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	345261	A. BUILDING _____ B. WING _____	C 05/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		6/22/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/15/2018

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F 584	Continued From page 1 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to repair stained floors around the base of toilets or repair broken grout around the base of toilets in resident bathrooms (#108, #401, #405, #408 and #412) and failed to repair floor tile that had separated or was broken in resident bathrooms (#401, #408 and #412) on 2 of 4 resident hallways. The facility also failed to repair a baseboard at the floor that had separated and pulled away from the wall between resident room #401 and #403 on 1 of 4 resident hallways (400 hall). Findings included: 1. a. Observations on 05/21/18 at 3:42 PM in the bathroom of resident room #108 revealed the grout was cracked around the base of the toilet with brown stains around the toilet on the floor. Observations on 05/23/18 at 8:46 AM in the bathroom of resident room #108 revealed the grout was cracked around the base of the toilet with brown stains around the toilet on the floor. Observations on 05/24/18 10:10 AM in the bathroom of resident room #108 revealed the grout was cracked around the base of the toilet with brown stains around the toilet on the floor. b. Observations on 05/21/18 at 2:24 PM in the bathroom of resident room #401 revealed the tile around the toilet was stained with brown stains. The observations also revealed the tile was cracked around the toilet.	F 584	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction Genesis HealthCare Alleghany Center does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency statements, facts, and conclusions that form the basis for the deficiency. 1. On 6/13/18 & 6/14/18, Maintenance Director repaired stained floors and broken grout around base of toilets and/or separated or broken floor tiles in bathrooms for rooms 401 & 408. The stained floors and broken grout around base of toilets and/or separated or broken floor tiles in bathrooms in rooms 108, 405 and 412 will be completed on or before 6/22/18. The baseboard b/w resident rooms 401 & 403 will be repaired on or before 6/22/18. 2. By 6/22/18 all remaining bathroom floors and baseboards b/w rooms will be audited by the Center Executive Director to assure in good repair without stains, broken grout, separated or broken floor tiles and baseboards.	

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F 584	Continued From page 2 Observations on 05/23/18 at 9:10 AM in the bathroom of resident room #401 revealed the tile around the toilet was stained with brown stains. The observations also revealed the tile was cracked around the toilet. Observations on 05/24/18 at 10:22 AM in the bathroom of resident room #401 revealed the tile around the toilet was stained with brown stains. The observations also revealed the tile was cracked around the toilet. c. Observations on 05/21/18 at 2:27 PM in the bathroom of resident room #405 revealed brown stains around the base of the toilet on the floor with a stale urine odor in the room. Observations on 05/23/18 at 9:13 AM in the bathroom of resident room #405 revealed brown stains around the base of the toilet on the floor with a stale urine odor in the room. Observations on 05/24/18 at 10:27 AM in the bathroom of resident room #405 revealed brown stains around the base of the toilet on the floor with a stale urine odor in the room. d. Observations on 05/21/18 at 2:35 PM in the bathroom of resident room #408 revealed brown stains around the base of the toilet. The observations also revealed floor tile was broken around the sides and back of the toilet. Observations on 05/23/18 at 9:25 AM in the bathroom of resident room #408 revealed brown stains around the base of the toilet. The observations also revealed floor tile was broken around the sides and back of the toilet.	F 584	3. On 6/15/18, the Center Executive Director reeducated the Maintenance Director on the importance of assuring bathroom floors remain free of stains, broken grout, separated/broken floor tiles and damaged baseboards between rooms. Findings/needed repairs will be completed or scheduled for completion by Maintenance Director on or before 6/22/18. 4. Center Executive Director will monitor one of three halls 3 x monthly x 3 months. Any issues noted as a result of monitoring will be reported to the Maintenance Director for repairs or scheduled for repairs. Center Executive Director will report findings to the Performance Improvement Committee every month x 3 months and ongoing as needed.	

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F 584	Continued From page 3	F 584		

Observations on 05/24/18 at 10:32 AM in the bathroom of resident room #408 revealed brown stains around the base of the toilet. The observations also revealed floor tile was broken around the sides and back of the toilet.

e. Observations on 05/21/18 at 2:42 PM in the bathroom of resident room #412 revealed brown stains around the base of the toilet. The observations also revealed floor tile had separated leaving gaps between the tiles around the sides and back of the toilet.

Observations on 05/23/18 at 9:30 AM in the bathroom of resident room #412 revealed brown stains around the base of the toilet. The observations also revealed floor tile had separated leaving gaps between the tiles around the sides and back of the toilet.

Observations on 05/24/18 at 10:35 AM in the bathroom of resident room #412 revealed brown stains around the base of the toilet. The observations also revealed floor tile had separated leaving gaps between the tiles around the sides and back of the toilet.

2. Observations on 05/22/18 at 11:15 AM revealed damaged baseboard at the floor between resident rooms #401 and #403 on the 400 hall. The observations also revealed an open gap in the baseboard where it had separated and had pulled away from the sheetrock on the wall.

Observations on 05/23/18 at 9:35 AM revealed damaged baseboard at the floor between resident rooms #401 and #403 on the 400 hall. The

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F 584	Continued From page 4	F 584		

observations also revealed an open gap in the baseboard where it had separated and had pulled away from the sheetrock on the wall.

Observations on 05/24/18 at 10:42 AM revealed damaged baseboard at the floor between resident rooms #401 and #403 on the 400 hall. The observations also revealed an open gap in the baseboard where it had separated and had pulled away from the sheetrock on the wall.

An environmental tour was conducted on 05/25/18 at 2:13 PM with the Maintenance Supervisor and the Housekeeping Manager. The Maintenance Supervisor explained the facility utilized a work order system and staff were expected to complete work orders for anything that needed repair. He stated the work orders were prioritized but emergencies were handled first before any other work was done. He confirmed he did not have any renovation projects underway at the present time and took care of the work orders as he had time.

During an interviews on 05/25/18 at 2:20 PM, the Maintenance Supervisor confirmed the bathroom floor in resident room #412 needed to be re-done because of stains on the floor and around the base of the toilet. He stated it was his expectation for staff to report when they saw stains around the base of toilets or damaged tile on the bathroom floors. He verified he was not aware of the damaged baseboard between resident room #401 and #403.

