STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING _____ B. WING _____	C 09/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE NURSING & REHAB	300 NORTH MAIN STREET RICH SQUARE, NC 27869

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F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		10/18/18

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

Electronically Signed | 10/17/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on physician interview, staff interview, and record review the facility failed to notify the primary physician/Medical Director on two separate occasions about observations of maggots in the arterial/venous wounds of 1 of 5 residents (Resident #43) reviewed for wounds. Findings included: Record review revealed Resident #43 was initially admitted to the facility on 03/22/18, and was readmitted to the facility on 06/22/18. The resident's documented diagnoses included cellulitis of right lower limb, chronic venous hypertension with ulcer of lower extremity, pressure ulcers to right and left heels, and end stage renal disease (ESRD) with hemodialysis. Resident #43's 06/22/18 Admit/Readmit Screener documented he had suspected bilateral deep tissue injury (DTIs) to his heels, an arterial/venous ulcer to his right lower inner leg, and an arterial/venous ulcer to his left lower inner leg. Review of a care plan from a previous admission dated 04/03/18 revealed "The resident has DTI and potential for pressure ulcer development r/t	F 580	The plan for correcting this specific deficiency. On September 27, 2018 Dr. Khoury, the primary care physician and Medical Director was made aware of the nurse's allegation of maggots in Resident #43 vascular wounds on July 30, 2018 physician notification. Residents with wounds were assessed by the nursing staff for debris in wounds. Assessments of wounds were negative. A procedure for implementing an acceptable plan of correction. On September 27, 2018 the Staff Development Coordinator in-serviced the nursing staff regarding physician notification relate to a change in condition of a resident's wound. This information will be included in the new nurse employee orientation program for licensed nurses. The monitoring process to ensure that the plan of correction is effective and that specific deficiency remains corrected and or in compliance. The Administrative Nurses will audit 5 residents with wounds 3 X weekly 4 weeks, 2 X weekly X 2	

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F 580	Continued From page 2 (related to) impaired bed mobility, bowel bladder incontinence" was identified as a problem. Interventions to this problem included administering treatments as ordered and monitoring for effectiveness, assessing/recording/monitoring wound healing, and reporting improvements/declines to the primary physician/Medical Director. A 07/30/18 a progress note, written at 11:06 PM by Nurse #2, documented, "While changing resident's BLE (bilateral lower extremity) dressings, noted left lower extremity to have foul, foul odor with copious amounts of drainage noted coming from all sites, also noted large amount of larvae coming out of wounds on lower left leg, Administrative nurse ...notified, resident sent to hospital to be evaluated and treated ....Dressing to RLE (right lower extremity) was changed without difficulty with copious amounts of foul purulent drainage noted ...." On 09/26/18 at 4:20 PM Nurse #2 stated on 07/30/18 nursing assistant (NA) #1 came to her stating that when she provided incontinent care to Resident #43 the dressings to his bilateral lower legs rolled down and needed to be secured and/or changed. The nurse reported she decided to change the dressings, and there was a large amount of wet, yellow to slightly green drainage on the existing dressings. She also commented there was a strong odor coming from both arterial/venous wounds, but the odor coming from the left lower leg wound was extremely strong and foul. According to Nurse #2, when she unwrapped the old dressing on the left leg five or six very large and plump maggots fell from the wound onto the resident's bed. Nurse #2 reported one of the dressings to the lower legs had a date	F 580	weeks, weekly X 4 and monthly thereafter to ensure physician notification for changes in wound condition. The Staff Development Coordinator or designee will re-educate the staff ensure compliance. The audits will be reviewed weekly and signed off by the Director of Nursing or designee. Data results will be monitored and reviewed by the monthly Quality Assurance Process Improvement meeting for 3 months with subsequent plan of correction as needed. The Director of Nursing is responsible for the overall compliance.	

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on it, but she could not remember which one, and she could not remember what the date was. She stated she had experience dealing with maggots and infected wounds, and using that knowledge base, she would estimate that it had taken a week for the maggots to reach the stage at which they presented on 07/30/18. Nurse #2 commented she could not remember if she obtained the order to send Resident #43 to the ER from the primary physician or the on-call physician so she could not say for sure that she notified the primary physician about the maggots.

A 07/30/18 transfer form documented Resident #43 was sent to the emergency room (ER) due to "ulcers to BLE (with) maggot infestation."

On 09/27/18 at 4:18 PM Nurse #5, the current Treatment Nurse, stated he did see a single maggot on Resident #43's bed after the resident's wound dressings were changed. He reported this sighting occurred a couple of weeks after the resident was sent out to the ER on 07/30/18 due to maggot infestation and decline in wound status. He commented that he did not notify the resident's primary physician or document his observation of the maggot, but he did call the wound clinic to discuss his observation, and the resident was seen there the next day.

On 09/27/18 at 5:05 PM NA #1 stated she sometimes helped the nurses position and hold Resident #43's legs when the nurses were changing the dressings on his arterial/venous wounds. She reported that sometimes the resident received dressing changes on first shift before he left for dialysis, but on other days it was too hectic on first shift, and his dressings were supposed to be changed on second shift after the

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resident returned from dialysis. According to NA #1, she had observed maggots in Resident #43's lower leg wounds twice. She commented the first time was on 07/30/18 and the next time was one to two weeks later. NA #1 stated that both times very large maggots fell from the wound bed onto the floor and the resident's bed. She also remarked that there were at least five or six very plump maggots present both times and that the resident went out to the wound clinic the day after both observations.

On 09/27/18 at 5:41 PM NA #2 stated he worked on third shift, and about one and a half to two months ago when he was rounding on residents who were in his assignment, Resident #43 seemed restless so he decided to check him to see if he was wet or soiled. The NA reported when he pulled the covers back the resident's bed was full of large maggots.

On 09/27/18 at 6:02 PM Resident #43's primary physician and the facility's Medical Director stated that he was informed by the facility staff that the resident's wounds were deteriorating, but he had not been told that maggots were found in the resident's arterial/venous wounds. He reported this deterioration of the wounds was eminent because Resident #43 was already on a "bad vascular path" which would eventually end in the bilateral amputation of his legs. He commented that if the maggots were as big as staff described them, it had probably taken a week for them to mature. He reported obviously they were not being used therapeutically, and they grew in the wound due to contamination. He stated that by not informing him about the maggots the facility deprived him of the opportunity to coordinate root-cause analysis to determine where and how

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the contamination occurred since the resident resided in the facility but left the facility with family, and went to the dialysis center three times a week, to the wound clinic, and to the surgeon's office every two weeks.

On 09/27/18 at 11:16 PM, during a telephone interview, Nurse #3 stated she worked on third shift. She reported on 07/30/18 she had maggots collected from Resident #43's bed, placed them in a sterile container, and refrigerated them. However, she commented she disposed of them at the end of her shift. According to Nurse #3, she thought six large maggots were probably collected on 07/30/18, but she commented about a week or a week and a half later eight to nine maggots were once again found in Resident #43's wound and bedding. She stated she did not notify Resident #43's primary physician either time she observed maggots because she thought Nurse #2 had already done so since she was the first staff member who observed them on the night of 07/30/18. Nurse #3 reported she forgot to document about her second observation of maggots a week or two later.

On 09/28/18 at 3:55 PM, during a telephone interview, Nurse #4 stated she was assisting Nurse #2 with Resident #43's dressing changes on 07/30/18. She stated the arterial wounds had a very pungent odor, and when they got to the left leg arterial/venous wound she saw something drop on the bed. She commented she saw at least three large maggots fall from the wound bed before she had to leave the room. She reported she called 911 and started the paperwork for sending Resident #43 to the ER, but did not notify the resident's primary physician. Nurse #4 commented she was not sure how long it had

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F 580	Continued From page 6 been since the resident's dressings had been changed last, but she thought it could have been awhile since there was some confusion about whether first or second shift was responsible for the wound treatments. According to Nurse #4, she was prepared to make a statement about what she saw since it was such an infection control issue, but she reported she was never asked to do so by the facility.	F 580		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on physician interview, staff interview, and record review the facility neglected to address missing documentation of treatment/dressing changes on the Treatment Administration Record (TAR), and neglected to determine where and how wound contamination occurred after maggots were found in arterial/venous wounds on 07/30/18 for 1 of 5 residents (Resident #43) reviewed for wounds. As a result maggots were	F 600	The plan for correction this specific deficiency. On September 25, 2018 Resident #43 was discharged to the hospital. On September 28, 2018 residents with wounds had a skin assessment done by the Treatment Nurse, Staff Development Coordinator, MDS nurses and Director of Nursing. There was no indication of neglect.	10/18/18

