STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(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		9/20/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/17/2018

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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 observation and staff interviews the facility failed to ensure the ceiling, wall and privacy curtains were clean 1 of 4 sampled rooms (Room #411). The facility also failed to ensure clean linen was available for patient care on two of six hallways (200 and 400 hallways). Findings included: 1. During an observation in room 411 on 8/20/18 at 8:25 AM a light brown liquid was observed dried and on the ceiling and on the wall, the privacy curtains had multiple brown stains. During an observation in room 411 on 8/22/18 at 9:00 AM a light brown liquid was observed dried and on the ceiling and on the wall, the privacy curtains had multiple brown stains. On 08/23/18 8:30 AM Housekeeper #1 indicated one room was deep cleaned daily. Deep cleaning required the room cleaned floor to ceiling, including the walls. She indicated she didn't know who cleaned the privacy curtains. During an observation and interview on 08/23/18 at 8:45 AM Housekeeping Supervisor observed the light brown dried liquid on the ceiling and the wall and the dirty privacy curtains in rood 411. The Housekeeping supervisor confirmed the ceiling, wall and privacy curtain needed to be cleaned. He indicated that all staff knew how to put in work orders into the kiosk, any staff member could put in a work order to have the privacy curtains changed or the ceiling cleaned. During an interview and observation on 8/23/18 at 10:30 AM Nurse Aide #1 indicated when the room was dirty or smelled she notified the	F 584	F 584 This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law to remove the deficiency. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. The privacy curtain for resident 411A was changed on 8/23/18. The ceiling and walls were also cleaned 8/23/18. The Director of Health services checked the curtain and wall to validate it was clean with the Housekeeping Supervisor. All residents have the potential to be affected by the alleged deficient practice. An audit was completed on 8/24/18 of all residents privacy curtains, walls, and ceilings. All privacy curtains, walls, and ceilings needing attention were cleaned and will be monitored until substantial compliance is achieved. Staff was in serviced on monitoring resident rooms for soiled privacy curtains,	

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F 584	Continued From page 2 housekeeping management and they deep cleaned. She had not noticed the dry light brown stain on the ceiling and wall or the stains on the privacy curtains. On 08/23/18 at 10:37 AM Housekeeper #2 indicated housekeepers did not change the privacy curtains around the beds. She observed the light brown dried stain on the ceiling above the bed and down the wall. She stated she was not aware of the stain and she doesn't clean that high up. She indicated that she would verbally tell the floor technician to clean the stain or to change the privacy curtains. She was not aware of a kiosk to place a work order. On 8/23/18 at 2:38PM Nurse Aide #7 indicated that when the privacy curtains were dirty she notified her charge nurse. On 8/23/18 at 7:04 PM, the Director of Nursing indicated her expectation was for all residents to have clean privacy curtains, ceilings and walls. 2. On 8/22/18 at 9:00AM Nurse Aide #1 indicated that she was going to provide patient care in room 411. Nurse Aide #1 went to the 400 linen closet to obtain towels, washcloths and bedding for the care and wasn't any linen available. Nurse Aide #1 indicated that it was not unusual not to have linen to do care in the morning. The Laundry Aide walked by with empty soiled linen bin, Nurse Aide #1 asked for clean linen. Laundry Aide acknowledged the request. Observation revealed at 9:52AM Nurse Aide #1 went to hall 200 linen closet to obtain linen, there was no linen. Nurse Aide #1 indicated she had found 2 towels and a wash cloth. She was ready to provide care. During the observation of patient care Nurse Aide #1 stopped care and confirmed she needed more washcloths and towels to finish the care. She covered the resident and went to	F 584	walls and ceilings. Once per week for the next month one hall will be monitored daily for soiled privacy curtains, walls, and ceilings by the Maintenance Director. Then 6 rooms will be randomly selected daily times one month for soiled privacy curtains, wall and ceilings. The Housekeeping Supervisor and the Maintenance Director will bring all information collected from the audits to QAPI for the next three months to determine if it is effective or until substantial compliance is met.	