During an interview on 05/25/18 at 2:43 PM, the Housekeeping Manager stated it was a challenge to keep resident bathrooms clean. He further stated he expected for staff to clean around the

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F 584	Continued From page 5 base of toilets in the bathroom but when the floor was stained or the grout was damaged they needed to be repaired or replaced. During an interview on 05/25/18 at 2:53 PM, the Administrator stated it was ongoing process to keep repairs made and to keep the building clean. She explained it was her expectation for staff to report repairs that needed to be made and they should complete work orders for repairs to be done.	F 584		
F 641 SS=D	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 reviews and staff interviews the facility failed to code a Minimum Data Set to accurately reflect a resident's range of motion for upper extremities (Resident #268). Findings included: Resident #268 was admitted to the facility on 08/03/01 with diagnoses which included in part brain damage, contractures of the hands and depression. A review of a care plan with a revised date of 10/14/16 indicated Resident #268 had a self-care deficit due in part to contractures and impaired range of motion to both upper extremities and required assistance with activities of daily living (ADL). The goal further indicated Resident #268's ADL care needs would be anticipated and	F 641	1. On 6/13/18 a modification of the annual Minimum Data Set dated 9/6/17 was completed by the Clinical Reimbursement Coordinator to correct the inaccurate coding in the range of motion (Section G) of upper and lower extremities for resident #268. 2. On 6/13/18, the Clinical Reimbursement Coordinator was re-educated by the Center Executive Director to assure all sections of the MDS are coded accurately for all residents. 3. To assure the range of motion section of the most recent MDS (Section G) is coded correctly, all current residents will be reassessed by the Center Nurse Executive or the Assistant Center Nurse	6/22/18

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F 641	Continued From page 6 met in order to maintain the highest practicable level of functioning and physical well-being. The interventions were listed in part for staff to complete all ADL care and maintain good body alignment. A review of the annual Minimum Data Set (MDS) dated 09/06/17 indicated Resident #268 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #268 was totally dependent on staff for ADLs and the range of motion for Resident #268 was coded as no impairment for upper extremities and impairment of lower extremities on both sides. A review of the quarterly MDS dated 03/06/18 revealed the range of motion for Resident #268's upper extremities was coded as impairment on both sides and no impairment of lower extremities on both sides. During an interview on 05/25/18 at 3:14 PM, the Clinical Reimbursement Coordinator (CRC) explained she had been working at the facility since November 2017 and was responsible for the sign off of the resident's MDS. She confirmed she completed the section for range of motion for Resident #268's quarterly MDS dated 03/06/18 and coded her upper extremities as impairment on both sides based on her observations and assessment of Resident #268. After review of the annual MDS dated 09/06/18 she stated the range of motion section had been coded incorrectly as no impairment of upper extremities but impairment of lower extremities on both sides. She explained a nurse who had filled in to code MDs's on as needed basis had completed that	F 641	Executive on or before 6/22/18 and compared to the most recent MDS. Any negative findings will be modified by Clinical Reimbursement Coordinator as reported. 4. The Center Nurse Executive will audit section G of the MDS for 20% of all current residents 1 x monthly x 3 months. Findings will be reviewed and Center Nurse Executive will report findings to Performance Improvement Committee every month x 3 months and on-going as needed.	

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F 641	Continued From page 7 section of the MDS. During an interview on 05/25/18 at 3:30 PM, the Director of Nursing stated she was not familiar with coding of the resident's MDS. During an interview on 05/25/18 at 4:13 PM, the Administrator explained the facility organizational chart indicated MDS staff reported to nursing administration. She stated it was her expectation when the MDS nurse signed off on the MDS it was completed accurately.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and physician and staff interviews the facility failed to assess the size or appearance of a wound for a resident who had a slit in the skin on the underside of his penis (Resident #55). Findings included: Resident #55 was re-admitted to the facility on 12/29/17 with diagnoses which included brain injury, chronic respiratory failure, neuromuscular dysfunction of the bladder (disease of nerves in	F 684	1. On 6/15/18 a full body skin assessment was completed for resident #55 by the Center Nurse Executive and the Assistant Center Nurse Executive to assure all wounds/skin areas present were assessed and documented. 2. Full body skin assessments for all current residents will be completed on or before 6/22/18 by the Center Nurse Executive, the Clinical Reimbursement Coordinator and/or the Assistant Center	6/22/18

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F 684	Continued From page 8 the bladder to control urination), failure to thrive, contractures and muscle spasms, chronic respiratory failure and chronic pain. A review of a significant change Minimum Data Set (MDS) dated 01/29/18 indicated Resident #55 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #55 was totally dependent on staff for activities of daily living and had an indwelling urinary catheter. A review of a care plan created by Nurse #2 and dated 02/16/18 indicated in part Resident #55 had actual skin breakdown related to incontinence and indwelling catheter. A goal revealed the wound would remain free from signs and symptoms of infection and the intervention were listed as indwelling catheter was removed, evaluate wound area daily including surrounding tissue and presence or absence of drainage or infection and/or new wound pain and report to physician as indicated. A review of a nurse's progress note dated 02/16/18 at 1:50 AM documented by Nurse #2 indicated Resident #55 had a change in condition. The notes revealed symptoms included a skin wound or ulcer on Resident #55's penis and the change had been reported to the physician on 02/16/18 at 1:00 AM. The notes further revealed orders were obtained to discontinue indwelling catheter and monitor urinary output and a message was left for Resident #55's responsible party (RP) to return call. A review of a skin check document in Resident #55's electronic medical record dated 02/16/18 at	F 684	Nurse Executive to assure any wounds/skin areas present are assessed and documented. 3. Nursing staff will be reeducated on or before 6/22/18 by the Assistant Center Nurse Executive to assure wounds/skin concerns are assessed and documented appropriately. 4. The Center Nurse Executive or Assistant Center Nurse Executive will perform random full body skin assessments on 20% of all residents 2 x monthly x 1 month then 1 x monthly x 2 months. Findings will be reviewed and Center Nurse Executive or Assistant Center Nurse Executive will report findings to Performance Improvement Committee 1 x monthly x 3 months and on-going as needed.	

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1:50 AM indicated a skin and tissue tear on Resident #55's penis. The notes further indicated the indwelling catheter was removed and continue to monitor urinary output but there was no assessment as to the size or appearance of the wound.