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F 600	Continued From page 7 found a second time in Resident #43's wound bed and bedding one to two weeks after the initial observation of maggots on 07/30/18. Immediate Jeopardy (IJ) began on 07/30/18 when maggots were observed in Resident #43's arterial/venous wound which had not been receiving documented daily dressing changes per the TAR. Review of the resident's medical record and facility in-servicing records, as well as staff interviews, revealed after the 07/30/18 incident the staff was not in-serviced about contamination of wounds resulting in maggot formation, and root-cause analysis was not completed to try and determine where and how the resident's arterial/venous wounds were contaminated. One to two weeks after 07/30/18 a nurse and nursing assistant (NA) observed more maggots in Resident #43's arterial/venous wound bed and in his bedding. The IJ was removed on 09/28/18 when the facility implemented an acceptable credible allegation of IJ removal. The facility remained out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not IJ) to ensure monitoring of systems were carried out and employee in-servicing was completed. Findings included: Record review revealed Resident #43 was initially admitted to the facility on 03/22/18, and was readmitted to the facility on 06/22/18. The resident's documented diagnoses included cellulitis of right lower limb, chronic venous hypertension with ulcer of lower extremity, pressure ulcers to right and left heels, and end stage renal disease (ESRD) with hemodialysis.	F 600	A procedure for implementing an acceptable plan of correction. On September 28, 2018 the Staff Development Coordinator in-serviced the nursing staff on Recognizing Signs and Symptoms of Abuse/Neglect. On September 28, 2018 staff were in-serviced on education of "living matter" and the reporting procedure. This information will be included in the new employee orientation. The monitoring process to ensure that plan of correction is effective and that specific deficiency remain corrected and or in compliance. Administrative Nurses will audit 5 residents with wound dressing and 5 Treatment Administrative Records (TARs)3 X Weekly X 4 weeks, 2 X weekly X 2 weeks, then weekly X 4 and monthly thereafter to ensure ongoing compliance with wound dressing changes and documentation of treatments. Wound dressing changes found to be noncompliant with physician orders will result in employee corrective action plan. The Staff Development Coordinator or designee will re-educate the staff to ensure compliance. Data results will be monitored by the monthly Quality Assurance Process Improvement meeting for 6 months with subsequent plan of correction as needed. The Director of Nursing is responsible for the overall compliance.	

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Resident #43's 06/22/18 Admit/Readmit Screener documented he had suspected bilateral deep tissue injury (DTIs) to his heels, an arterial/venous ulcer to his right lower inner leg, and an arterial/venous ulcer to his left lower inner leg.

Review of a care plan from a previous admission dated 04/03/18 revealed "The resident has DTI and potential for pressure ulcer development r/t (related to) impaired bed mobility, bowel bladder incontinence" was identified as a problem. Interventions to this problem included administering treatments as ordered and monitoring for effectiveness, assessing/recording/monitoring wound healing, and reporting improvements/declines to the primary physician/Medical Director.

The resident's 06/29/18 admission minimum data set (MDS) documented his cognition was severely impaired, he did not exhibit rejection of care, he required extensive assistance from staff to being dependent on staff for his activities of daily living (ADLs) except for requiring only supervision with eating, he had two unstageable deep tissue injury pressure ulcers, he had two arterial/venous ulcers, and he was receiving dialysis services.

Review of the resident's July 2018 TAR revealed the treatments/dressing changes to his bilateral lower extremity ulcers were not initialed off as being completed on 07/02/18, 07/03/18, 07/04/18, 07/06/18, 07/07/18, 07/08/18, 07/09/18, 07/16/18 (the resident was seen at the wound clinic on this day), 07/18/18, 07/19/18, 07/20/18, 07/21/18, 07/23/18 (the resident was sent out to the emergency room and returned to the facility on

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this day), 07/25/18, 07/27/18, 07/28/18, and 07/30/18 (Nurse #2 changed some of the dressings on this evening until she observed maggots in an arterial/venous wound).

Consult notes documented Resident #43 was seen by the wound clinic on 07/16/18, and there was no documentation of infection or the presence of maggots in the wound clinic treatment notes.

On 07/17/18 the resident's care plan was updated to reflect that he had bilateral DTIs to his heels, an arterial/venous ulcer to his right lower lateral leg, and an arterial/venous ulcer to his left lower medial leg.

A 07/30/18 progress note, written at 11:06 PM by Nurse #2, documented, "While changing resident's BLE (bilateral lower extremity) dressings, noted left lower extremity to have foul, foul odor with copious amounts of drainage noted coming from all sites, also noted large amount of larvae coming out of wounds on lower left leg, Administrative nurse ...notified, resident sent to hospital to be evaluated and treated ....Dressing to RLE (right lower extremity) was changed without difficulty with copious amounts of foul purulent drainage noted ...."

On 09/26/18 at 4:20 PM Nurse #2 stated on 07/30/18 nursing assistant (NA) #1 came to her stating that when she provided incontinent care to Resident #43 the dressings to his bilateral lower legs rolled down and needed to be secured and/or changed. The nurse reported she decided to change the dressings, and there was a large amount of wet, yellow to slightly green drainage on the existing dressings. She also commented

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there was a strong odor coming from both arterial/venous wounds, but the odor coming from the left lower leg wound was extremely strong and foul. According to Nurse #2, when she unwrapped the old dressing on the left leg five or six very large and plump maggots fell from the wound onto the resident's bed. Nurse #2 reported one of the dressings to the lower legs had a date on it, but she could not remember which one, and she could not remember what the date was. She stated she had experience dealing with maggots and infected wounds, and using that knowledge base, she would estimate that it had taken a week for the maggots to reach the stage at which they presented on 07/30/18.

A 07/30/18 transfer form documented Resident #43 was sent to the emergency room (ER) due to "ulcers to BLE (with) maggot infestation."

A 07/30/18 ER report documented, " ...Wounds are not purulent and do not appear infected. There are no maggots seen in any of the wounds ....Patient certainly has chronic changes and chronic wounds to both feet. However, there is no evidence of acute infection to either foot though (it require antibiotics or hospitalization). Discharge patient back to the nursing home and recommend that he resume treatments at his wound care center."

Review of wound clinic consults revealed Resident #43's wounds were assessed and treated at the wound clinic on 07/31/18 and 08/09/18. There was no documentation of maggots to the wounds on any of these consult notes.

Review of the resident's August 2018 TAR

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revealed the treatments/dressing changes to his bilateral lower extremity ulcers were not initialed off as being completed on 08/01/18, 08/06/18, 08/08/18, 08/09/18 (the resident was seen at the wound clinic on this day), and 08/10/18.

On 09/27/18 at 12:43 PM the Director of Nursing (DON) stated she assumed her current position on 08/01/18, but was not aware of any residents having maggots in their wounds until questions were asked during the survey. She commented when she talked with Nurse #8 (the Staff Development Coordinator-SDC), Nurse #8 reported no in-servicing or root cause analysis was done concerning maggot infestation because the facility felt it had handled the problem appropriately by sending Resident #43 to the ER and wound clinic.

On 09/27/18 at 4:18 PM Nurse #5, the current Treatment Nurse, stated he did see a single maggot on Resident #43's bed after the resident's wound dressings were changed. He reported this sighting occurred a couple of weeks after the resident was sent out to the ER on 07/30/18 due to maggot infestation and decline in wound status. He commented that he called the wound clinic to discuss his observation, and the resident was seen there the next day.

On 09/27/18 at 5:05 PM NA #1 stated she sometimes helped the nurses position and hold Resident #43's legs when the nurses were changing the dressings on his arterial/venous wounds. She reported that sometimes the resident received dressing changes on first shift before he left for dialysis, but on other days it was too hectic on first shift, and his dressings were supposed to be changed on second shift after the

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resident returned from dialysis. According to NA #1, she had observed maggots in Resident #43's lower leg wounds twice. She commented the first time was on 07/30/18 and the next time was one to two weeks later. NA #1 stated that both times very large maggots fell from the wound bed onto the floor and the resident's bed. She also remarked that there were at least five or six very plump maggots present both times and that the resident went out to the wound clinic the day after both observations.

On 09/27/18 at 5:26 PM the DON stated she was not aware of any problems with staff not signing treatments off on the TARs. However, she commented that no staff had complained to her that they were unable to complete treatments/dressings changes.

On 09/27/18 at 5:41 PM NA #2 stated he worked on third shift, and about one and a half to two months ago when he was rounding on residents who were in his assignment, Resident #43 seemed restless so he decided to check him to see if he was wet or soiled. The NA reported when he pulled the covers back the resident's bed was full of large maggots.

On 09/27/18 at 6:02 PM Resident #43's primary physician and the facility's Medical Director stated if the maggots in the resident's arterial/venous wounds were as big as staff described them, it had probably taken a week for them to mature. He reported that obviously these maggots were not being used therapeutically, and they grew in the wound due to contamination. He commented that it would be important to determine where and how the contamination occurred since the resident resided in the facility but left the facility

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with family, and went to the dialysis center three times a week, to the wound clinic, and to the surgeon's office every two weeks. According to the Medical Director, if there were maggots, they had no negative effect since the resident was already on a "bad vascular path" which would eventually end in the bilateral amputation of Resident #43's legs.