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F 584	Continued From page 3 400 hall to linen closet at 10:28 AM, observation revealed there was no linen. She stated she was unable to finish her patient care without linen. Nurse #2 came to the room at 10:39 AM with clean linen and stated the linen was just brought to the floor. During an interview on 08/23/18 at 8:45 AM Housekeeping Supervisor indicated that it was unusual for the staff not to have linen by 9:00AM. Linen was replenished every two hours. On 8/23/18 at 7:04 PM, the Director of Nursing indicated her expectation was for linen to be available for patient care.	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §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.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete the required Significant Change in Status Assessment (SCSA) following admission to hospice care for 1 of 1 residents (Resident # 11) reviewed for hospice.	F 637	Resident 11 was transmitted on transmitted All residents have the potential to be affected by the alleged deficient practice.	9/20/18

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F 637	Continued From page 4 The findings included: Resident #11 was admitted to the facility on 2/12/18 with diagnoses that included Cerebral Vascular Accident and paraplegia. Review of physician's order dated 5/1/18 revealed Resident # 11 admitted to hospice. Review of hospice documentation indicated Resident #11 was admitted to hospice care on 5/1/18. Review of the electronic assessments in progress for Resident #153 revealed a Significant Change in Status Assessment (SCSA) dated 5/1/18 that was not complete. Resident # 11's SCSA had not been completed within 14 days of admission to hospice care (by 5/15/18). During an interview on 8/23/18 at 3:58 PM, the MDS coordinator indicated she identified the significant change was not done. She completed the significant change on 8/3/18. She indicated that the significant change assessment was required no later than 14 days of the hospice start date. During an interview on 8/23/18 at 7:07 PM, the Director of Nursing indicated her expectation was significant changes to be completed in a timely fashion.	F 637	An Audit of 100% of the resident s to identify significant change of status by 9/20/2018 significant changes will be completed and submitted within 14 days. MDs will review the daily 24-hour report for significant changes and review MDS calendar for timely transmission ongoing. MDs will review the daily 24-hour report for significant changes and review MDS calendar to ensure timely transmission ongoing. MDs will review the daily 24-hour report for significant changes and review MDS calendar to ensure timely transmission. Administrator will review weekly audit X 3 months of Hospice admissions and discharges to ensure significant changes were captured by 9/20/2018 Administrator will review weekly X 3 month□s transmission with signing RN to ensure timely transmission	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the	F 638		9/20/18

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F 638	Continued From page 5 quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to conduct a quarterly Minimum Data Set (MDS) assessment for 1 of 2 residents selected to be reviewed for Resident Assessments. (Resident #2). The Findings Included: Resident #2 was admitted to the facility on 3/21/18. A review of the Minimum Data Set (MDS) assessments for Resident #2 revealed the last assessment completed and transmitted was an admission assessment completed on 4/17/18. Review of the recent MDS assessment for Resident #2 had ARD (Assessment Reference Date) of 6/27/18 and was coded as quarterly assessment. The MDS was not completed or signed by the MDS coordinator. During an interview on 8/23/18 at 4: 05 PM, the MDS coordinator indicated the last transmitted assessment for Resident #2 was on 4/14/18. She stated the quarterly assessment dated 6/27/18 for Resident #2 with a ADR date of 6/27/18 was still open and not completed. She stated the assessment should be completed and transmitted within 14 days of the ARD. During an interview on 8/23/18 at 7:18 PM, the Administrator indicated she expected the MDS nurse to complete accurate assessment in timely manner according to facility policy. She continued that all department participate in MDS	F 638	Resident # 2 MDS was completed on 9/13/18. MDS for OBRA compliance opened 9/13/2018 All residents have the potential to be affected by the alleged allegation. MDS coordinator will perform a 100% audit MDS summary to identify missing assessments by 9/20/2018 MDS coordinator will perform an audit of the MDS summary to identify any missing OBRA/PPS assessments Administrator will review with MDS coordinator weekly X 4 weeks, then bi-weekly X 2 months or until deficiency practice is sustained	

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F 638	Continued From page 6 assessment.	F 638		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		9/20/18