A review of a skin check document dated 02/16/18 at 3:54 PM indicated a skin injury/wound had been identified on Resident #55's penis but there was no assessment of the size or appearance of the wound.

A review of a skin check document dated 02/17/18 at 1:50 PM indicated Resident #55 was voiding without difficulty but there was no assessment of the size or appearance of the wound on Resident #55's penis.

A review of a nurse's progress note dated 02/17/18 at 6:18 PM documented by Nurse #3 indicated follow up note for change in condition but there was no assessment of the size or appearance of the wound on Resident #55's penis.

A review of a nurse's progress note dated 02/18/18 at 1:50 PM documented by Nurse #3 indicated area to penis continued to have no noted swelling or odor but there was no assessment of the size of the wound.

A review of a skin check document dated 02/18/18 at 5:45 PM indicated to continue to monitor penis but there was no assessment of the size or appearance of the wound on Resident #55's penis

A review of a facility document titled

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Grievance/Concern Form dated 02/19/18 indicated Resident #55's RP requested determination as to what had caused the area on Resident #55's penis. A section labeled actions taken to investigate the grievance/concern was to speak to the physician, speak with nurse and hall staff, treat resident and provide in-services as needed.

A review of a physician's progress note dated 02/20/18 indicated Resident #55's physician who was also the facility Medical Director made rounds to evaluate Resident #55. The notes revealed staff reported Resident #55's RP had increased concerns about redness on his penis and wondered if it was due to trauma. The notes further revealed Resident #55's indwelling catheter was removed 4-5 days ago and he was urinating without difficulty. The physician's notes indicated Resident #55 had a history of genital herpes (viral infection) and received Acyclovir (antiviral medication). A section under assessments labeled Genitourinary indicated erythema (redness) of penis with 3 vesicles (blisters) with ulcerated lesions and a ventral (underneath) slit with an inflamed ulcer. The note revealed a recommendation to increase Acyclovir for 5 days then return to daily suppressive treatment and apply Mycolog cream and monitor. The notes further revealed Resident #55 may see urology for follow up if RP desired.

A review of a physician's order dated 02/20/18 indicated to change Acyclovir to 10 milliliters via PEG (stomach tube) 3 times a day for 5 days then daily for genital herpes and Mycolog cream to penis 2 times a day for 10 days.

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A review of a skin check document dated 02/23/18 at 3:54 PM indicated blisters to penis but there was no assessment of the ventral slit on Resident #55's penis.

A section of the Grievance/Concern Form labeled Recommended Corrective Actions indicated a phone conversation was conducted with the RP 02/26/18 who voiced no further concerns. A letter attached to the Grievance/Concern Form indicated in part the Medical Director had seen Resident #55 and they were starting a new treatment.

A review of a Nurse Practitioner (NP) progress note dated 03/22/18 in a section labeled Genitourinary revealed erythema of penis with 3 vesicles and ulcerated lesions and a ventral slit on Resident #55's penis with an inflamed ulcer.

A review of a physician's progress note dated 04/17/18 revealed in a section labeled Genitourinary indicated erythema of penis with 3 vesicles with ulcerated lesions and a ventral slit with an inflamed ulcer.

A review of a physician's progress note dated 04/24/18 revealed in a section labeled Genitourinary indicated erythema of penis with 3 vesicles with ulcerated lesions and a ventral slit with an inflamed ulcer.

A review of a NP progress note dated 05/15/18 indicated Resident #55 was seen on rounds and a section labeled Genitourinary indicated erythema of penis with 3 vesicles with ulcerated lesions and a ventral slit with an inflamed ulcer.

During an observation of resident care on

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05/24/18 at 10:10 AM NA #3 and NA #4 provided care to Resident #55 to prepare him for a shower. NA #4 opened Resident #55's brief and there was a split of the skin on the right underside of his penis from the end of the penis down to the shaft approximately 1 inch in length. The observations also revealed several blisters and redness on Resident #55's penis.

During an interview on 05/24/18 at 1:30 PM, Nurse #3 explained Resident #55 had a condom catheter in the past but it was a problem because every time they changed it his skin was irritated. She stated then he had orders for an indwelling catheter because he was unable to urinate. She explained she worked until 7:00 PM on 02/15/18 and came back the next morning and heard in report from Nurse #2 that when staff had provided care to Resident #55 the skin on his penis was split. She stated she did not understand why the skin had split and she could find no reason for it. She further explained she put a note for the physician to look at it during her next round. She confirmed the physician saw Resident #55 during rounds the next Tuesday on 02/20/18 and was told Resident #55 had an active herpes flair up which had caused the opening in the skin on his penis. She stated his indwelling catheter had already been removed and they had not put one back in since then. She verified the facility did not have a wound nurse but nurses were responsible to do wound assessments and the Director of Nursing documented wound measurements.

During a telephone interview on 05/24/18 at 1:56 PM, the NP explained she saw Resident #55 after the physician saw him for the skin tear on his penis but was not sure what had caused the tear.

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She stated it was difficult to heal skin breakdown for Resident #55 due to malnutrition issues.

During an interview on 05/24/18 at 2:04 PM, NA #3 stated she was usually assigned to Resident #55's care on day shift. She explained she recalled Resident #55 had a condom catheter in the past but that didn't stay on so they switched to an indwelling catheter when Resident #55 was unable to urinate. She verified she worked day shift on 02/15/18 from 6:30 AM until 6:30 PM with NA #4 and they provided care to Resident #55 that day and he was fine when they finished their shift and had no skin tear to his penis. She explained when she and NA #4 came to work the next morning on 02/16/18 NA #5 told them in report Resident #55 did not have an indwelling catheter anymore but she did not say why. She stated when she and NA #4 provided incontinent care to Resident #55 they saw the tear on his penis and reported it to Nurse #3.