On 09/27/18 at 11:16 PM, during a telephone interview, Nurse #3 stated she worked on third shift. She reported on 07/30/18 she had maggots collected from Resident #43's bed, placed them in a sterile container, and refrigerated them. However, she commented she disposed of them at the end of her shift. According to Nurse #3, she thought six large maggots were probably collected on 07/30/18, but she commented about a week or a week and a half later eight to nine maggots were once again found in Resident #43's wound and bedding.

On 09/28/18 at 10:17 AM Nurse #8 (SDC and Infection Control) stated she remembered hearing mention of maggots in a resident's wound, and that from an infection control standpoint, you would want to figure out when and where the resident's wounds were contaminated by flies. She commented in-servicing about pest control, prompt removal of meal trays from resident rooms, frequent emptying of trash in resident rooms, and the importance of timely incontinent care would have been important topics to educate the staff about. However, she stated that root-cause analysis and infection and pest control in-servicing were not conducted after maggots were found either time in Resident #43's wound and/or room.

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On 09/28/18 at 11:50 AM the DON stated she had asked staff about the wound treatments that were not initialed off on the TAR for Resident #43. However, she reported that no staff member, other than Nurse #1 who stated she was sure she did all dressing changes for the resident on 07/28/18, could say without a shadow of a doubt that treatments were provided to Resident #43 on the days when they were not initialed off on the TAR. According to the DON, her expectation was that nurses initial treatments as being done on the TAR as soon as they were completed. She also commented that during report first shift nurses should have shared with second shift nurses if Resident #43 left for dialysis before his wound dressings could be changed on first shift, but she was not sure that this was happening based on the missing TAR documentation.

On 09/28/18 at 3:55 PM, during a telephone interview, Nurse #4 stated she was assisting Nurse #2 with Resident #43's dressing changes on 07/30/18. She stated the arterial wounds had a very pungent odor, and when they got to the left leg arterial/venous wound she saw something drop on the bed. She commented she saw at least three large maggots fall from the wound bed before she had to leave the room. She reported she called 911 and started the paperwork for sending Resident #43 to the ER. Nurse #4 commented she was not sure how long it had been since the resident's dressings had been changed last, but she thought it could have been awhile since there was some confusion about whether first or second shift was responsible for the wound treatments. According to Nurse #4, she was prepared to make a statement about what she saw since it was such an infection control issue, but she reported she was never

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asked to do so by the facility.

The DON and Corporate Consultants were notified of the Immediate Jeopardy on 09/27/18 at 6:25 PM.

On 09/28/18 the facility provided an acceptable credible allegation for Immediate Jeopardy removal that included the following:

The plan of correcting the specific deficiency including the processes that led to the deficient practice cited on 9/27/2018 at approximately 6pm:

0n 7/30/18 the nurse working second shift noted larvae and maggots in wound. The nurse documented the assessment of larva in the wound of the resident and notified nursing administration. The nurse sent the resident to the emergency department for wound evaluation. The emergency department reports no record of larva present in the wound. The resident returned to the facility 7/30/18 with recommendations to resume treatment with the wound care clinic.

8/8/18 a nurse and certified nursing assistant again witnessed larvae and maggots to wound. The wound clinic was notified and the facility was instructed for the resident to keep scheduled appointment with wound clinic the following day.

The interdisciplinary team (IDT) including the Director of Nursing (DON), Minimal data set Nurse (MDS) and Corporate Minimum data set Nursing supervisor met on 9/27/2018 and determined the root cause to be a breakdown in the wound care delivery process resulting in

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inconsistent documentation of treatment performed. An additional root cause was determined that there was inconsistent communication when the resident did not receive their wound treatment because the resident was out to dialysis during day shift hours and wound care needed to be completed on evening shift. An additional root cause was that the wound treatments could not be performed on day shift because resident was out of the facility for dialysis.

On 9/28/18 24 hour initial allegation report for neglect related to failure to document wound care delivery completed and submitted to Health Care Personnel Registry.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited:

On 9/27/18 the Quality Assurance and Performance Improvement committee met. They were notified of the Immediate Jeopardy and reviewed wound care documentation practices. The team participated in root cause analysis and development of acceptable plan of correction.

On 9/27/18 administration time for residents that receive dialysis treatment during day shift hours wound care has been scheduled to be completed on evening shift.

On 9/27/2018 education by nursing supervisor began for all licensed nurses that wound care to be documented on TAR upon completion of treatment. Out of 20 licensed nurses on staff 18 have been educated. Licensed nurses who have yet to receive the education will not be permitted to work until the education is received.

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On 9/27/2018 in-service education by nursing supervisor began for all licensed nurses that for any resident receiving dialysis treatment during day shift hours that wound care to be scheduled for completion on evening shift. Out of 20 licensed nurses on staff 18 have been educated. Licensed nurses who have yet to receive the education will not be permitted to work until the education is received.

On 9/28/18 in-service education began by nursing supervisor for all staff for neglect. Out of 83 staff members 66 have been educated. Staff who have yet to receive the education will not be permitted to work until the education is received.

On 9/28/18 in-service education began by nursing supervisor for certified nursing assistants related to reporting to licensed nurse if resident wound dressing is heavily soiled and / or not in place. Out of 33 certified nursing assistants 6 have been educated. Staff who have yet to receive the education will not be permitted to work until the education is received.

On 9/27/2018 the treatment assessment record (TAR) for all residents were checked by the Director of Nursing to ensure wound care had been documented. Documentation was validated by observation of resident's dressings in place and noted to be clean, dry and intact.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:

On 9/27/18 the Quality Assurance and

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Performance Committee met and decided that on 9/28/18 the Director of Nursing, Assistant Director of Nursing and/or Nursing supervisor began audits of TAR for completion of documentation of wound care completion daily. Documentation of wound care documentation will be validated by observation of resident's dressings in place and noted to be clean, dry and intact. If a licensed nurse is identified as not documenting wound care completion the nurse will be provided a one to one re-education.

The Director of Nursing will report the findings of TAR wound care documentation audits to the Quality Assurance and Performance Improvement Committee monthly x 6 months for recommendations including new interventions to assure compliance is sustained ongoing.

The title of the person responsible for implementing the acceptable plan of correction:

The Director of Nursing is responsible for implementing this acceptable credible allegation of compliance

Immediate Jeopardy removal date: 09/28/18

Validation:

Immediate Jeopardy (IJ) was removed on 09/28/18 at 4:00 PM. Validation of the credible allegation for IJ removal was completed as evidenced by interviews with nurses, nursing assistants, housekeeping, and dietary services related to in-servicing which was received as a result of the survey. Any staff members not receiving the in-servicing prior to IJ removal were not allowed to clock in for work again until

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F 600	Continued From page 19 receiving the in-servicing. Review of the facility-wide skin sweeps revealed no other residents in the facility had larvae/maggots in their wounds. Contracted pest control services made an on-site facility visit on 09/28/18 during which they reviewed the facility's current treatment regimen for flies and suggested ways in which to improve management of flying insects in all areas of the building.	F 600		
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 observation, staff interview and record review the facility failed to accurately code Minimum Data Set (MDS) assessments for 3 of 21 sampled residents (Residents #11, #41, and #62). Findings included: 1. Resident #11 was admitted to the facility on 09/22/17 with diagnoses that included benign prostatic hyperplasia without lower urinary tract symptoms, retention of urine and neuromuscular dysfunction of the bladder. Review of the quarterly Minimum Data Set (MDS) Assessment dated 07/02/18 revealed that Resident #11 had moderately impaired cognition, required extensive to total care with all activities of daily living and had an indwelling urinary catheter. The assessment also documented that the resident was frequently incontinent of urine.	F 641	The plan for correcting this specific deficiency. An MDS modification was done on Residents #41, #62, and #11. A 6 month look back audit was done by the MDS nurses to ensure accuracy of assessments for catheters and discharges. This was completed on October 18, 2018. A procedure for implementing an acceptable plan of correction. On October 11, 2018 the MDS Consultant for Maximus Health Group in-serviced those employees that complete sections of the MDS on accuracy of MDS assessments and coding. The monitoring process to ensure that plan of correction is effective and that specific deficiency remain corrected and or in compliance. The Interdisciplinary	10/18/18

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F 641	Continued From page 20 An observation of care provided to Resident #11 was made on 09/26/18 at 2:30 PM. The resident had a suprapubic urinary catheter in place. His adult brief was clean and dry with no evidence of urinary incontinence. In an interview conducted with Nurse #9 on 9/26/18 at 2:15 PM, she stated that Resident #11 was not frequently incontinent of urine as he had a suprapubic catheter and did not urinate otherwise. She stated that she would generate an assessment modification to correct the error on the resident's 7/02/18 MDS assessment. In an interview conducted with the Director of Nursing on 9/26/18 at 2:45 PM, she stated that if a resident had a suprapubic catheter she would not expect the MDS assessment to be coded "frequently incontinent of urine." She stated that she expected all resident assessments to be coded accurately. 2. Resident #41 was admitted to the facility on 02/07/18 and expired on 09/25/18. Her diagnoses included pneumonia, liver cancer, atherosclerotic heart disease and Type 2 diabetes mellitus. Review of the Minimum Data Set (MDS) Assessments documented revealed that Resident #11 was discharged to the hospital and returned to the facility on 05/05/18, 07/09/18, 09/04/18 and 09/16/18. On 07/09/18 and 09/16/18 the MDS assessments were coded "return anticipated" and on 05/05/18 and 09/04/18 the MDS assessments were coded "return not anticipated." In an interview conducted on 09/27/18 at 10:15	F 641	Team will audit assessments completed by the MDS nurses for accuracy in discharge coding and catheter continence status. . Audits will be completed weekly. The Staff Development Coordinator or designee will re-educate to ensure compliance. Data results will be monitored and reviewed by the monthly Quality Assurance Process Improvement meeting for 3 months with subsequent plan of correction as needed. The Director of Nursing is responsible for the overall compliance.	

