significant change MDS assessment dated 11/28/17 and miscoded that Resident #39 had a fall without major injury. The MDS coordinator stated she should have coded Section J1900C that Resident #39 had a fall with major injury. The MDS Coordinator stated Resident #39 had a fractured pelvis related to a fall in the facility. The MDS Coordinator stated she would need to modify the significant change MDS assessment dated 11/28/17 to indicate Resident #39 had a fall with major injury and transmit.</p> <p>On 04/25/18 at 10:16 AM an interview was conducted with the Director of nursing (DON) who stated her expectation was that the MDS Coordinator would have accurately coded the significant change MDS assessment dated 11/28/17 to reflect Resident #39 had a fall with major injury. The DON stated Resident #39 had a fractured pelvis related to a fall in the facility. The DON stated the MDS Coordinator completed a significant change MDS assessment on 11/28/17</p>	F 641	<p>performed on one MDS weekly x 4 weeks, two MDSs monthly x 3 months, then one MDS monthly for 12 months to ensure accurate coding.</p> <p>4. Tracking log will be reviewed by Director of Nursing or Assistant Director of Nursing and results will be reported during Quality Assurance Performance Improvement Committee, consisting of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Social Services Director, Admissions Director, Activity Director, Business Office Manager, Dietary Manager, Human Resources Manager, Maintenance Director, Environmental Services Supervisor, Medical Records, MDS Coordinator, Direct Care Licensed Nurse, and Direct Care CNA, meeting monthly x 12 months for follow up and/or recommendations.</p>		

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F 641	<p>Continued From page 6</p> <p>because Resident #39 had a fractured pelvis related to a fall in the facility. The DON stated her expectation was that the MDS Coordinator would modify the significant change MDS assessment dated 11/28/17 to indicate Resident #39 had a fall with major injury and transmit.</p> <p>On 04/25/18 at 10:23 AM an interview was conducted with the Administrator who stated her expectation was that the MDS Coordinator would have accurately coded the significant change MDS assessment dated 11/28/17 to reflect Resident #39 had a fall with major injury. The Administrator stated Resident #39 had fallen in the facility and fractured her pelvis. The Administrator stated her expectation was that the MDS Coordinator would modify the significant change MDS assessment dated 11/28/17 to indicate Resident #39 had a fall with major injury and transmit.</p> <p>3. Resident #84 was admitted to the facility on 02/01/13 with diagnoses that included dementia with behavioral disturbance and Alzheimer's disease.</p> <p>A physician's order dated 01/23/18 indicated a hospice consult related to end stage dementia was ordered for Resident #84.</p> <p>A review of hospice documentation indicated Resident #84 was admitted to hospice care on 01/26/18 and a hospice care agreement between the hospice provider and the facility had been</p>	F 641			

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F 641	<p>Continued From page 7 signed on the same day.</p> <p>A review of Resident #84's Quarterly Minimum Data Set (MDS) assessments dated 01/30/18 under Section O, O0100K indicated Resident #84 was not receiving hospice care.</p> <p>An interview was conducted with the Business Office Manager on 04/25/18 at 09:55 AM. She confirmed Resident #84 was admitted to hospice service on 01/26/18 and the services were ongoing.</p> <p>An interview was conducted with the MDS Coordinator on 04/25/18 at 10:19 AM. She confirmed she was responsible for coding Section O, O100K hospice status for Resident #84's Quarterly MDS dated 01/30/18. She stated she had not been made aware of Resident #84's admission to hospice in a timely manner. When she realized the significant changes, she immediately completed the Significant Change in Status Assessment (SCSA ) MDS on 04/02/18. Normally any significant changes among residents' status would be discussed in the morning meeting. She did not know why this information was missed out. She acknowledged that the Quarterly MDS dated 01/30/18 was miscoded and it should have indicated Resident #84 had enrolled in hospice care in a timely manner</p> <p>An interview was conducted with the Director of Nursing (DON) on 04/25/18 at 10:35 AM. The DON stated the MDS Coordinator was informed in the morning meeting following Resident #84's admission to hospice and it was her oversight for failing to complete the SCSA MDS on time as required. She indicated there was a staffing</p>	F 641			



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

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F 641	<p>Continued From page 8</p> <p>stability issues in the MDS office and it had affected its performance. She expected the MDS to be completed as required accurately and in timely manner.</p> <p>4. Resident #25 was admitted to the facility on 04/23/15. The annual Minimum Data Set (MDS) dated 02/13/18 indicated Resident #25 had diagnoses which included depression among others. The MDS also indicated Resident #25 had no cognitive impairment and was not taking an anti-depressant. The Care Area Assessment (CAA) also revealed Resident #25 had a "diagnosis of depression."</p> <p>Record review of physician's orders indicated Escitalopram (an antidepressant medication) 10 milligrams was scheduled to be given daily at 8:00AM from 11/28/17 until it was discontinued on 03/11/18.</p> <p>Record review of the Medication Administration Record (MAR) for February 2018 indicated Resident #25 received Escitalopram daily throughout the month.</p> <p>During an interview on 04/25/18 at 10:00 AM with the MDS Coordinator, she observed the MAR for February 2018 and the annual MDS dated 02/13/18 and verified Resident #25 had been on an antidepressant and the annual MDS was coded inaccurately. The MDS Coordinator stated antidepressant use should have been checked on the annual MDS.</p> <p>During an interview on 04/25/18 at 10:10 AM with the Director of Nursing, she stated her expectations were for the MDS to be accurately coded.</p>	F 641			