During an interview on 05/24/18 at 5:37 PM, NA #5 explained Resident #55 was supposed to be turned every 2 hours and she had to have help when she turned him. She stated she received report before her shift started at 7:00 PM on 02/15/18 and there was no report Resident #55 had a skin tear on his penis. She stated when she made her first round on 02/15/18 she did not see a tear on his penis. She explained she made a second round around 8:30 or 9:00 PM and they had to pull him up in bed because he slid down toward the foot of the bed. She stated there was a clip on his catheter and she thought it was clipped to the sheet but she did not see a skin tear on his penis during these rounds. She explained Resident #55 had spasms and he jerked his arms and legs when they turned him

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sometimes and she had not seen him put his hands down to his waist or pull on the catheter. She explained after midnight on 02/16/18 Nurse #2 assisted her to check and change Resident #55 and when she opened his brief she saw the skin tear on his penis. She stated it looked like a split in the skin and she had not seen it before. She further explained Resident #55 did not seem to be in pain and there was no bleeding.

During an interview on 05/24/18 at 6:34 PM, Nurse #2 explained Resident #55 had a condom catheter in the past but it kept falling off and it irritated his skin. She stated then Resident #55 stopped urinating so they put the indwelling catheter in. She further stated she had received no report at shift change on 02/15/18 that Resident #55 had a skin tear on his penis. She explained she made rounds with NA #5 between midnight and 1:00 AM after she finished giving medications and treatments. She stated she and NA #5 went into Resident #55's room and when they pulled the covers back she saw a skin tear on his penis and there was redness. She explained she called for the Charge Nurse to look at his skin while she called the physician and was told to take the catheter out. She verified the Charge Nurse no longer worked at the facility. She stated she also made a note on the physician's rounds sheet for the physician to see Resident #55 on next rounds. She explained she removed the indwelling catheter and there was no bleeding except for a tiny amount in his brief and he did not seem to be in pain. She stated she was surprised to see the skin tear but he also had a herpes outbreak at that time with blisters on his penis. She explained NA #5 usually got help from an adjacent hall because Resident #55 had to be turned by 2 staff because of spasms of his

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extremities. She stated another nurse did the weekly wound assessments because she could not do them. She confirmed she did not do wound measurements or any other description in her notes regarding the skin tear on Resident #55's penis. She explained the physician saw Resident #55 during her next rounds and ordered cream and it was her understanding the physician stated the skin tear came from the herpes outbreak.

During an interview on 05/25/18 at 10:00 AM, the DON confirmed the night shift Charge Nurse no longer worked at the facility. She explained she heard about the open skin on Resident #55's penis after 02/16/18 and the physician saw it on 02/20/18 during rounds. She explained the physician said it was due to an outbreak of herpes.

During a telephone interview on 05/25/18 at 10:25 AM the physician explained she was asked to see Resident #55 on rounds for an area on the end of his penis. She stated she saw an area when she examined him and there was an ulcerated lesion on the tip of his penis. She explained Resident #55 had active herpes and had been on chronic suppressive treatment. She stated it was hard to say if the indwelling catheter had caused the split in the skin on his penis or if the herpes had caused it because the tissue was friable and was at risk to tear. She explained when she examined Resident #55 on 02/20/18 there was a lot of swelling and redness but there was no bleeding or drainage. She stated she would think it was painful but the only way they could tell when he was in pain was when he grimaced and he was not grimacing during her exam except when he was repositioned. She stated it was her

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expectation for nurses to assess wounds which included measurements and descriptions of wounds.

During a follow up interview and observation on 05/25/18 at 11:50 AM, the DON stated she had not seen the slit recently on Resident #55's penis. The DON and Nurse #3 went into Resident #55's room and repositioned him on his back and opened resident's brief. The DON and Nurse #3 verified there was a slit in the skin approximately 1 inch from the head of Resident #55's penis down to the top portion of the shaft. The DON and Nurse #3 stated the split of the skin was not what they had seen when it was first reported on 02/16/18. They explained when they first saw it there was a herpes lesion farther down on the shaft of the penis that had now healed. Nurse #3 stated the physician had told them the lesion they saw before was caused by herpes.

During a follow up interview on 05/25/18 at 1:54 PM, the DON stated it was her expectation for wounds to be assessed and documented. She confirmed there were no measurements of the slit in the skin on Resident #55's penis or descriptions of the wound documented in the progress notes or on the skin checks.

During an interview on 05/25/18 at 4:13 PM, the Administrator stated she had conducted an investigation after the incident which was reported to her of the open skin on Resident #55's penis. She stated the physician had assessed the area and she had been told it was due to herpes. She further stated it was her expectation for nurses to assess wounds and document their assessments.

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F 800	Continued From page 17	F 800		
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure food was covered during transportation and distribution to the residents on 2 of 4 halls. The findings were: On 05/21/18 at 12:17 PM a meal cart was brought to 100 hall and parked between rooms 101 and 103. Nurse Aide (NA) #3 removed a meal tray from the cart and walked with the tray to room 112. The meal tray had a dome lid over the plate of food and two bowls of food which did not have lids or plastic wrap over them. On 05/21/18 at 12:18 PM a NA #4 removed a meal tray from the meal cart and walked with the tray to room 113. The meal tray had a dome lid over the plate of food but did not have a lid or plastic wrap over the bowl of fruit. On 05/23/18 at 11:45 AM during the kitchen observation task, the meal cart for 300 hall was in the process of being loaded for delivery to 300 hall. The meal tray for room 306 was observed to have a dome lid over the plate of food but the bowl of pureed peaches was left without a cover over it.	F 800	1. On 6/6/18 dietary staff were reeducated by the Regional Food Service Director on assuring all bowls containing foods to be served are covered prior to and during transportation and distribution to residents. 2. On 6/14/18 Cooks for dining services were reeducated on the importance of monitoring assistants regularly to assure all bowls containing foods to be served are covered prior to and during transportation and distribution to residents. 3. On 6/14/18 Cooks for dining services were reeducated on the importance of monitoring assistants regularly to assure all bowls containing foods to be served are covered prior to and during transportation and distribution to residents. 4. Regional Food Service Director, Assistant Food Service Director or assigned Cook will monitor meal service 1 x weekly x 1 month then 2 x monthly x 1 month then 1 x monthly x 1 month to	6/22/18