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AM with Nurse #10 she stated that on 5/5/18 and 09/04/18 the discharge assessments were coded incorrectly. She said that she was familiar with this resident who was long term care. She reported that she knew the resident was expected to return to the facility each time she was discharged to the hospital. She stated that she would generate assessment modifications to correct the errors on the resident's assessments dated 05/0518 and 09/04/18..

In an interview conducted on 09/27/18 at 12:15 PM with the Director of Nursing she stated that she expected the MDS assessments to be coded accurately for every resident.

3. Resident #62 was admitted to the facility on 05/11/18 and was discharged on 08/24/18. Her diagnoses included a fracture of the right pubis, dementia, cerebral infarction and dysphagia.

Review of the physician orders written on 08/24/18 included: Discharge resident to home on 08/24/18. Resume current medication, home health and physical therapy.

Review of the Minimum Data Set (MDS) discharge assessment dated 08/24/18 revealed that the resident was discharged to an acute care hospital with return not anticipated.

Review of the discharge progress note written by Nurse #11 on 08/24/18 at 1:17 PM read: "Resident discharged home with husband, meds sent with instructions on administration of meds. Meds not sent with resident was ordered from pharmacy to be picked up by resident. Diet explained to husband and copies of M.D. appts sent."

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F 641	Continued From page 22 In an interview conducted on 09/26/18 at 2:15 PM with Nurse #9 she stated that Resident #62 was discharged to home and not to the hospital as coded on the assessment. She stated that she would generate an assessment modification to correct the error on the resident's assessment dated 08/24/18. In an interview conducted on 09/26/18 at 2:45 PM with the Director of Nursing she said that if a resident were discharged to home that she expected the discharge MDS to be coded that the resident was discharged to home and not to the hospital.	F 641		
F 676 SS=G	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:	F 676		10/18/18

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F 676	Continued From page 23 §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to provide restorative nursing services to maintain the activity of daily living (ADL) progress made in therapy by 1 of 1 sampled residents (Resident #113) who was reviewed for therapy and restorative services. Findings included: Record review revealed Resident #113 was admitted to the facility on 01/03/18 and was discharged to another facility on 05/15/18. The resident's documented diagnoses included muscle weakness, difficulty walking, and lack of coordination. Review of therapy documentation revealed Resident #113 was on physical therapy caseload from 01/04/18 until 02/26/18, and was on occupational therapy caseload from 01/05/18 until 02/26/18.	F 676	The plan for correcting this specific deficiency. Resident #113 was discharged on 5/15/2018. A 6 month look back on therapy referrals to the restorative program were reviewed on October 15, 2018 to ensure compliance with restorative programming. A procedure for implementing an acceptable plan of correction. On October 11,2018 MDS Consultant for Maximus Health Group in-serviced the Director of Therapy, the Director of Nursing and the Restorative RN Nurse on the Restorative Nursing Program. The Restorative RN Nurse in-serviced the Restorative Nurse Aides on the program on October 15, 2018. The monitoring process to ensure that plan of correction is effective and that	

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F 676	Continued From page 24 The resident's 01/10/18 admission minimum data set (MDS) documented her cognition was moderately impaired, she exhibited no behaviors including rejection of care, she required extensive assistance by two staff members with transfers/locomotion off the unit/toileting, she required extensive assistance by one staff member with bed mobility/locomotion on the unit/dressing/hygiene, she required limited assistance by a staff member with bathing, and she did not walk in the room or corridor during the look-back period. On 01/25/18 "The resident requires limited to extensive assist with ADLs (activities of daily living) and is at fall risk due to need for assist with transfers and ambulation due to generalized weakness..." was identified as a problem in the resident's care plan. Interventions to this problem included referral to therapy to reach the resident's goal of going home. Resident #113's 02/26/18 Physical Therapy Discharge Summary documented she met her long term goal for bed mobility by progressing from requiring maximum assist and 75% verbal cuing to being independent with no verbal cuing required. The summary also documented the resident met her maximum potential with the following long term goals as evidenced by: the resident went from requiring maximum assist and 75% cuing with transfers to requiring only supervised assistance and 5% cuing, and the resident went from ambulating 50 feet using a rolling walker with maximum assist to ambulating 350 feet using a rolling walker with stand-by assist. The summary documented, "Maximum Potential Achieved, referred for RNP (restorative nursing program)."	F 676	specific deficiency remain corrected or in compliance. A weekly audit of new Restorative Programs will be completed by nursing management on all new referrals to ensure restorative programs are initiated. The Staff Development Coordinator or designee will re-educate the staff to ensure compliance. The audits will be reviewed weekly and signed off by the Director of Nursing or designee. Data results will be monitored and reviewed by the monthly Quality Assurance Process Improvement meeting for 3 months with subsequent plan of correction as needed. The Director of Nursing is responsible for the overall compliance	

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A Physical Therapy Restorative Nursing Program plan documented Resident #113 was to receive restorative nursing services starting on 03/01/18 and ending on 04/12/18. The plan called for the resident to receive sitting quad strengthening in the form of leg kicks, two sets of ten for each leg one time a day, and to receive sit to stand exercise from the wheelchair, two sets of ten one time a day. The plan was signed off on by the Director of Nursing (DON), a physical therapist, and Nurse #9 (Restorative) on 03/01/18.

The resident's 04/07/18 quarterly MDS documented her cognition was intact, she exhibited no behaviors including rejection of care, she required extensive assistance by two staff members with transfers, required extensive assistance by one staff member with bed mobility/locomotion on the unit/dressing/hygiene, was dependent on a staff member for toileting/bathing/locomotion off the unit, and she did not walk in the room or corridor during the look-back period.

On 09/26/18 at 10:45 AM Physical Therapist (PT) #1 stated between 01/04/18 and 02/26/18 Resident #113 went from requiring a lot of staff assistance with bed mobility to being independent, went from requiring a lot of staff assistance with transfers from the bed to the chair to requiring only staff supervision, and went from walking 50 feet using a walker with a lot of staff assistance to walking 350 feet using a walker with less staff assistance. He reported the resident was discharged from physical therapy because she met her maximum potential.

On 09/26/18 at 10:52 AM Occupational Therapist

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(OT) #1 stated between 01/05/18 and 02/26/18 Resident #113 cooperated and participated in therapy. She reported during the time the resident received occupational therapy she made the following improvements: the resident went from being barely able to move her arms to minimal resistance with full range of motion, went from requiring a lot of assistance to being independent with self-feeding, went from moderate assist to set-up only with grooming and hygiene, and went from requiring a lot of assistance to requiring a little bit of assistance with toileting. However, the OT commented Resident #113 seemed to give up on improving her toileting skills toward the end of her therapy.

On 09/26/18 at 11:23 AM Nursing Assistant (NA) #5 stated Resident #113 was alert and oriented, and required extensive assistance with her ADLs except she was able to feed herself. She reported the resident received therapy services, but she did not remember there being much difference in the resident's ability to help out with her ADLs after she was discharged from therapy. She commented the resident used the call bell, and would ask for assistance. The NA stated she did not remember seeing the resident ambulate, and when out of bed, the resident was in a wheelchair.

On 09/26/18 at 12:23 PM Nurse #5 stated Resident #113 was confused when admitted, but became more alert and oriented during her nursing home stay. He reported that the resident could use her hands, but had very little strength and mobility in her trunk and lower extremities. He commented the resident could not wheel herself in her wheelchair, and required extensive assistance from staff to being dependent on the

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staff for her ADLs. According to Nurse #5, Resident #113 could ring the call bell, but she did not use it very often because she did not want to bother the staff. He reported the resident's ADL status remained about the same during her stay.

On 09/26/18 at 1:02 PM Nurse #9 (Restorative) stated she was the staff member responsible for implementing restorative plans of care. However, she reported there was no restorative documentation for Resident #113 because the resident never received restorative services since she was not aware that Resident #113 was supposed to receive them. She reported that the therapists usually provided her with a copy of the restorative plan they designed, and she commented this plan outlined the services to be provided, the frequency of the services, and the duration of the services.

