STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001 SS=C	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to have comprehensive emergency preparedness (EP) plan. The EP manual failed to: -include community-based risk assessment, facility risk assessment and associated strategies, the emergency plans and procedures did not include missing resident in their EP program failed to identify its resident population. The EP did not include policy and procedures for sheltered residents and staff who remained in the facility, policy and procedures to track residents	E 001	DISCLAIMER RESPONSE PREFACE: Presbyterian Home of Hawfields Acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and	11/22/18

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

Electronically Signed | 11/14/2018

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E 001	Continued From page 1 and staff who were moved to other facilities and policy and procedure for staff, residents and others who remained in the facility during an emergency. The EP did not include policy and procedures to preserve resident information and protect resident confidentiality, secure and maintain availability of resident ' s medical records. The communication plan failed to include contact information of staff, resident ' s physician and other facilities, contact information of the State Licensing and Certification Agency and State Long Term Care Ombudsman. The plan failed to include procedure of sharing information and medical documentation of its resident with other health care providers and facilities that would be providing continuity of care and method of sharing information regarding facility needs and its ability to provide assistance for its occupancy to authorities having jurisdiction during an emergency. The EP failed to establish a procedure of sharing information and providing documents from its emergency plan to residents, family members or resident representatives. Findings included: Record review of the EP manual dated March 29, 2009, provided by the facility revealed EP manual was not updated to include community-based risk assessment, facility risk assessment and associated strategies. The emergency plans and procedures did not include missing resident in their EP program. A review of the EP manual revealed: a. The resident population within the facility were not addressed. The manual did not recognize residents that need specific care such as: resident who were immobile, residents	E 001	provisions of quality of care of Residents. The plan of correction is submitted as a written allegation of compliance. Presbyterian Home of Hawfields Response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Presbyterian Home of Hawfields reserves the right to refute any deficiency on this statement of deficiencies through informal dispute resolution, formal appeal, and/or other administrative or legal procedures. E-001 11/22/18 Presbyterian Home of Hawfields will continue to strive to ensure that the emergency preparedness requirements are met through Federal, State, and local emergencies preparedness guidelines. Presbyterian Home will develop and maintain a comprehensive emergency preparedness program utilizing an all-hazards approach. Emergency Preparedness Planning and Resource Manual was ordered on 10/25/2018. The emergency program has been updated. Administrator and/or designee reeducated staff on emergencies and preparedness. Administrator and/or designee will continue to monitor and update accordingly.	

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E 001	Continued From page 2 needing oxygen and so on. The manual also did not include the type of services that the facility was capable to provide to its residents during an emergency. Continuity of operations and succession plan were also not included in the EP program. Further review of the EP program also revealed that the risk assessment for the facility had not been completed. b. The policy and procedures did not show a way to track residents and staff on duty who remained in the facility during emergencies. The manual did not include any tracking system for residents and staff who left facility and were sheltered by other facilities. c. The facility did not establish a criterion for its residents or staff who will be sheltered in the facility in case of emergency. The facility did not include a procedure for sheltering staff, residents and others who remained in the facility in an event when evacuation could not be executed. d. The plan revealed lack of policies and procedures on how resident ' s confidentiality would be maintained, how resident ' s medical information would be protected and how resident ' s medical records will be available for continuity of care when residents were evacuated or transferred to other facilities during an emergency. e. The communication plan did not include names and contact information of all staff working in the facility, information of residents ' physicians and contact information of other facilities including but not limited to its sister facilities that would be providing services and care to the residents during an emergency. The	E 001	Administrator and/or designee will continue to randomly audit the emergency preparedness plan by actively practicing drills with all staff and evaluating the outcome. A QA audit tool will be used three (3) times per week for one (1) month and reviewed at least weekly by Administrator and/or designee. QA committee will review the QA action plan once a month for three (3) months and revise the action plan to ensure continued compliance.	

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E 001	Continued From page 3	E 001		

plan did not include contact information of the North Carolina Nursing Home Licensure and Certification Agency and contact information of Long Term Care Ombudsman.

f. The EP communication plan did not include process or procedure that indicated how resident information and medical documents would be shared with other facilities and health care providers who would be providing continuity of care for residents who are sheltered by other facilities and at other locations in an emergency situation. It also did not include the process or procedure as to how the facility would communicate and share information of its occupancy/ residents needs and facilities ability to provide assistance to authority having jurisdiction or "the Incident Command Center" during an emergency situation.

g. Review of the Communication Plan in the EP manual revealed no documentation as to how the facility ' s emergency plan would be shared with its residents, family members and/ or resident representatives.
During an interview on 10/25/18 at 11:30 AM, Administrator indicated that the maintenance director oversaw the EP. Interview with the Maintenance Director and the administrator on 10/25/18 at 11:40 am, revealed that they did not know that the EP needed to be updated each year to reflect the changing residents, their needs, how information would be shared with the community/families/other facilities. He also stated there were no tracking systems for the residents and the staff, or the need to have supplies/medications/food enough for each resident and staff to last more than one day.