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F 800	Continued From page 18 On 05/23/18 at 12:15 PM the meal cart for 300 hall was taken to 300 hall and parked near room 301. NA #2 removed a meal tray from the cart which had a dome lid over the plate of food and a bowl of puree peaches that did not have a covering over it and walked with the tray to room 306. On 05/23/18 at 12:40 PM the meal cart for 100 hall was parked near rooms 104 and 105. NA #5 removed a meal tray from the cart which had a dome lid over the plate of food and a bowl of cottage cheese that did not have a covering over it and walked with the tray to room 113. NA #5 then removed a tray from the meal cart and walked with the tray to room 106. The tray had a dome lid over the plate of food and a bowl of peaches that did not have a covering over it. On 05/23/18 at 3:34 PM during an interview with NA #2 she stated she was aware that the food served in bowls did not have coverings on them and it had been that way since she had been employed (10 months). On 05/24/18 at 4:25 PM during an interview with the Infection Control Nurse (ICN) she stated she was not aware that the trays delivered to the halls did not have coverings over the bowls of food. The ICN stated her expectation would be for the bowls of food to be covered because the food should not be open to air. On 05/25/18 at 10:55 AM during an interview with the Food Service Director (FSD) revealed she was aware that some food items were served uncovered in bowls to the residents and that the meal cart should be considered a closed	F 800	assure aides have covered all bowls containing foods to be served prior to transportation and distribution to residents. Any negative findings as a result of monitoring and observation will be reported to Center Executive Director and the Center Executive Director will report to Process Improvement Committee. Findings will be addressed by the Process Improvement Committee q month x 3 months and ongoing as needed.	

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F 800	Continued From page 19 container. An interview was conducted with NA #5 on 05/25/18 at 11:37 AM who stated she was aware the bowls of food on the meal trays never had lids on them but the plate of food did. She admitted she had never questioned why but that she would cover them from now on. On 05/25/18 at 3:44 PM during an interview with the Administrator she stated she expected the bowls served with food to be covered.	F 800		
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 discard expired food items,	F 812	1. On 5/25/18 the Food Service Director inspected to assure no expired food items	6/22/18

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F 812	Continued From page 20 maintain food item expiration dates and maintain proper seal on opened food with expiration date in 1 of 1 walk in refrigerator. The facility also failed to ensure food was properly sealed in 1 of 1 walk in freezer, failed to remove expired food items from shelves in 1 of 1 dry storage room and failed to properly label food item in 1 of 2 nourishment room refrigerators during 1 of 2 kitchen task observations. The facility further failed to ensure staff distributed and served food under sanitary conditions on 1 of 4 halls. The findings included: a. On 05/21/18 at 10:20 AM during the initial tour of the kitchen with the Food Service Director (FSD) the following observations were noted: the walk in refrigerator contained 3 unopened 2 pound tubs of strawberry flavored yogurt with the use by date of 05/15/18, (6) 16 ounce chicken base and (2) 16 ounce beef base containers with no expiration dates, ¼ opened bag of sausage links without opened or expiration dates. Observation of the walk in freezer revealed a large tray of cheese manicotti layered out on a tray that had plastic loosely placed over it and dated 05/06/18. The FSD stated she should throw the outdated and opened food items away because she would not want them served to her. Continued observation during the same initial tour of the kitchen revealed the following observation of the dry storage room: (8) 46 ounce cartons of nectar thickened orange juice with expiration dates of 12/04/17, 01/23/18, 01/31/18 and 03/20/18. (6) 46 ounce cartons of honey thickened orange juice with expiration dates of 01/23/18. (21) 46 ounce cartons of nectar thickened tea with lemon with expiration dates of	F 812	were present in all areas of the kitchen, food items in the freezer were sealed properly and all food items in the nourishment room refrigerators were labeled appropriately. On 5/22/18, the Center Nurse Executive and the Nurse Practice Educator distributed individual bottles of hand sanitizer to nursing staff to use between resident rooms and while passing trays. 2. On 6/6/18 the Regional Food Service Director re-educated dietary staff on assuring all food items are removed from all areas of the kitchen prior to expiration date, all items in nourishment refrigerators are labeled appropriately and that all items in the freezer are sealed properly. On or before 6/21/18 nursing staff will be reeducated by Center Nurse Executive or Assistance Center Nurse Executive to assure hand sanitation is performed appropriately between residents during meal times. 3. Regional Food Service Director and all Cooks will be reeducated on or before 6/22/18 by Center Executive Director, Center Nurse Executive or Assistant Center Nurse Executive to assure food items are removed from all areas of the kitchen prior to expiration date, all items in nourishment refrigerators are labeled appropriately and that all items in the freezer are sealed properly. The Center Nurse Executive or Assistant Center Nurse Executive will re-educate nursing staff on or before 6/22/18 to assure the appropriate use of hand sanitizer in	

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F 812	Continued From page 21 03/20/18, 04/10/18 and 04/16/18. (10) 46 ounce cartons of nectar thickened apple juice with expiration dates of 03/13/18 and 04/09/18. (5) 46 ounce cartons of nectar thickened cranberry juice with expiration date of 04/06/18. Lastly, there was an unopened box of coconut flakes which had a delivery date of 08/18/17 but had no expiration date. The FSD who was present during the tour stated it was every body's responsibility to check expiration dates every day and that it was a "closing" task meaning it should be done before staff went home. On 05/22/18 at 4:09 PM observation of the Nourishment Room freezer on 200 hall revealed a 16 ounce cottage cheese container which was opened but the substance in the container was not cottage cheese. The container was removed by Nurse #1. During an interview with the District Food Service Manager (DFSM) on 05/23/18 at 10:35 AM he stated it was dietary's responsibility to stock and move out foods according to the expiration dates for the refrigerators on the units. The DM added that everyone should check the freezer, refrigerator and dry storage room for expired foods but ultimately it was the responsibility of the FSD. During an interview with the Administrator on 05/25/18 at 3:44 PM she stated her expectation for the expired foods in the kitchen and nourishment room were to be removed before they were expired. b. On 05/23/18 at 12:15 PM the meal cart was delivered to hall 300 where nurse aide (NA) #2 began to pass out the hall trays. NA #2 was	F 812	between residents while serving meal trays. 4.Regional Food Service Director, Assistant Food Service Director, Center Executive Director or Center Nurse Executive will monitor that food items are removed from all areas of the kitchen prior to expiration date, all items in nourishment refrigerators are labeled appropriately and that all items in the freezer are sealed properly 1 x weekly x 1 month, 2 x monthly x 1 month and 1 x monthly x 1 month. Center Nurse Executive or Assistant Center Nurse Executive will monitor nursing staff on random halls while serving meal trays to assure using hand sanitizer appropriately between residents 1 x weekly x 1 month, 2 x monthly x 1 month and 1 x monthly x 1 month. Center Nurse Executive or Assistant Center Nurse Executive will review finding and present to Performance Improvement Committee 1 x monthly x 3 months and on-going as needed.	