On 09/26/18 at 1:08 PM PT #1 stated he could only select two ADL areas to carry forward in Resident #113's restorative care plan. He reported he selected two types of exercises to keep the resident mobile, limber, and to maintain her strength. According to PT #1, the restorative program was important because it kept residents from losing the ADL progress they made while working with therapy. He commented when he designed a restorative plan he signed off on it, the DON signed off on it, and the Restorative Nurse signed off on it.

On 09/26/18 at 3:46 PM NA #4 stated Resident #113 required extensive assistance with her ADLs during her entire nursing home stay. She reported the resident tried to do as much as possible for herself, but would use the call bell for staff assistance when she needed help. She

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F 676	Continued From page 28 commented the only difference she saw in the resident after therapy was that she could help turn and reposition herself more in the bed. On 09/28/18 at 11:50 AM the DON stated therapists designed restorative nursing plans when residents met their maximum potential and had shown significant ADL improvement which could be continued through the provision of restorative nursing services. She commented Nurse #9 (Restorative) was responsible for seeing that the plans were implemented. She reported if Resident #113 had a restorative nursing plan which had been signed off on by a therapist, the DON, and the Restorative Nurse, then the plan should have been implemented. She commented the lack of implementation had the potential of causing the resident to lose progress which had been made with physical and occupational therapy.	F 676		
F 684 SS=J	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 observation, physician interview, staff interview, and record review the facility failed to document provision of basic care and treatment to prevent maggots from developing in the	F 684	The plan for correction this specific deficiency. On September 25, 2018 Resident #43 was discharged to the hospital. On September 27, 2018 the	10/18/18

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F 684	Continued From page 29 arterial/venous wounds of 1 of 1 sampled residents (Resident #43) reviewed for wound care. Resident #43 was observed to have maggots in his wound on 07/30/18. The facility also failed to conduct a root-cause analysis to determine where and how the resident's wound became contaminated. As a result there was a second observation of maggots in Resident #43's arterial/venous wounds one to two weeks after the initial sighting on 07/30/18. Immediate Jeopardy (IJ) began on 07/30/18 when basic wound care and treatment was not documented for Resident #43, and maggots were observed in his arterial/venous wound. One to two weeks after 07/30/18 maggots were again observed in the resident's arterial/venous wound beds and on his bedding. The IJ was removed on 09/28/18 when the facility implemented an acceptable credible allegation of IJ removal. The facility remained out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not IJ) to ensure monitoring of systems were carried out and employee in-servicing was completed. Findings included: Record review revealed Resident #43 was initially admitted to the facility on 03/22/18, and was readmitted to the facility on 06/22/18. The resident's documented diagnoses included cellulitis of right lower limb, chronic venous hypertension with ulcer of lower extremity, pressure ulcers to right and left heels, and end stage renal disease (ESRD) with hemodialysis. Resident #43's 06/22/18 Admit/Readmit Screener documented he had a suspected deep tissue	F 684	Director of Nursing audited Treatment Administrative Records to ensure wound care had been documented. Validated by observation of dressing in place, clean, dry and intact. On September 28, 2018 residents had a skin assessment done by Treatment Nurse, Staff Development Coordinator, MDS nurses and Director of Nursing. A procedure for implementing an acceptable plan of correction. On September 27, 2018 the Staff Development Coordinator in-serviced the nursing staff on documentation of wound care on the Treatment Administrative Record for completion of treatments. This information will be included in the new employee orientation for licensed nurses. The monitoring process to ensure that plan of correction is effective and that specific deficiency remain corrected and or in compliance. The Administrative Nurses will audit 5 residents with wound dressings and 5 Treatment Administrative Records (TARs) 3 X weekly X 4 weeks, 2 X weekly X 2 weeks, then weekly X 4 weeks and monthly thereafter to ensure ongoing compliance with wound dressing changes and documentation of treatments. The Staff Development Coordinator or designee will re-educate the staff to ensure compliance. Data results will be monitored and reviewed by the monthly Quality Assurance Process Improvement meeting for 6 months with subsequent plan of	

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F 684	Continued From page 30 injury (DTI) to his right heel measuring 3.2 x 3.5 centimeters (cm), an arterial/venous ulcer to his right lower inner leg measuring 13 x 3.2 x 0.2 cm, a suspected DTI to his left heel measuring 7.6 x 6.5 cm, and an arterial/venous ulcer to his left lower inner leg measuring 4.09 x 7.5 x 0.2 cm. Review of a care plan from a previous admission dated 04/03/18 revealed "The resident has DTI and potential for pressure ulcer development r/t (related to) impaired bed mobility, bowel bladder incontinence" was identified as a problem. Interventions to this problem included administering treatments as ordered and monitoring for effectiveness, assessing/recording/monitoring wound healing, and reporting improvements/declines to the primary physician/Medical Director. A 06/25/18 physician order documented Resident #43's right and left lower leg arterial/venous ulcers were to be cleansed with normal saline, patted dry, a foam dressing was to be applied, and the dressing was to be secured with roll gauze daily on day shift. Weekly wound assessments completed on 06/26/18, 07/03/18, and 07/10/18 documented the change in the measurements of Resident #43's four ulcers were minimal. There was no documentation about wound bed tissue, odor, and exudate in these assessments. The resident's 06/29/18 admission minimum data set (MDS) documented his cognition was severely impaired, he did not exhibit rejection of care, he required extensive assistance from staff to being dependent on staff for his activities of daily living (ADLs) except for requiring only	F 684	correction as needed. The Director of Nursing is responsible for the overall compliance.	

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supervision with eating, he had two unstageable deep tissue injury pressure ulcers, he had two arterial/venous ulcers, and he was receiving dialysis services.

Review of the resident's July 2018 TAR revealed the treatments/dressing changes to his bilateral lower extremity ulcers were not initialed off as being completed on 07/02/18, 07/03/18, 07/04/18, 07/06/18, 07/07/18, 07/08/18, 07/09/18, and 07/16/18 (the resident went to the wound clinic on this day).

Consult notes documented Resident #43 was seen by the wound clinic on 07/16/18 with a return appointment scheduled for 07/23/18 at 9:30 AM. There was no documentation of infection or the presence of maggots in the 07/16/18 wound clinic treatment notes.

On 07/17/18 the resident's care plan was updated to reflect that he had bilateral DTIs to his heels, an arterial/venous ulcer to his right lower lateral leg, and an arterial/venous ulcer to his left lower medial leg.

A 07/17/18 progress note, written by Nurse #5, documented, "Wound assessment completed, Vascular ulcer at right lower leg measures 10.4 cm x 5.1 cm, wound bed is beefy red, mild odor, pain to touch, minimal serosanguineous drainage, edges smooth, peri-wound tissue is dry. Vascular ulcer at left lower leg measures 0.7 cm x 0.9, wound bed is beefy red, no odor, pain to touch, minimal serosanguineous drainage, edges smooth, peri-wound tissue is dry. Current tx (treatment) for vascular wounds of foam dressings with dressing changes daily continue. DTI right heal measures 4.5 cm x 4.5 cm, DTI left

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heel measures 9.7 cm x 10.5 cm, both DTIs are hard/black eschar, peri-wound skin is intact/very dry. Current treatment of Silvercel with dry dressings daily continues."

A 07/18/18 physician order documented Resident #43's right and left lower leg arterial/venous ulcers were to be cleaned with wound cleanser, patted dry, Honey-Gel was to be applied and the wounds were to be covered with dry gauze (4 x 4's), and the dressing was to be secured with roll gauze daily.

Review of the resident's July 2018 TAR revealed the treatments/dressing changes to his bilateral lower extremity ulcers were not initialed off as being completed on 07/18/18, 07/19/18, 07/20/18, 07/21/18, 07/23/18 (the resident was sent out to the emergency room and returned back to the facility on this same day), 07/25/18, 07/27/18, 07/28/18, and 07/30/18 (Nurse #2 changed some of the dressings on this evening until she observed maggots in an arterial/venous wound).

A 07/23/18 transfer form documented Resident #43 was sent to the emergency room (ER) due to a change in mental status. The resident was not admitted to the hospital, but missed his 07/23/18 wound clinic appointment.

The resident's July 2018 TAR documented that on 07/29/18 Nurse #1 did the treatments and dressing changes to the bilateral heels DTIs and the bilateral arterial/venous ulcers for Resident #43.

On 09/26/18 at 4:12 PM, during a telephone interview, Nurse #1 stated she did dressing changes for Resident #43 on the weekends. She

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reported the resident's arterial/venous wounds "were not in good shape." She commented these wounds always had odor which was not pleasant but not foul. She stated the tissue and drainage varied from weekend to weekend. Nurse #1 reported she could not remember for sure what the resident's wounds looked like on 07/29/18 when she did the dressing changes, but if they had been different from usual she would have made contact with the resident's primary physician. According to this nurse, on 07/29/18 she did not remember seeing maggots in the resident's wound beds.