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F 641	<p>Continued From page 9</p> <p>Resident #74 was admitted to the facility on 11/30/17 with medical diagnoses that included dementia with behavioral disturbance, anxiety disorder and Parkinson's disease among others.</p> <p>A review of Resident #74's most recently recorded Minimum Data Set (MDS) dated 2/6/18 on 4/25/18 at 11:36 AM revealed Resident #74 was coded as receiving an antidepressant 7 of 7 days during the look-back period. Further review of the same MDS revealed no corresponding diagnoses of depression to support the administration of an antidepressant.</p> <p>A review of Resident #74's electronic physician orders from February 2018 revealed a physician order for Celexa, a medication classified as an antidepressant.</p> <p>During an interview with the MDS Coordinator on 4/26/18 at 10:29 AM revealed if a resident was coded as receiving an antidepressant 7 of 7 days on the MDS, then a diagnosis of depression should have been entered under section I of the MDS dated 2/6/18. She further reported there was not a diagnosis of depression coded under section I on the MDS dated 2/6/18 and stated it was a previous MDS nurse that had completed it. She then reported she did not know why a diagnosis of depression was coded.</p> <p>On 4/26/18 at 11:19 AM an interview with the Administrator revealed it was her expectation that MDS' be coded accurately and in accordance with regulation. She reported the issue would be handled and a correction made to include an appropriate diagnosis for all medications given to the resident.</p>	F 641			

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F 677 SS=D	<p>ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)</p> <p>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident/staff interviews, the facility failed to provide nail care to 1 of 2 sampled residents reviewed for activities of daily living (Resident #22).</p> <p>The findings included:</p> <p>Resident #22 was admitted to the facility 05/10/14 with diagnoses which included diabetes mellitus (DM), Parkinson's disease, and depression.</p> <p>An annually MDS dated 02/03/18 indicated resident's cognition was severely impaired and she required extensive staff assistance for all activities of daily living except eating and locomotion on and off units.</p> <p>A care plan that was last revised on 11/03/17 identified Resident #22 with self-care performance deficit. The care plan goal specified the resident would receive appropriate staff assistance for personal care. Interventions included extensive assist of staff for grooming that included the shaving of facial hair and nail care.</p> <p>Review of staffing records dated 04/20/18 revealed Resident #22 had received shower provided by Nurse Aide (NA) #1.</p>	F 677	<ol style="list-style-type: none"> <li>1. Resident #22 was assisted with bathing and did not receive nail care. Nursing aide that provide the assistance with bathing failed to communicate nail care needs to nurse on floor. Resident's fingernails and toenails were trimmed by licensed nurse.</li> <li>2. An audit of the condition of all current resident's fingernail and toenails was completed by May 14, 2018. All current residents' fingernails and toenails have been assessed for appropriate length and cleanliness. Fingernails and toenails were groomed immediately upon assessment.</li> <li>3. Nursing Aide shower sheets and weekly skin check sheets have been modified to reflect condition of fingernails and toenails. A log of residents' nail conditions will be maintained by Director of Nursing and Assistant Director of Nursing will be reviewed weekly x 4 weeks and monthly x 12 months.</li> <li>4. Tracking log will be reviewed by Director of Nursing or Assistant Director of Nursing and results will be reported during Quality Assurance Performance Improvement Committee, consisting of Medical Director, Administrator, Director</li> </ol>	5/14/18	

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NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN HOME HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 HERITAGE DRIVE HENDERSONVILLE, NC 28739</b>		
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F 677	<p>Continued From page 11</p> <p>An observation on 04/23/18 at 05:02 PM revealed all Resident #22's fingernails extended approximately 3-4 millimeter (mm) beyond her fingertips. In addition, the left and right big toe nails extended approximately 5 mm beyond her toe tips. All 5 nails on each hand and both big toe nails were not observed with brownish substances caked under each nail.</p> <p>Interview on 04/23/18 at 05:41 PM with Resident #22 revealed she was scheduled for shower 2 times weekly on the first shift of Tuesday and Friday. She stated she wanted her fingernails and toe nails to be trimmed but she did not know why it was not done. Normally the nurse would trim her fingernails as needed and she did not even have to ask for it. Resident #22 stated she could not recall how long she had not received nail care from the nursing staff and toe nail care from the foot doctor.</p> <p>An additional observation 04/24/18 at 09:06 AM and 04/25/18 at 08:47 AM revealed the fingernails remained unchanged in appearance and length. No brownish substances were observed underneath each nail. During the observation on 04/24/18 at 09:06 AM, Resident #22 reiterated that she wanted her nails to be trimmed.</p> <p>An observation was conducted on 04/25/18 at 11:20 AM with Nurse #1. Resident #22's nails remained as previously observed.</p> <p>An interview with Nurse #1 was conducted on 04/25/18 at 11:33 AM. She stated she was not aware of Resident#22's nail care needs, especially the need to trim the toe nails. She acknowledged that Resident #22's fingernails and toe nails were long and had not been trimmed for</p>	F 677	<p>of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Social Services Director, Admissions Director, Activity Director, Business Office Manager, Dietary Manager, Human Resources Manager, Maintenance Director, Environmental Services Supervisor, Medical Records, MDS Coordinator, Direct Care Licensed Nurse, and Direct Care CNA, meeting monthly x 12 months for follow up and/or recommendations.</p>		