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observed to give the resident in room 306 his tray but before doing so she moved cups of liquids out of the way in order to place the tray on his over bed table. NA #2 did not use hand sanitizer after she came out of room 306 and before she removed another tray from the cart. Another observation of NA #2 noted her to remove a tray from the meal cart and walked with it to room 311. Before NA #2 placed the tray on the resident's over bed table she moved cups of fluids in order to make a place to put the resident's meal tray. NA #2 did not use hand sanitizer before she removed another tray from the meal cart.

During an interview with NA #2 on 05/23/18 at 3:34 PM revealed she had only been employed by the facility for 10 months. In that interview she stated she did not know that she needed to use hand sanitizer between each resident when she passed out the meal trays but she became aware of it after the surveyor watched her pass out the trays.

On 05/24/18 at 4:25 PM during an interview with the Infection Control Nurse (ICN) she stated she had educated the staff to use hand sanitizer between each resident and if they touched anything in the resident's room. The ICN stated she requested that hand sanitizers be mounted in the halls about 6 months ago and was told the property manager would have to approve it. She further stated she had not heard anything else about it.

On 05/25/18 at 3:44 PM during an interview with the Administrator she stated she would expect the staff to use hand sanitizer after they had touched anything in a resident's room while they were

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F 812	Continued From page 23 passing out their trays.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure garbage and refuse was disposed of properly for 1 of 2 dumpsters. The findings included: On 05/23/18 at 11:10 AM during a tour of the dumpster area an observation was made of the cardboard dumpster which was broken. The top of the dumpster had two lids of which the lid on the right was broken and missing. Observations revealed cardboard items were protruding from the top of the dumpster where the missing lid should be. On 05/24/18 at 10:23 AM an observation of the dumpster revealed the cardboard dumpster was empty but the right lid of the dumpster remained missing. During an interview with the District Food Service Manager (DFSM) on 05/24/18 at 10:23 AM revealed it was the responsibility of the Maintenance Department to call the garbage company for problems with the dumpsters. On 05/24/18 at 2:19 PM during an interview with the Maintenance Supervisor (MS) he stated he was aware of the cardboard dumpster lid having a crack but was not aware that the lid had broken	F 814	1. Lid to cardboard dumpster was replaced with new lid on 5/24/18. 2. On 5/24/18, Center Nurse Executive reeducated Maintenance Director that dumpster lids should be replaced if found to be broken or damaged. 3. On 5/25/18, Maintenance Director inspected all other dumpsters to assure lids were in good repair. No other issues noted. 4. Environmental Services Director will audit all dumpster lids 1 x weekly x 1 month then 2 x monthly x 1 month then 1 x monthly x 1 month. Findings will be reviewed by, and presented to Performance Improvement Committee, by Environmental Services Director and addressed by Performance Improvement Committee 1 x monthly x 3 months and on-going as needed	6/22/18

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F 814	Continued From page 24 off. The MS stated that the garbage company had been called several times and every time he was told they would take care of it. On 05/25/18 at 3:44 PM during an interview with the Administrator she stated the MS told her about 2 months ago that the dumpster lid was broken. The Administrator stated that although she had no other choice but to use the garbage company they currently utilized she had given the MS specific instructions to call the garbage company and demand a new dumpster be delivered to the facility.	F 814		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,	F 842		6/22/18

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

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

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

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

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F 842	Continued From page 26 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and physician and staff interviews the facility failed to document the dimensions or a description of a wound for a resident who had a slit in the skin on the underside of his penis (Resident #55). Findings included: Resident #55 was re-admitted to the facility on 12/29/17 with diagnoses which included brain injury, chronic respiratory failure, neuromuscular dysfunction of the bladder (disease of nerves in the bladder to control urination), failure to thrive, contractures and muscle spasms, chronic respiratory failure and chronic pain. A review of a significant change Minimum Data Set (MDS) dated 01/29/18 indicated Resident #55 had short term and long term memory problems and was severely impaired in cognition for daily decision making. The MDS also indicated Resident #55 was totally dependent on staff for activities of daily living and had an indwelling urinary catheter. A review of a care plan created by Nurse #2 and dated 02/16/18 indicated in part Resident #55 had actual skin breakdown related to incontinence and indwelling catheter. A goal revealed the wound would remain free from signs and symptoms of infection and the intervention were listed as indwelling catheter was removed and evaluate wound area daily including surrounding tissue and presence or absence of drainage or	F 842	1. On 6/15/18 a full body skin assessment was completed for resident #55 by the Center Nurse Executive and the Assistant Center Nurse Executive to assure all wounds/skin areas present were assessed and documented. 2. Full body skin assessments for all current residents will be completed on or before 6/22/18 by the Center Nurse Executive, the Clinical Reimbursement Coordinator and/or the Assistant Center Nurse Executive to assure any wounds/skin areas present are assessed and documented. 3. Nursing staff will be reeducated on or before 6/22/18 by the Assistant Center Nurse Executive to assure wounds/skin concerns are assessed and documented appropriately. 4. The Center Nurse Executive or Assistant Center Nurse Executive will perform random full body skin assessments on 20% of all residents 2 x monthly x 1 month then 1 x monthly x 2 months. Findings will be reviewed by, and presented to Performance Improvement Committee by Center Nurse Executive and Assistant Center Nurse Executive and addressed by Performance Improvement Committee 1 x monthly x 3 months and on-going as needed.	

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infection and/or new wound pain and report to physician as indicated.

A review of a nurse's progress note dated 02/16/18 at 1:50 AM documented by Nurse #2 indicated Resident #55 had a change in condition. The notes revealed symptoms included a skin wound or ulcer and the change had been reported to the physician on 02/16/18 at 1:00 AM. The notes further revealed orders were obtained to discontinue indwelling catheter and monitor urinary output and a message was left message for Resident #55's responsible party (RP) to return call.