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F 656	Continued From page 7 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interview, the facility failed to complete a care plan for indwelling catheter for 1 of 3 residents reviewed for indwelling catheter (Resident # 1). The findings included: Resident #1 was admitted to the facility on 4/24/18, with diagnoses that included neurogenic bladder and decubitus ulcer. A review of the recent Minimum Data Set (MDS), dated 8/23/18. Revealed the resident's cognition was severely impaired. The MDS specified Resident # 1 required total assistance with activities of daily living and used an indwelling urinary catheter. Review of physician's order dated 8/1/18 revealed Resident # 1 had an indwelling catheter for neurogenic bladder and sacral decubitus ulcer. Review of Resident #1 ' s plan of care, not dated when initially developed and last reviewed on 7/14/18, revealed resident used an indwelling catheter related to neurogenic bladder , stage (sic) decubitus ulcer. The goal was for the resident to have no infection from catheter used until next review, but the goal was not dated. The approaches were in part, catheter care as ordered. The care plan approaches did not include to secure the catheter to the resident. During an observation and interview on 8/22/18 AM, 10:10 AM There was no catheter strap to secure the indwelling catheter tubing to Resident	F 656	Resident #1 care plan was updated with initial date 9/13/2018 All resident has the potential to be affected by the alleged deficient practice. A 100 % audit of care plans for residents with catheters will be completed by 9/20/18. MDS will review completed care plans for initiation and goal dates. MDS will review completed care plans for initiation and goal dates updates and accuracy weekly. Administrator will review with MDS coordinator care plans of completed MDS□s bi-weekly x 3 months or until deficient free practice is maintained	

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F 656	Continued From page 8 #1 leg. Nurse Aid #6 confirmed there was no strap in place to secure the resident's catheter to the resident's leg. She indicated it was the nurse's responsibility to check for a strap. During an interview on 8/22/18 at 11:02 AM Nurse #11 stated that the indwelling urinary catheter needed to be secured to the resident's inner thigh to prevent friction/movement. She indicated the aides were responsible for reporting to the nurses if there was not a catheter strap to secure the resident's catheter tubing. During interview on 8/23/18 at 4:30 PM Minimum Data Set Nurse indicated that every care plan was required to have an onset date, a target date for the goal and a review date. She indicated the care plan for indwelling catheter needed to include, to apply a secure strap for the catheter tubing and assign which staff was responsible for securing the catheter to the resident. During an interview on 8/23/18 at 7:04 PM the Director of Nursing indicated the expectation was all care plans to be updated.	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		9/20/18

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F 690	Continued From page 9 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to secure the indwelling urinary catheter for 1 of 3 sampled residents reviewed for urinary catheter use. (Resident # 1.) Findings Included: Resident # 1 was admitted on 4/24/18. Her diagnoses included neurogenic bladder. A review of the recent Minimum Data Set (MDS), dated 8/23/18. Revealed the resident's cognition was severely impaired. The MDS specified Resident # 1 required total assistance with activities of daily living and used an indwelling urinary catheter.	F 690	On 8/23/18 the Unit Manager assessed the affected resident for signs and symptoms of damage related to friction or movement of the indwelling catheter, no injury was observed. On8/23/18 a security strap was attached to the thigh of the identified resident with an indwelling catheter. On 8/23/18 the Director of Nursing met with the nurse to educate her on the responsibility of checking the resident and initialing on the MAR, to validate the leg strap is secured to the resident to prevent friction/ movement of the catheter. The DHS met with the CNA to ensure she understands she is	

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F 690	Continued From page 10 Review of Resident #1 ' s plan of care, not dated and last reviewed on 7/14/18, revealed resident used an indwelling catheter related to neurogenic bladder , stage (sic) decubitus ulcer. The goal was no infection from catheter used until next review. The approaches were in part, catheter care as ordered. During an observation and interview on 8/22/18 AM, 10:10 AM while providing bathing Nurse Aide # 6 removed the blanket and exposed the catheter tubing. There was no catheter strap to secure the indwelling catheter tubing to Resident #1 leg. Nurse Aid #6 confirmed there was no strap in place to secure the resident's catheter to the resident's leg. She indicated it was the nurse's responsibility to check for a strap. During an interview on 8/22/18 at 11:02 AM Nurse #11 stated that the indwelling urinary catheter needed to be secured to the resident's inner thigh to prevent friction/movement. She indicated the aides were responsible for reporting to the nurses if there was not a catheter strap to secure the resident's catheter tubing. Nurse #1 stated she was unaware Resident #1's catheter tubing was not secured to the resident's leg. On 8/23/18 at 7:04 AM, during an interview, the Director of Nursing stated that she expected the staff to maintain indwelling urinary catheters secured to resident's leg.	F 690	responsible for attaching the leg strap to any resident with an indwelling catheter to prevent friction/movement. All residents with an indwelling Foley catheter have the potential to be affected by the alleged deficient practice. 100 percent audit of all residents with indwelling Foley catheters was conducted. The Director of Health Services, Clinical competency coordinator and the unit manager will provide QA checks on all residents with indwelling catheters to ensure catheter straps are secured to the resident□s leg to prevent friction/movement. All residents with indwelling catheters were reviewed, care plans and CNA care guides updated to include the date started and last reviewed 1.The nursing staff will be in-serviced on the responsibility of securing catheter straps for all residents with an indwelling catheter. The nurse will check to ensure placement of the catheter strap and initial compliance on the MAR. The CNA will attach the strap to the leg of the resident to prevent friction/movement of the indwelling catheter. In servicing will start on 8/23/18 and will be completed by 9/20/18 2.Securing the catheter strap to prevent friction/movement and thus decreasing the risk of injury will be added to the skills check off for new employees, 9/20/18 The Director of Health Services, Clinical Competency Coordinator, Unit Manager	