A 07/30/18 progress note, written at 11:06 PM by Nurse #2, documented, "While changing resident's BLE (bilateral lower extremity) dressings, noted left lower extremity to have foul, foul odor with copious amounts of drainage noted coming from all sites, also noted large amount of larvae coming out of wounds on lower left leg, Administrative nurse ...notified, resident sent to hospital to be evaluated and treated ....Dressing to RLE (right lower extremity) was changed without difficulty with copious amounts of foul purulent drainage noted ...."

On 09/26/18 at 4:20 PM Nurse #2 stated on 07/30/18 nursing assistant (NA) #1 came to her stating that when she provided incontinent care to Resident #43 the dressings to his bilateral lower legs rolled down and needed to be secured and/or changed. The nurse reported she decided to change the dressings, and there was a large amount of wet, yellow to slightly green drainage on the existing dressings. She also commented there was a strong odor coming from both arterial/venous wounds, but the odor coming from the left lower leg wound was extremely strong

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and foul. According to Nurse #2, when she unwrapped the old dressing on the left leg five or six very large and plump maggots fell from the wound onto the resident's bed. Nurse #2 reported one of the dressings to the lower legs had a date on it, but she could not remember which one, and she could not remember what the date was. She stated she had experience dealing with maggots and infected wounds, and using that knowledge base, she would estimate that it had taken a week for the maggots to reach the stage at which they presented on 07/30/18. Nurse #2 commented she could not remember if she obtained the order to send Resident #43 to the ER from the primary physician or the on-call physician.

A 07/30/18 transfer form documented Resident #43 was sent to the emergency room (ER) due to "ulcers to BLE (with) maggot infestation."

A 07/30/18 ER report documented, " ...Wounds are not purulent and do not appear infected. There are no maggots seen in any of the wounds ....Patient certainly has chronic changes and chronic wounds to both feet. However, there is no evidence of acute infection to either foot though (it require antibiotics or hospitalization). Discharge patient back to the nursing home and recommend that he resume treatments at his wound care center."

Review of wound clinic consults revealed Resident #43's wounds were assessed and treated at the wound clinic on 07/31/18, 08/09/18, and 08/23/18. There was no documentation of maggots to the wounds on any of these consult notes.

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A 08/01/18 physician order documented Resident #43's right and left lower leg arterial/venous ulcers were to be cleaned with mild soap and water, patted dry, covered with dry gauze (4 x 4's), and secured with roll gauze daily.

Review of the resident's August 2018 TAR revealed the treatments/dressing changes to his bilateral lower extremity ulcers were not initialed off as being completed on 08/01/18, 08/06/18, 08/08/18, 08/09/18 (the resident was seen at the wound clinic on this day), and 08/10/18.

The resident's 08/07/18 significant change MDS documented his cognition was severely impaired, he did not exhibit rejection of care, he required extensive assistance from staff to being dependent on staff for his activities of daily living (ADLs) except for requiring only supervision with eating, he had two unstageable deep tissue injury pressure ulcers, he had two arterial/venous ulcers, and he was receiving dialysis services.

On 09/26/18 at 8:15 AM Nurse #5 stated that observations of Resident #43's wounds/treatments would not be possible because the resident had been sent out to the emergency room the night before with a low grade temperature and mental status changes. This nurse reported the resident was admitted to the hospital.

On 09/27/18 at 9:38 AM Nurse #5, the current Treatment Nurse, stated he took over as full time Treatment Nurse on 08/14/18. Prior to 8/14/18 he reported he was changing Resident #43's dressing two to three times weekly. He reported back in July 2018 there was minimal drainage and no odor from the resident's arterial/venous

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wounds. According to Nurse #5, on the weekends Nurse #1 did the dressing changes/wound treatments for residents. He reported Nurse #1 dated her dressings, and he did not recall there being evidence that dressings were not being changed on the weekends. Nurse #5 commented that in general he thought the treatments/dressing changes were being done timely because of the consistent presentation of Resident #43's wounds.

On 09/27/18 at 12:43 PM the Director of Nursing (DON) stated she assumed her current position on 08/01/18, but was not aware of any residents having maggots in their wounds until questions were asked during the survey. She commented when she talked with Nurse #8 (the Staff Development Coordinator-SDC), Nurse #8 reported no in-servicing or root cause analysis was done concerning maggot infestation because the facility felt it had handled the problem appropriately by sending Resident #43 to the ER and wound clinic.

On 09/27/18 at 4:18 PM Nurse #5, the current Treatment Nurse, stated he did see a single maggot on Resident #43's bed after the resident's wound dressings were changed. He reported this sighting occurred a couple of weeks after the resident was sent out to the ER on 07/30/18 due to maggot infestation and decline in wound status. He commented that he did not notify the resident's primary physician or document his observation of the maggot, but he did call the wound clinic to discuss his observation, and the resident was seen there the next day.

On 09/27/18 at 5:05 PM NA #1 stated she sometimes helped the nurses position and hold

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Resident #43's legs when the nurses were changing the dressings on his arterial/venous wounds. She reported that sometimes the resident received dressing changes on first shift before he left for dialysis, but on other days it was too hectic on first shift, and his dressings were supposed to be changed on second shift after the resident returned from dialysis. According to NA #1, she had observed maggots in Resident #43's lower leg wounds twice. She commented the first time was on 07/30/18 and the next time was one to two weeks later. NA #1 stated that both times very large maggots fell from the wound bed onto the floor and the resident's bed. She also remarked that there were at least five or six very plump maggots present both times and that the resident went out to the wound clinic the day after both observations.

On 09/27/18 at 5:26 PM the DON stated she was not aware of any problems with staff not signing treatments off on the TARs. However, she commented that no staff had complained to her that they were unable to complete treatments/dressings changes.

On 09/27/18 at 5:41 PM NA #2 stated he worked on third shift, and about one and a half to two months ago when he was rounding on residents who were in his assignment, Resident #43 seemed restless so he decided to check him to see if he was wet or soiled. The NA reported when he pulled the covers back the resident's bed was full of large maggots. He commented he alerted Nurse #3 who gathered them and placed them in a cup.

On 09/27/18 at 6:02 PM Resident #43's primary physician and the facility's Medical Director stated

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if the maggots in the resident's arterial/venous wounds were as big as staff described them, it had probably taken a week for them to mature. He reported that obviously these maggots were not being used therapeutically, and they grew in the wound due to contamination. He commented that it would be important to determine where and how the contamination occurred since the resident resided in the facility but left the facility with family, and went to the dialysis center three times a week, to the wound clinic, and to the surgeon's office every two weeks. According to the Medical Director, if there were maggots, they had no negative effect since the resident was already on a "bad vascular path" which would eventually end in the bilateral amputation of Resident #43's legs.

On 09/27/18 at 11:16 PM, during a telephone interview, Nurse #3 stated she worked on third shift. She reported on 07/30/18 she had maggots collected from Resident #43's bed, placed them in a sterile container, and refrigerated them. However, she commented she disposed of them at the end of her shift. According to Nurse #3, she thought six large maggots were probably collected on 07/30/18, but she commented about a week or a week and a half later eight to nine maggots were once again found in Resident #43's wound and bedding. She stated she did not notify Resident #43's primary physician either time she observed maggots because she thought Nurse #2 had already done so since she was the first staff member who observed them on the night of 07/30/18. Nurse #3 reported she forgot to document about her observation of maggots a week or two later.

On 09/28/18 at 10:17 AM Nurse #8 (SDC and

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Infection Control) stated she remembered hearing mention of maggots in a resident's wound, and that from an infection control standpoint, you would want to figure out when and where the resident's wounds were contaminated by flies. She commented in-servicing about pest control, prompt removal of meal trays from resident rooms, frequent emptying of trash in resident rooms, and the importance of timely incontinent care would have been important topics to educate the staff about. However, she stated that root-cause analysis and infection and pest control in-servicing were not conducted after maggots were found either time in Resident #43's wound and/or room.

On 09/28/18 at 11:50 AM the DON stated she had asked staff about the wound treatments that were not initialed off on the TAR for Resident #43. However, she reported that no staff member, other than Nurse #1 who stated she was sure she did all dressing changes for the resident on 07/28/18, could say without a shadow of a doubt that treatments were provided to Resident #43 on the days when they were not initialed off on the TAR. According to the DON, her expectation was that nurses initial treatments as being done on the TAR as soon as they were completed. She also commented that during report first shift nurses should have shared with second shift nurses if Resident #43 left for dialysis before his wound dressings could be changed on first shift, but she was not sure that this was happening based on the missing documentation on the TARs.

On 09/28/18 at 3:55 PM, during a telephone interview, Nurse #4 stated she was assisting Nurse #2 with Resident #43's dressing changes

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on 07/30/18. She stated the arterial wounds had a very pungent odor, and when they got to the left leg arterial/venous wound she saw something drop on the bed. She commented she saw at least three large maggots fall from the wound bed before she had to leave the room. She reported she called 911 and started the paperwork for sending Resident #43 to the ER, but did not notify the resident's primary physician. Nurse #4 commented she was not sure how long it had been since the resident's dressings had been changed last, but she thought it could have been awhile since there was some confusion about whether first or second shift was responsible for the wound treatments. According to Nurse #4, she was prepared to make a statement about what she saw since it was such an infection control issue, but she reported she was never asked to do so by the facility.