A review of a skin check document in Resident #55's electronic medical record dated 02/16/18 at 1:50 AM indicated a skin and tissue tear. The notes further indicated skin and tissue was torn on the head of Resident #55's penis and the indwelling catheter was removed and monitor urinary output however, there was no documentation as to the size or appearance of the wound.

A review of a skin check document dated 02/16/18 at 3:54 PM indicated a skin injury/wound had been identified on Resident #55's penis but there was no description of the size or appearance of the wound.

A review of a skin check document dated 02/17/18 at 1:50 PM indicated Resident #55 was voiding without difficulty but there was no description of the size or appearance of the wound on Resident #55's penis.

A review of a nurse's progress note dated 02/17/18 at 6:18 PM documented by Nurse #3

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indicated follow up note for change in condition but there was no description of the size or appearance of the wound on Resident #55's penis.

A review of a nurse's progress note dated 02/18/18 at 1:50 PM documented by Nurse #3 indicated area to penis continued to have no noted swelling or odor but there was no description of the size of the wound.

A review of a skin check document dated 02/18/18 at 5:45 PM indicated to continue to monitor penis but there was no description of the size or appearance of the wound on Resident #55's penis

A review of a facility document titled Grievance/Concern Form dated 02/19/18 indicated Resident #55's RP requested determination as to what had caused the area on Resident #55's penis.

A review of a physician's progress note dated 02/20/18 indicated Resident #55's physician who was also the facility Medical Director made rounds to evaluate Resident #55's penis. The notes revealed staff reported Resident #55's RP had increased concerns about redness and wondered if it was due to trauma. The notes further revealed Resident #55's indwelling catheter was removed 4-5 days ago and he was urinating without difficulty. The physician's notes indicated Resident #55 had a history of genital herpes (viral infection) and received Acyclovir (antiviral medication). A section under assessments labeled Genitourinary indicated erythema (redness) of penis with 3 vesicles (blisters) with ulcerated lesions and a ventral

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(underneath) slit with an inflamed ulcer.

A review of a skin check document dated 02/23/18 at 3:54 PM indicated blisters to penis but there was no description or appearance of the ventral slit on Resident #55's penis.

A review of a Nurse Practitioner (NP) progress note dated 03/22/18 in a section labeled Genitourinary revealed erythema of penis with 3 vesicles and ulcerated lesions and a ventral slit on Resident #55's penis with an inflamed ulcer.

A review of a physician's progress note dated 04/17/18 revealed in a section labeled Genitourinary erythema of penis with 3 vesicles with ulcerated lesions and a ventral slit with an inflamed ulcer.

A review of a physician's progress note dated 04/24/18 revealed in a section labeled Genitourinary erythema of penis with 3 vesicles with ulcerated lesions and a ventral slit with an inflamed ulcer.

A review of a NP progress note dated 05/15/18 indicated Resident #55 was seen on rounds and a section labeled Genitourinary indicated erythema of penis with 3 vesicles with ulcerated lesions and a ventral slit with an inflamed ulcer.

During an observation of resident care on 05/24/18 at 10:10 AM NA #3 and NA #4 provided care to Resident #55 to prepare him for a shower. NA #4 opened Resident #55's brief and there was a split in the skin on the right underside of his penis from the top of the penis down to the shaft approximately 1 inch in length. There was also a red vesicle observed but no drainage.

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During an interview on 05/24/18 at 1:30 PM, Nurse #3 explained she heard in shift report from Nurse #2 on 02/16/18 that when staff provided care to Resident #55 the skin on his penis was split. She stated she did not understand why the skin had split and she could find no reason for it. She further explained she put a note for the physician to look at it during her next round. She confirmed the physician saw Resident #55 during rounds the next Tuesday on 02/20/18 and was told Resident #55 had an active herpes flair up. She stated his indwelling catheter had already been removed and they had not put one back in since then. She verified the facility did not have a wound nurse but nurses were responsible to do wound assessments and document them and the Director of Nursing documented wound measurements.

During an interview on 05/24/18 at 6:34 PM, Nurse #2 explained she did rounds with NA #5 between midnight and 1:00 AM after she finished giving medications and treatments. She stated she and NA #5 went into Resident #55's room and when they pulled the covers back she saw a skin tear on his penis and there was redness. She stated she made a note on the physician's rounds sheet for the physician to see Resident #55 on next rounds. She explained she removed the indwelling catheter and there was no bleeding except for a tiny amount in his brief and he did not seem to be in pain and he had a herpes outbreak at the time. She explained another nurse did the weekly wound assessments because she could not do them. She confirmed she did not do measurements or any other description in her notes regarding the skin tear on Resident #55's penis.

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F 842	Continued From page 31 During an interview on 05/25/18 at 10:00 AM, the DON explained she heard about Resident #55's skin on his penis after 02/16/18 and the physician saw it on 02/20/18 during rounds. She further explained the physician said it was due to an outbreak of herpes. During a telephone interview on 05/25/18 at 10:25 AM the physician explained she was asked to see Resident #55 on rounds for an area on the end of his penis. She stated she saw a new area when she examined him and there was an ulcerated lesion on the tip of his penis. She explained Resident #55 had active herpes and it was hard to say if the catheter had caused the split in skin on his penis or if the herpes had caused it because the tissue was friable and was at risk to tear his skin. She stated it was her expectation for nurses to document wounds which included measurements and descriptions. During a follow up interview on 05/25/18 at 1:54 PM, the DON stated it was her expectation for wounds to be assessed and documented. She confirmed there were no measurements of the slit in the skin on Resident #55's penis or descriptions of the wound documented in the progress notes or on the skin checks. During an interview on 05/25/18 at 4:13 PM, the Administrator stated it was her expectation for nurses to assess wounds and document their assessments.	F 842		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance	F 865		6/22/18