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F 690	Continued From page 11	F 690	will monitor each resident for placement of Foley strap for one week, then randomly select three residents every day for two weeks for placement of leg strap. Then monitor 3 random residents weekly for 3 months or until compliance is achieved.	
F 812 SS=F	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, staff interviews and record review the facility failed to keep the floor of the dry food storage room clean, failed to label leftovers and discard expired food from their walk- in refrigerator and bread rack, the staff failed to wear beard guard. The facility also failed to use the sanitizing solution per manufacturer's recommendations and ensure the kitchen was	F 812	All residents have the potential to be affected by the stated deficient practice. All unlabeled/undated/out of date food items in refrigerator and on bread rack were discarded on 8-19-18. Floor in dry storage room was cleaned on 8-19-18. Dirty plates and bowls were removed from service, and bowls were removed from	9/20/18

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F 812	Continued From page 12 free of flies. Findings included: 1a. An observation of the kitchen's dry food storage room on 08/19/18 at 09:25 AM, revealed loose pieces of cereals, salt packets, dirt and debris on the floor under the storage rack. During an interview on 08/19/18 at 09:30 AM, dietary aide #1 stated the staff responsible for stocking the boxes in the dry storage was usually the person responsible to clean the floors. 1b. An observation of the bread rack on 08/19/18 at 09:27 AM, revealed an opened bag with 6 roll labeled " Sweet Hawaiian rolls - 12 count ". with expiration date 8/17/18. Observation also revealed an opened bag with one hamburger bun that was not labeled, a bag of dinner rolls and 2 bags of hamburger buns with no expiration or use by date on it. Observation also revealed an opened bag labeled "potato chips- 16 oz "that was not closed or labeled. On 08/19/18 at 09:30 AM, during an interview, dietary aide #1 indicated the bag of chips was opened for previous day meal. During an interview on 8/22/18 at 3:00 PM, the assistant dietary manager stated the bread should be labeled when opened and discarded appropriately. 1c. An observation of the walk- in refrigerator on 08/19/18 at 9:35 AM revealed a plastic container containing red colored food, with a label " chilly beans, date 8/13/18 and use by date of 8/17/18 ". Observation also revealed a plastic container	F 812	storage under the steam table counter on 8-22-18. Quaternary sanitizing solution buckets were refilled and tested on 8-22-18. All residents have the potential to be affected by the stated deficient practice. Kitchen Supervisor will re-educate Dietary staff on proper labeling of leftover and opened food items, use of hair nets and beard guards, use of quaternary sanitizing solution, and cleaning schedules/assignments, began 8-19-18, completed 8-24-18. Cleaning assignments will be posted by Dietary Manager/Kitchen Supervisor for daily, weekly, and monthly cleaning tasks to ensure all areas of the kitchen are cleaned according to company policy, began 8-22-18, ongoing. Daily cleaning schedules will be checked each morning by Dietary Manager/Kitchen Supervisor to ensure all daily assignments were completed. Weekly cleaning schedules will be checked each Monday by Dietary Manager/Kitchen Manager/ Supervisor to ensure all weekly assignments were completed. Monthly cleaning schedules will be checked the 1st date of each consecutive month by Dietary Manager/Kitchen Supervisor to ensure all monthly assignments were completed. Quaternary sanitizing solution will be tested and logged three times daily and monitored by Dietary Manager/Kitchen Supervisor. Kitchen will be assessed by contracted pest control professionals on a monthly and as needed basis to ensure current pest	