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

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F 677	<p>Continued From page 12</p> <p>at least 3-4 weeks. She stated the NAs were supposed to assess skin and perform nail care as needed for residents during shower. For diabetic residents, NAs had to report identified nail care needs to the nurse as they were not allowed to provide nail care for this specific population. Fingernails of diabetic residents would be trimmed by the nurses but toe nails had to be trimmed by a podiatrist. Nurse #1 stated the NAs who had given shower to Resident #22 had failed to assess and/or communicate with the nurse regarding nail care needs. She added nurses who had provided care for Resident #22 on regular basis had failed to identify and provide/arrange nail care needs in a timely manner.</p> <p>Interview on 04/25/18 at 12:06 PM with Social Service Director (SSD) revealed Resident #22 was last visited by a podiatrist on 12/15/17. The next podiatrist visit was scheduled on 05/22/18. The SSD stated if a diabetic resident required toe nails clipping between scheduled foot doctor's visits, the facility would arrange the resident to receive services from a podiatrist in the nearby community. The SSD added Resident #22 did not have history of refusal of care.</p> <p>An interview was conducted with the Director of Nursing (DON) on 04/25/18 at 12:19 PM. The DON stated NAs who provided shower should evaluate and inform the nurse regarding diabetic residents' nail care needs. It was her expectation for all the residents who wanted to have nail care would receive nail care as needed by the appropriate staff in a timely manner.</p> <p>A phone interview was conducted with NA #1 on 04/25/18 at 04:08 PM. NA #1 confirmed she had given shower to Resident #22 on 04/20/18 and</p>	F 677			

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F 677	Continued From page 13 had observed long fingernails and toe nails. However, she had forgotten to report her observation to the nurse. She added she heard the foot doctor would visit the facility soon and admitted it was her oversight.	F 677			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)  §483.60(i) Food safety requirements. The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.  §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain regulatory temperatures for dairy products in 1 of 1 milk cooler.  Findings included:  Review of the facility Food Receiving and Storage policy statement initiated in 2001 and revised in July 2014 revealed the following:	F 812	1. Milk cooler was found not to be working properly. Temperature log prior to occurrence showed that cooler temperature was in compliance. Cooler seals were found to be ineffective with maintaining needed temperatures.  2. Milk cooler has the potential for this to occur again, so cooler was taken out of	4/27/18	

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F 812	<p>Continued From page 14</p> <p>Refrigerated foods must be stored below 41 degrees Fahrenheit unless otherwise specified by law.</p> <p>An initial tour of the kitchen with the Dietary Manager (DM) on 04/23/18 at 9:20 AM revealed the milk cooler had an external thermometer which read 42 degrees Fahrenheit (F). An observation inside the milk cooler revealed the internal thermometer also read 42 degrees F. The exterior cardboard boxes containing the half pint cartons of milk indicated the product was to be maintained between 34-40 degrees. Further observation inside the milk cooler revealed there were 3 cardboard boxes with small milk cartons. Three individual half pint cartons of milk were tested via thermometer and registered 41.2, 40.3 and 42 degrees. The milk included was 48 chocolate low fat half pint milk cartons, 33 whole milk half pint cartons, and 47 low fat milk half pint cartons.</p> <p>During an interview on 04/23/18 at 9:47 AM, the DM stated her expectation was for the milk cooler be in an appropriate temperature range. The DM also instructed the Dietary Aide (DA) to dispose of all the milk in the milk cooler.</p> <p>During an interview on 04/23/18 at 9:50 AM, the Dietary Aide (DA) stated there had been problems with the cooler seals in the past and they had been replaced in the past year.</p> <p>During an interview on 04/26/18 at 12:02 PM, the Administrator stated her expectations were for the milk cooler to be functioning correctly and within the proper temperature range.</p>	F 812	<p>use. Milk was removed and will be stored in main food cooler.</p> <p>3. Dietary manager will take the temperature of the milk daily to ensure that milk is within compliant temperature x 4 weeks, then weekly x 4weeks and then monthly.</p> <p>4. Tracking log will be reviewed by administrator and results will be reported during Quality Assurance Performance Improvement Committee, consisting of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Social Services Director, Admissions Director, Activity Director, Business Office Manager, Dietary Manager, Human Resources Manager, Maintenance Director, Environmental Services Supervisor, Medical Records, MDS Coordinator, Direct Care Licensed Nurse, and Direct Care CNA, meeting monthly x 12 months for follow up and/or recommendations.</p>		