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F 865	Continued From page 32 improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(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. §483.75(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, record reviews and staff interviews, the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in June, 2017. This was for two recited deficiencies which were originally cited in April of 2016 on a recertification and complaint survey and was recited on the recertification and complaint survey of June 2017 and was subsequently recited on the current recertification and complaint survey. The deficiencies were in the areas of safe, clean, comfortable and homelike environment and food sanitation. The continued failure of the facility during three federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included:	F 865	1. On 6/13/18 & 6/14/18, Maintenance Director repaired stained floors and broken grout around base of toilets and/or separated or broken floor tiles in bathrooms for rooms 401 & 408. The stained floors and broken grout around base of toilets and/or separated or broken floor tiles in bathrooms in rooms 108, 405 and 412 will be completed on or before 6/22/18. The baseboard b/w resident rooms 401 & 403 will be repaired on or before 6/22/18. On 6/6/18 dietary staff were reeducated by the Regional Food Service Director on assuring all bowls containing foods to be served are covered prior to and during transportation and distribution to residents. 2. By 6/22/18 all remaining bathroom floors and baseboards b/w rooms will be	

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F 865	Continued From page 33 This tag is cross referred to: 1. F 584 Safe, Clean, Comfortable and Homelike Environment: Based on observations and staff interviews, the facility failed to repair stained floors around the base of toilets or repair broken grout around the base of toilets in resident bathrooms (#108, #401, #405, #408 and #412) and failed to repair floor tile that had separated or was broken in resident bathrooms (#401, #408 and #412) on 2 of 4 resident hallways. The facility also failed to repair a baseboard at the floor that had separated and pulled away from the wall between resident room #401 and #403 on 1 of 4 resident hallways (400 hall). During the recertification and complaint survey, June 2, 2017, the facility failed to repair 4 of 4 sets of double smoke prevention doors with broken and splintered laminate and wood on the lower edges of the doors (100, 200, 300 and 400 halls). The facility failed to repair the main dining room door with broken and splintered laminate and wood on the lower edges of the door on the 200 hall on 1 of 3 residents' hallways, failed to repair a door leading out to the courtyard smoking area with broken and splintered laminate and wood on the lower edges of the door and a large vinyl skin on the bottom of the door was chipped on the edges. The facility also failed to repair 2 resident's room doors with broken and splintered laminate and wood on the lower edges of the door with an area where the vinyl skin had peeled back and caused a sharp edge in 2 of 22 occupied resident rooms (Room #311 and #110), failed to repair resident room and bathroom doors with broken and splintered edges on the lower half of the door that were rough to touch in 6 of 35 occupied resident rooms (Room #200, #309,	F 865	audited by the Center Executive Director to assure in good repair without stains, broken grout, separated or broken floor tiles and baseboards. On 6/14/18 Cooks for dining services were reeducated on the importance of monitoring assistants regularly to assure all bowls containing foods to be served are covered prior to and during transportation and distribution to residents. 3. On 6/15/18, the Center Executive Director reeducated the Maintenance Director on the importance of assuring bathroom floors remain free of stains, broken grout, separated/broken floor tiles and damaged baseboards between rooms. Findings/needed repairs will be completed or scheduled for completion by Maintenance Director on or before 6/22/18. On 6/14/18 Cooks for dining services were reeducated on the importance of monitoring assistants regularly to assure all bowls containing foods to be served are covered prior to and during transportation and distribution to residents. 4. Center Executive Director will monitor one of three halls 3 x monthly x 3 months. Any issues noted as a result of monitoring will be reported to the Maintenance Director for repairs or scheduled for repairs. Findings will be reviewed by Center Executive Director and Center Executive Director will present to Performance Improvement Committee	

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F 865	Continued From page 34 #310, #403, #405 and #412). During the recertification and complaint survey, April 14, 2016, the facility failed to maintain ceilings, walls, 1 AC/Heating unit, fixtures including light covers and toilet paper holders in bedrooms and bathrooms for 6 of 30 rooms (Rooms 200, 207, 303, 305, 308 and 406) reviewed for environmental issue. 2. F 812 Food Procurement, Storage and Sanitation: Based on observations and staff interviews the facility failed to discard expired food items, maintain food item expiration dates and maintain proper seal on opened food with expiration date in 1 of 1 walk in refrigerator. The facility also failed to ensure food was properly sealed in 1 of 1 walk in freezer, failed to remove expired food items from shelves in 1 of 1 dry storage room and failed to properly label food item in 1 of 2 nourishment room refrigerators during 1 of 2 kitchen task observations. The facility further failed to ensure staff distributed and served food under sanitary conditions on 1 of 4 halls. During the recertification and complaint survey, June 02, 2017, the facility failed to maintain a sanitary kitchen by sanitizing dishes, wash hands and change gloves to prevent food contamination, keep the food protected from contamination during service, keep the ice scoop from contaminating the ice, and clean the kitchen floors. During the recertification and complaint survey, April 14, 2016, the facility failed to label and date stored food in the kitchen refrigerator and freezer, failed to label and date food in the nourishment	F 865	every month x 3 months and ongoing as needed. Regional Food Service Director, Assistant Food Service Director or assigned Cook will monitor meal service 1 x weekly x 1 month then 2 x monthly x 1 month then 1 x monthly x 1 month to assure aides have covered all bowls containing foods to be served prior to transportation and distribution to residents. Any negative findings as a result of monitoring and observation will be reported to and addressed by the Process Improvement Committee q month x 3 months and ongoing as needed.	

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refrigerator/freezer across from the 400 hall nurse's station, failed to cover food in dry storage, failed to ensure only resident beverages and food were kept in the nourishment refrigerator, and failed to replace insulated dome lids with degrading interior plastic in 1 of 1 kitchen refrigerator/freezers, 1 of 1 dry storage rooms, 1 of 1 nourishment refrigerator/freezers and 26 of 26 insulated dome lids.

During an interview on 05/25/18 at 4:31 PM with the Administrator she explained the Quality Assessment and Assurance Committee met monthly and they had audited plans of correction for deficiencies cited in the Recertification Survey in June, 2017. She stated some of the regulations were very broad and she could not fix every problem that happened every day. She further stated they had audited work orders since the last survey and they were aware of damage to floors and baseboards, but there wasn't enough manpower to keep up with the work that needed to be done. She explained the kitchen issues that were cited last year had to do with other issues, but this year the areas of concern were different. She stated she felt the process was in place but there was not resources to get it all done. The administrator stated deficiencies identified during the current recertification survey would be discussed with ongoing monitoring as the committee determined. She stated the environmental deficiencies were due in part to an older building that was difficult to maintain but she expected for staff to keep the facility clean and maintained. She explained it was an ongoing process to prevent repeat deficiencies, but they would continue to put processes in place to monitor problems.