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F 812	Continued From page 13 containing food that looked like tomatoes, labeled " Tomatoes, dated 8/13/18 and use by date 8/16/18 ". Observation revealed a plastic container that was half full containing green colored food, labeled " Okra, date 8/13/18". The walk-in refrigerator also contained a canister that was one fourth filled with a brown colored fluid that had no label or date. The canister lid was partially opened. During an interview on 08/19/18 at 09:40 AM, dietary aide #1 stated the cooks were responsible to use or discard the food before the use by date. Dietary aide was unsure what the brown colored fluid. During an interview on 8/22/18 at 3:00 PM, the assistant dietary manager stated staff should be labelling all food when opened and left-over food should be used within expiration date or discarded after the expiration date. 2a. During the continuous tray line observation on 8/22/18 from 12:10 PM - 1:00 PM, observation revealed 5 of the 17 plates and 2 of the 12-small bowls to be used for the upcoming meal had dried food on them. Observation also revealed approximately 8-10 stacks of clean bowls where placed on a rack below the steam table counter. Water and other food particles from the steam table counter were dripping on to the bowls placed under it. An opened soda can was observed in a multiple compartment tray that was used to hold napkins, condiments, weighted spoon. The soda was observed in the condiment compartment that was to be used for the upcoming meal. During an interview on 8/22/18 at 3:00 PM, the	F 812	control methods are sufficient.	

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F 812	Continued From page 14	F 812		

assistant dietary manager stated she was not sure why an open soda can was placed on the tray. She stated if the can was opened for a resident then it should be discarded appropriately.

During a phone interview on 8/23/18 at 12: 43 PM, the Dietitian stated staff should not be placing clean bowls on the rack under the steam table as there was a possibility of food and water to drip into the clean bowl.

2b. Observations on 8/22/18 from 12:10 to 1:00 PM revealed dietary aide #2 was helping at the tray line to prepare resident meals, he had a beard, but was not wearing beard guard. Interview with dietary aide #2 on 8/22/18 at 1:10 PM revealed he forgot to wear the beard guard.

During an interview on 8/22/18 at 3:00 PM, the assistant dietary manager stated hairnets and beard guards should be used appropriately by staff.

3. During an observation on 8/22/18 at 2:00 PM, a small red bucket containing a quaternary sanitizer solution was placed under the cook's prep table. A testing strip was used to test the concentration of the solution. The strip did not change color indicating 0 parts per million (ppm) of sanitizer was in the bucket. Another red bucket containing quaternary sanitizer solution placed under the steam table was also tested for sanitizer concentration. The solution had food particles in them and the testing strip did not change color. The manufacturer of the quaternary sanitizer used recommended a concentration of 150 -200 ppm.

During an interview on 8/22/18 at 3:00 PM, the

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F 812	Continued From page 15	F 812		

assistant dietary manager stated the sanitizer solution should be tested before use and discarded when food particles are in the solution and after the meal completion. She stated the dietary staff was responsible to check the concentration of the solution before using it to sanitize the work area and discard the solution after the steam table and work area was cleaned and sanitized. She stated the sanitizer solution was used to sanitize the steam table and cook prep area.

During an interview 08/23/18 10:36 AM, the administrator she indicated the facility was just approved to purchase a new steam table and the freezer was in the process of repair. She stated she had nothing else to add.

4. Review of the facility's pest control service report dated 8/10/18 read in part "pest activity found in the kitchen area interior. Large flies noted during services. Reinstalled fly light in kitchen area.".

During the continuous tray line observation and interview on 8/22/18 from 12:10 PM -1:00 PM, flies were observed in the kitchen. Three flies were observed in the kitchen area during the meal service. Flies were observed landing on foods that were on the kitchen tray line that had not yet been served to residents. Two fly traps were observed in the kitchen. The kitchen's exit door was intermittently opened by dietary staff walking in and out of the kitchen during this observation.