During the survey several flies were noted in resident rooms and commons areas, but the presence of flies was minimal.

Review of pest control visits revealed that the contracted pest control company was in the facility on 04/30/18 (when no pest activity was noted), 05/30/18 (when a problem was noted with ants and treatment was provided for ants, mice, and roaches), 06/22/18 (when the presence of mice and roaches were noted and there was the creation of a perimeter for spiders), 07/31/18 (when treatment was provided for mice and ants), and 08/30/18 (when the dining room and kitchen were treated for miscellaneous insects and the exterior of the building was treated for mice). No fly problems or treatments for flies were documented in these visits. The facility's maintenance manager was unavailable during the

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survey.

The DON and Corporate Consultants were notified of the Immediate Jeopardy on 09/27/18 at 6:25 PM.

On 09/28/18 the facility provided an acceptable credible allegation for Immediate Jeopardy removal that included the following:

The plan of correcting the specific deficiency including the processes that led to the deficient practice cited on 9/27/2018 at approximately 6pm:

0n 7/30/18 the nurse working second shift noted larvae and maggots in wound. The nurse documented the assessment of larva in the wound of the resident and notified nursing administration. The nurse sent the resident to the emergency department for wound evaluation. The emergency department reports no record of larva present in the wound. The resident returned to the facility 7/30/18 with recommendations to resume treatment with the wound care clinic.

8/8/18 a nurse and certified nursing assistant again witnessed larvae and maggots to wound. The wound clinic was notified and the facility was instructed for the resident to keep scheduled appointment with wound clinic the following day.

The interdisciplinary team (IDT) including the Director of Nursing (DON), Minimal Data Set Nurse (MDS) and Corporate Minimum Data Set Nursing Supervisor met on 9/27/2018. Root cause was determined that the facility failed to provide adequate pest control. Research has shown that for larvae and/or maggots to be noted

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there had to be a presence of flies. The resident frequently left the facility for dialysis treatment and wound clinic visits. These transfers out of the facility were during the summer months when flies can be prevalent. Additional root cause is failure of staff to report the presence of larvae/maggots in resident care area to administration.

The interdisciplinary team (IDT) including the Director of Nursing (DON), Minimal data set Nurse (MDS) and Corporate Minimum data set Nursing supervisor met on 9/27/2018 and determined the root cause to be a breakdown in the wound care delivery process resulting in inconsistent documentation of treatment performed. An additional root cause was determined that there was inconsistent communication when the resident did not receive their wound treatment because the resident was out to dialysis during day shift hours and wound care needed to be completed on evening shift. An additional root cause was that the wound treatments could not be performed on day shift because resident was out of the facility for dialysis. Additional root cause for failure to document treatment completion on TAR is lack of education regarding the importance of documenting as soon as treatment is rendered and lack of communication.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited:

9/27/18 all resident care areas were inspected by IDT team to include MDS nurses, Staff Development Coordinator, Director of Nursing and Nursing Supervisor for larvae/maggots and flies with no observations of larvae/maggots or

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flies in any resident care area.

9/28/18 skin assessments completed for all residents in the facility by MDS nurses, Director of Nursing, Staff Development Coordinator and treatment nurse. Skin assessment includes inspection of any wounds and/or open areas for the presence of larvae/maggots. Skin assessments indicate no larvae/maggots noted in any wounds and/or open areas.

9/28/18 the Director of Nursing contacted the facility contracted pest control provider to visit the facility and complete a facility wide assessment for pest control. Visit scheduled for 9/28/18.

On 9/27/2018 the nurse who documented the presence of larva in the wound on 7/30/18 was educated by the nursing supervisor on the need for physician notification if larva or maggots were noted in the wound and notification to administration related to the presence of larvae/maggots.

On 9/28/18 the nurse who observed larvae/maggots in the wound on 8/8/18 was educated by the nursing supervisor on the need for physician notification if larva or maggots were noted in the wound and notification of administration related to the presence of larvae/maggots.

On 9/27/18 in-service education by the nursing supervisor began for all staff regarding notification of administration if any maggot, larva or flies was found in the facility. Education includes notification of maintenance and/or environmental services if flies are observed in the residents' rooms. Out of 83 staff members 66

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have been educated. Staff who have yet to receive the education will not be permitted to work until the education is received.

On 9/28/18 in-service education by the nursing supervisor began for all staff regarding environmental services to include emptying of trash cans in a timely manner, removal of meal trays upon completion of meal and resident care promptly provided. Out of 83 staff members 10 have been educated. Staff who have yet to receive the education will not be permitted to work until the education is received.

On 9/28/18 in-service education began by nursing supervisor for certified nursing assistants related to reporting to licensed nurse if resident wound dressing is heavily soiled and / or not in place. Out of 33 certified nursing assistants 6 have been educated. Staff who have yet to receive the education will not be permitted to work until the education is received.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:

On 9/27/18 the Quality Assurance and Performance Improvement committee met. They were notified of the immediate jeopardy and reviewed pest control practices. The team participated in root cause analysis and development of acceptable plan of correction.

Beginning on 9/28/2018 during twice daily ambassador rounds the staff will perform observation of resident care areas. If any pests including flies are identified the ambassador will

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attempt to eradicate as appropriate and notify administration immediately. Administration will contact pest control as indicated. Upon completion of ambassador rounds the completed ambassador rounds sheets will be submitted to the facility administrator for review.

Beginning on 9/28/18 during twice daily ambassador rounds the staff will perform observation of resident care areas to include uncovered food / perishable items, meal trays removed from room and trash removed from the room. If uncovered food / perishable items, meal trays and /or excess trash observed they will be removed at time of rounds completion. Upon completion ambassador rounds the completed ambassador rounds sheets will be submitted to the facility administrator for review.

Beginning on 9/28/18 during twice daily ambassador rounds the staff will perform observation to include evidence of completion of prompt resident care. Observations of residents requiring resident care will be reported to licensed nurse assigned to resident for care to be completed. Upon completion of ambassador rounds the completed ambassador rounds sheets will be submitted to the facility administrator for review.

Beginning on 9/28/18 environmental services staff to round all areas of facility twice daily for monitoring of emptying of trash cans in a timely manner, removal of meal trays, and uncovered / perishable food items. During rounds any concerns related to emptying of trash cans, removal of meal trays and/or uncovered / perishable food items will be corrected at the time of rounds completion. Results of twice daily

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environmental rounds will be submitted to the facility administrator for review.

Beginning on 9/28/18 the dietary manager and / or dietary supervisor will round food storage areas of the facility twice daily for monitoring of removal of meal trays, uncovered / perishable items. During rounds any concerns related to food storage including removal of meal trays and / or uncovered / perishable items will be corrected at the time of rounds completion. Results of twice daily food storage rounds will be submitted to the facility administrator for review.

Beginning on 9/28/18 the Director of Nursing, Assistant Director of Nursing and / or Nursing Supervisor will complete wound observations weekly for all residents with wounds to monitor for the presence of larvae and/or maggots in wounds. Any observations of larvae and/or maggots in wounds will be reported to physician at time of observation.

The facility Administrator will report the findings of ambassador care rounds and environmental services rounds to the Quality Assurance and Performance Improvement Committee monthly x 6 months for recommendations including new interventions to assure compliance is sustained ongoing.

The Director of Nursing will report the findings of wound care observations and progress notes review for notification of the physician for change of condition to the Quality Assurance and Performance Improvement Committee monthly x 6 months for recommendations including new interventions to assure compliance is sustained ongoing.