During an interview on 8/22/18 at 12:45 PM, the Administrator indicated previously the kitchen had 3 fly traps with one placed near the exit door. She

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F 812	Continued From page 16 stated during one of the regular pest control visit, the pest control staff from Ecolab removed the 3 fly traps and replaced them with only 2 fly traps. She further stated when the exit door was opened there was the possibilities of flies coming into the kitchen. During an interview on 08/22/18 12:55 PM, the maintenance director stated he was not sure why the pest control company had removed three of the fly lights and replaced them with only 2 fly lights. During a phone interview with on 8/23/18 at 12: 43 PM, the Dietitian stated the facility's pest control company had removed the fly lights without any indications and replaced them with only 2 fly lights in the kitchen.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's Quality Assessment and Assurance Committee failed to effectively maintain implemented procedures and effectively monitor these interventions that the committee put into place in August 2017. This was for recited deficiency, which was originally cited on 8/10/17 during the recertification survey and on the current recertification survey. The deficiency was	F 867	1. Resident affected a. No resident was negatively impacted by this concern. 2. Resident with potential to be affected a. All residents in the facility can be impacted by this practice. There was no adverse outcome related to this concern b. On 9/03/18, the Administrator will be	9/20/18

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F 867	Continued From page 17 in the area of food procurement. The continued failure of the facility during two federal survey of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. Findings included: This tag is cross-referenced to: F812 Food Procurement: Based on observations, staff interviews and record review the facility failed to keep the floor of the dry food storage room clean, failed to label leftovers and discard expired food from their walk- in refrigerator and bread rack, the staff failed to wear beard guard. The facility also failed to use the sanitizing solution per manufacturer's recommendations and ensure the kitchen was free of flies. The facility was sited during the 8/10/17 recertification survey for failure to maintain the nourishment refrigerator temperature below 40 degrees, discard food and inappropriately stored staff personal food in two of the three nourishment refrigerators. On 8/23/18 at 5:25 PM, during an interview, the Administrator indicated the Quality Assessment and Assurance Committee meetings occurred monthly or as needed. The Quality Assessment and Assurance Committee worked constantly to correct multiple ongoing issues, as well as previously identified deficiencies. The Quality Assessment an Assurance Committee tried to identify, prevent and correct all the deficiencies in the facility.	F 867	re-educated by the Vice President of Quality Assurance and Performance Improvement on the quality assurance process. 3. Systemic Change/Interventions a. Re-education began 8/12/17 provided via Pruitt U class to all members of the Quality Assurance and Performance Improvement (QAPI) Committee, which is comprised of the Administer, Director of Coordinator, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Financial counselor, Social Services Director, Activity Director, Case Mix Coordinator, Admissions Director and Medical Records Coordinator. Assigned class on Pruitt U included PruittHealth QAPI Developing and Sustaining a Quality Culture, and QAPI Root Cause Analysis and PIP Development for SNF All employees that are on the QAPI committee are full time. There are no PRN or weekend staff on this committee. b. The Area Vice President of Operations will designate a member of the Regional Leadership team to participate in the Quality Assurance/Performance Improvement meetings for the facility monthly X 6 months. c. The Regional Leadership team will review performance improvement plans for the facility monthly X 6 months to ensure effectiveness. Any negative findings will be reviewed at the Regional Leadership team at the quarterly Quality Assurance/Performance Improvement meeting for opportunities for re-education	

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F 867	Continued From page 18	F 867	or correction. 4. Plan to monitor a. The Administrator will bring results of all open PI Plans to the Monthly Quality Assurance Performance Improvement Committee Meetings X 3 months or until substantial compliance is achieved to ensure we have appropriate corrective action. Changes will be made to plan by the committee as indicated to include re-education and/or immediate corrective action. b. The Regional Leadership team will review performance improvement plans for the facility monthly X 6 months to ensure effectiveness. Any negative findings will be reviewed at the Regional Leadership team at the quarterly Quality Assurance/Performance Improvement meeting for opportunities for re-education or correction.	
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain one of one walk-in freezer and the kitchen's steam table in safe operating condition. The kitchen's walk-in freezer had accumulated ice on the freezer floor and on food stored inside the freezer and the kitchen's steam table had a leak which distributed water on the floor in staff work areas.	F 908	A: 9/19/18 R&S Mech. (HVAC contractor) was called out to diagnosed and fix temperature and ice in freezer. We ordered parts and will be fixed by 9/20/18 Maintenance Department Director will document and check freezer for proper operation during morning PM rounds	9/20/18

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F 908	Continued From page 19 Findings included: 1. An observation of the walk-in freezer on 08/19/18 at 9:45 AM revealed the internal temperature was 5 degrees Fahrenheit as indicated on the freezer's outside built-in thermometer. Observations inside the freezer revealed there was a thin layer of ice on the freezer's floor. The freezer's compressor had huge icicle hanging from it. All the racks in the freezer had icicles on them. Observation of the boxes of food placed under and beside the freezer compressor revealed the boxes had a layer of ice on them. A white box label "Chocolate cream pie", a white box labelled "Frozen pastry 10 pounds (lb.)", a white box labeled "White Ranch dinner rolls - 22.5 lb." were wet and had ice on them. An opened brown box labeled "Light breaded okra. 4- 5 lb. "had a thick layer of ice on the bags inside. A bag labelled "sliced yellow squash - 3 lb" had squash with freezer burn on them. An unlabeled cardboard box that was stored on the rack beside the freezer door was wet with ice on it. Dietary aide #1 indicated the box contained breakfast turkey patties. During an interview on 08/19/18 at 09:55 AM, Dietary aide #1 indicated she was not sure why the boxes were wet and some boxes with ice formed on them. She further stated the previous night there was a pipe leak in the facility and was unsure if the freezer issue was related to it. Staff indicated she has not seen it previously and has not reported it to the maintenance staff. During an interview on 8/19/18 at 10:10 AM, the maintenance personnel indicated he was not	F 908	starting 9/20/18 Maintenance Department Director will check Temps and fix any problems during morning PM rounds that might have occurred Starting 9/20/18 Maintenance Department Director will bring results to QAPI meeting for 3 months any concerns will be discussed, and interventions will be added until compliance is achieved. B: 9/19/18 Maintenance Department Director fixed leaking well on steam table. Maintenance Department Director will document and check steam table during morning PM rounds starting 9/20/18. New steam table was approved by corp. Maintenance Department Director. will check steam table to ensure proper operation and will document daily for 1 month then 2 times weekly for 3 months Maintenance Department Director. will bring results to Q.A.P.I. for 3 months and any concerns will be discussed, and interventions will be added until compliance is achieved	

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aware of the issue and not sure why the freezer had ice on the floor or on the racks. He stated an emergency service call would be made to the service company.

During an interview on 8/20/18 at 9:00 AM, the maintenance personnel stated the service company had completed the emergency service and noted the compressor was in defrost mode resulting in the ice issue in the walk- in freezer. He further indicated there may be a possibility of water leak from the roof of the freezer and the heavy rains may have caused the leak through the roof.

During an interview on 8/22/18 at 3:00 PM, the assistant dietary manager stated she was unsure why the freezer was not working appropriately. She further stated no dietary staff had informed her about this issue. She stated she had not placed a work order for maintenance department as she was not aware of the issue.

2. An observation of the tray line on 08/19/18 at 09:20 AM revealed the last of the resident breakfast trays had been plated by staff on the tray line. Observation of the steam table revealed water dripping under the steam table. Water was also observed on the floor under the steam table. An empty aluminum pan was placed underneath the dripping steam well. Staff were standing near the table with water under their feet.

During an interview on 08/19/18 at 10:00 AM, dietary aide #1 indicated one of the steam wells was leaking for some time and a work order had been placed. She further stated someone had come in to check the steam table previously and

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had indicated it was not repairable.

During the continuous tray line observation on 8/22/18 from 12:10 PM - 1:00 PM, the steam table was observed to be dripping water on the floor while the staff plating lunch meals for the residents.

During an interview with the assistant dietary manager on 8/22/18 at 12:30 PM, the assistant dietary manager acknowledged that the steam table had been leaking for some time. She further stated the steam table had been repaired few months earlier.

During an interview on 8/22/18 at 12:55 PM, the maintenance director stated he had repaired the steam well earlier and was unaware of the current leak.

During a phone interview on 8/23/18 at 12: 43 PM, the Dietitian stated the steam well was leaking for some time now and the administrator was notified about it in her report a week ago. She stated the steam well was repaired earlier and the Administrator was in the process of getting approval to purchase a new one.

During an interview 08/23/18 10:36 AM, the administrator she indicated the facility was just approved to purchase a new steam table and the freezer was in the process of repair. Administrator indicated she was not aware of the current leak in the steam table and not notified or placed a work order for the maintenance department to repair it.