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F 684	Continued From page 47 The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing is responsible for implementing this acceptable credible allegation of compliance. Immediate Jeopardy removal date: 09/28/18 Validation: Immediate Jeopardy (IJ) was removed on 09/28/18 at 4:00 PM. Validation of the credible allegation for IJ removal was completed as evidenced by interviews with nurses, nursing assistants, housekeeping, and dietary services related to in-servicing which was received as a result of the survey. Any staff members not receiving the in-servicing prior to IJ removal were not allowed to clock in for work again until receiving the in-servicing. Review of the facility-wide skin sweeps revealed no other residents in the facility had larvae/maggots in their wounds. Contracted pest control services made an on-site facility visit on 09/28/18 during which they reviewed the facility's current treatment regimen for flies and suggested ways in which to improve management of flying insects in all areas of the building.	F 684		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and	F 698		10/18/18

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F 698	Continued From page 48 the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility staff failed to monitor a dialysis resident's access/shunt site and failed to provide nursing assessments for a resident after dialysis treatments for one of two residents reviewed for dialysis (Resident #57). Findings included: Record review revealed Resident #57 was re-admitted to the facility on 08/18/18 with diagnoses which included End Stage Renal Disease (ESRD) with Hemodialysis three times per week. Review of the most recent Minimum Data Set (MDS) dated 09/15/18 revealed Resident #57 had no cognitive impairments, and needed supervision to extensive assistance for Activities of Daily Living (ADLs). Review of Resident #57's Care Plan (CP) dated 08/21/18 revealed the resident needed dialysis related to ESRD. The CP interventions included: dialysis treatments (Mondays, Wednesdays, and Fridays), assessment of the resident upon return from dialysis treatment, and to monitor/document to MD as needed (PRN) for signs and symptoms (S/S) of infection, and to assess site (for redness, swelling, warmth, drainage, bleeding, or hemorrhage). Review of Resident #57's dialysis communication book on 09/26/18 at 1:30 PM with Nurse #6 (Charge Nurse) revealed the dialysis return assessment for 09/26/18 had not been completed.	F 698	The plan for correcting this specific deficiency. On September 27, 2018 a post analysis assessment was done by Charge Nurse on Resident #57. Post dialysis assessment was negative. Upon review of dialysis residents, post dialysis assessments were appropriately documented. A procedure for implementing an acceptable plan of correction. On September 27, 2018 the Staff Development Coordinator in-serviced the nursing staff on completion of the Dialysis Communication Notebook by completion of the pre-dialysis assessment, post-dialysis assessment and assessment of shunt site on each shift. This information will be included in the new nurse employee orientation. The monitoring process to ensure that plan of correction is effective and that specific deficiency remain corrected and or in compliance. An audit of the Dialysis Communication Notebook will be done 3 X weekly for completion by nursing management. The staff Development Coordinator or designee will re-educate the staff to ensure compliance. The audits will be reviewed weekly and signed off by the Director of Nursing. Data results will be monitored and reviewed by the monthly Quality Assurance Process Improvement meeting	

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F 698	Continued From page 49 Further review of the Dialysis Communication Notebook Record for Resident #57 revealed no post dialysis entries for assessing the resident or her shunt site for the following dates: 09/24/18, 09/21/18, 09/17/18, 09/15/18, 09/12/18, 09/10/18, 09/07/18, 09/05/18, 08/29/18, 08/27/18, 08/24/18, and 08/22/18. There were no documents in the electronic medical record/nursing notes/assessments for the resident or the shunt site. An interview with Resident #57 was conducted on 09/26/18 at 1:25 PM. The resident reported she went to dialysis three times a week. The resident said the nursing staff did not assess her or the shunt after she returned from dialysis. An interview on 09/26/18 at 1:40 PM with Nurse Aide (NA) #3 (transport aide) revealed she transported Resident #57 to dialysis on Monday, Wednesday, and Fridays. The NA also reported she always took the resident's dialysis communication book with her to dialysis. She said when she returned back from dialysis she would drop off the resident's dialysis communication book at the nursing station for a nurse to fill out. An interview was conducted with the Director of Nursing (DON) on 09/26/18 at 1:50 PM. The DON stated the facility expectation was for all dialysis residents to be assessed prior to dialysis, to be assessed immediately post dialysis, and the shunt site to be assessed every shift. The DON stated these assessments should be documented in the resident's Electronic Medical Record (EMR), as well as the dialysis communication book, and had not. The DON stated it was also a	F 698	for 3 months with subsequent plan of correction as needed. The Director of Nursing is responsible for the overall compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING _____ B. WING _____	C 09/28/2018

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F 698	Continued From page 50 facility expectation that all dialysis residents have a dialysis communication book to ensure there was communication for any issues documented from the dialysis center staff.	F 698		
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 observation and staff interview the facility failed to keep kitchen sanitizing solutions at the strength required to effectively kill germs and bacteria. The facility also failed to discard kitchenware compromised by cracks and abraded interior surfaces. Findings included: 1. Observation of the dish machine process began at 9:30 AM on 09/26/18. Dietary Aide (DA) #1 was spraying dirty kitchenware and placing	F 812	The plan of correcting this specific deficiency. On September 26, 2018 dishes were inspected for cracks and abrasions and removed from use. Chemical sanitizer concentration were check to ensure within appropriate guidelines. A procedure for implementing an acceptable plan of correction. On	10/18/18

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F 812	Continued From page 51 some of it in a pre-soak solution. She placed her hands in a deep bowl of sanitizing solution as she moved from handling dirty kitchenware on one side of the dish machine to handling sanitized kitchenware that was exiting on the other side of the dish machine. At 9:42 AM 09/26/18 DA #2 was observed wiping the exterior and interior of the emptied meal carts that had been in the dining room and on resident halls with a cloth kept in a red bucket of sanitizing solution. At 9:59 AM on 09/26/18 the aides stated that both the deep bowl and the red bucket kept at the dish machine contained a bleach solution which should register at least 50 part per million (PPM) of hypochlorite. At this time a strip used to monitor the sanitizing solution in both containers only registered 0 - 25 PPM hypochlorite. DA #1 reported she had placed only a few drops of bleach into the water in the deep bowl she kept at the dish machine because even a half cap full of the bleach made the solution too strong. DA #2 commented she made up the solution in the red bucket at 9:00 AM, and at that time the strip she used to check its strength registered 50 PPM. She explained she had saved the strip, and provided it for inspection (which verified that the solution initially met facility expectations at 50 PPM hypochlorite). According to both aides, they only checked the strength of their sanitizing solutions when they first made them up. At 10:05 AM on 09/28/18 the Dietary Manager (DM) stated when bleach was added to water it was important that strips used to check the strength of the bleach-based sanitizing solutions registered 50 - 100 PPM of hypochlorite. She	F 812	September 26, 2018 the Dietary Manager in-serviced the dietary staff on food safety requirements related to kitchen sanitizing solution requirements and discarding of crack/abraded dishes. Return Demonstration with dietary staff were completed by October 15, 2018.This information will be included in the new employee orientation. The monitoring process to ensure that plan of correction is effective and that specific deficiency remain corrected and or in compliance. Dietary Sanitation Pail Blue (hand rinsing) will have chemical sanitizer concentration checked after each meal cart for each meal service for appropriate chemical sanitizer concentration. Dietary Sanitation Pail Red (cleaning surfaces)will have chemical sanitizer concentration checked four times per day. Chemical concentration corrected if indicated. Dishware will be inspected weekly by the Dietary Manager or designee. Replacement dishes will be ordered as indicated. The audits will be reviewed weekly and signed off by the Dietary Manager or designee. Data results will be analyzed and reviewed monthly at the monthly safety committee meeting. The monthly safety meeting data will be reviewed by the month Quality Assurance Process Improvement meeting for 3 months with subsequent plan of correction as needed. The Dietary Manager is responsible for the overall compliance.	

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F 812	Continued From page 52	F 812		

reported this was necessary to kill germs and bacteria that might be present in food carts which had been in the dining room and on halls where resident care was being provided. She commented if germs and bacteria were not killed then there could be cross contamination which could make residents sick. She also stated that 50 PPM of hypochlorite was required to kill any germs that might be on the the hands of employees handling dishes and silverware used by residents during meal consumption.

At 10:12 AM on 09/28/18 DA #3 stated she had been taught that strips used to check the strength of bleach-based sanitizing solutions had to register at least 50 PPM in order to kill germs and bacteria. She reported she always used strips to check the strength of sanitizing solutions when they were made up, but did not go back and recheck the strength as the dish machine process or cleaning of food preparation surfaces progressed.

2. Beginning at 11:18 AM on 09/26/18, during the inspection of kitchenware with the potential of being used at the upcoming lunch meal, 8 of 23 (35%) plastic soup and cereal bowls had deep interior abrasions inside of them. In addition, 6 of 20 (30%) plastic coffee mugs had deep interior abrasions inside of them, and 3 of 9 (33%) sectional plates had cracks in the bottoms of them.

At 10:05 AM on 09/28/18 the Dietary Manager (DM) stated the dietary staff had been in-serviced prior to the survey that any kitchenware that was chipped or cracked was supposed to be disposed of. She reported staff were told to count the number of items that were being discarded, and

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F 812	Continued From page 53	F 812		

report that number to her (the DM) so that she could re-order. She commented she did not think that staff were aware that the same procedure applied to kitchenware which had abraded interior surfaces. The DM stated using scrubbers on the soup/cereal bowls and coffee mugs might have contributed to the compromised condition of this kitchenware. According to the DM, using cracked and abraded kitchenware posed the risk that materials in the kitchenware might slough off and choke residents or make them sick. The DM also commented that it was more difficult to keep cracked and abraded kitchenware clean and sanitized.

At 10:12 AM on 09/28/18 Dietary Aide (DA) #3 stated chipped and abraded kitchenware posed a safety risk and a sanitation risk for residents. She reported she was instructed to throw this type of kitchenware away because it was not safe to serve food or beverage in. She explained plastic or china particles from compromised kitchenware could cut or choke residents, and the germs hidden in cracks or abrasions could make residents sick.