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F 550	Continued From page 4	F 550		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and	F 550		11/22/18

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F 550	Continued From page 5 reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to respond to call light for 1 of 2 residents who needed medical assistance (Resident #35) . The findings included: 1.Resident #35 was admitted to the facility on 8/4/18. The diagnoses included chronic urinary tract infection, hypertension, anxiety and gastro-esophageal reflux. The most recent Minimum Data Set(MDS) dated 7/23/18, indicated Resident #35 ' s had no cognition impairments and she required total assistance with activities of daily living activities. Review of the care plan dated 8/1/18 identified the problem as the resident was at risk for urinary tract infection related to history of UTI. The goal included resident urinary tract infections would be resolved without complications. The approaches included education was provided to the resident and family on urinary tract infection, encouragement of adequate fluids, incontinent care as needed, lab work as ordered, monitor and document for signs and symptoms of urinary tract infection and report to physician. During observation and interview on 10/22/18 at 2:00 PM, Resident #35 was lying in bed on left side holding her stomach. Resident#35 stated she was not feeling well and thought that she was developing a urinary tract infection(UTI) due to	F 550	F-550 11/22/18 Presbyterian Home of Hawfields will continue to strive to ensure that all residents have a right to a dignified existence, self determination, and communication with and access to persons and services inside and outside the facility. DON and or designee will monitor all activities and interactions with residents by any staff, temporary agency staff or volunteers on a regular basis to assure each resident□s individuality, as well as honor and value their input. All staff were reeducated regarding resident□s right and the resident right to exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. The DON and/or designee will continue to randomly audit in-house residents to ensure staff is providing quality care and all resident□s needs are met. A QA audit toll will be used three (3) times per week for one (1) month and reviewed at least weekly by DON, Administrator and/or designee. QA committee will review the QA Action Plan once a month for three (3) months	

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F 550	Continued From page 6 some burning during urination. Resident #35 stated "I just don ' t feel right", when I press the button staff come in my room and turn it off and say they would come back. It would be more than hour before someone comes back and I had to ring the button several times or call my daughter and tell her what is going on with me. "It just breaks my heart to have to wait and hold my bladder so long. On Sunday I had to wait several hours, and I wet all over myself and bed before anyone came to check on me. ' I don't like to call my daughter for everything, but this was the only way I can get somebody to come in the room and help me." During a continuous observation on 10/22/18 at 2:00 PM to 3:15 PM, Resident #35 pressed the call light button and NA #8 came in and ask resident what was wrong. Resident #35 stated she did not feel well. NA#8 turns off the call light and walked out the room. NA#8 did not ask the resident any further questions or what other assistance she may have needed. Resident #35 stated "this happens all the time it just upset me so much." Resident pressed the call light at 3:00 PM, another aide arrived at 3:09 PM, resident stated she did not feel well and thought she may have a UTI. At which time resident was attempting to reach her daughter, by telephone. During an interview on 10/22/18 at 3:15 PM, Nurse #5 stated this was the first time she became aware that Resident #35 needed nursing assistance. She further stated that NA #8 had not informed her the resident wasn't feeling well. During an interview on 10/22/18 at 3:18 PM, NA#8 was asked when she responded to Resident #35 ' s call light why did she just turned the light out and not find out what else the	F 550	and revise the action plan t ensure continued compliance.	

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F 550	Continued From page 7 resident needed and walk out of the room, there was no response. NA #8 stated she told Nurse #5 that the resident was not feeling well. "I don ' t know what the nurse did after that point." During an interview on 10/23/18 at 12:13 PM, the Responsible Person(RP) stated she received a call from Resident #35 about staff not responding to her call light and her possible urinary tract infection. The RP stated call light response had been an ongoing issue which had been reported several times to management. RP further stated due to Resident #35 ' s chronic health issues the delay in response time frustrates her mother and she would call and ask her to call the facility to get assistance. The RP reported this had been a problem for a while and when it was reported to management; it just seems that management would ignore the concern. The wait time can be problematic for my mother at times due to her holding bladder and the long history of UTI. When staff don ' t respond it frustrates her and she gets upset. Then I would receive a call for things that should have been taken care of. This had been reported to management numerous times. During an interview on 10/24/18 at 2:58 PM, the Director of Nursing state the expectation would be for staff to respond to the call light timely and ask the resident what assistance was needed. Staff should not turn the light out until assistance was provided. She further stated the expectation would be for the nurse to go in assess the resident for care needs and provided care accordingly.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		11/22/18

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F 584	Continued From page 8 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable	F 584		

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F 584	Continued From page 9 sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and review of records, the facility failed to clean resident room and bathroom for 1 of 6 resident rooms (Resident #6). The findings included: Resident #6 was admitted to the facility on 8/1/14. The diagnoses included muscle weakness, cerebral vascular disease, hypertension, chronic kidney disease and diabetes. The most recent Minimum Data Set(MDS) dated 9/21/18, indicated Resident #6 ' s cognition was intact, and he required total care. Observation on 10/24/18 at 2:13 PM, of the bathroom in Resident #6 ' s room revealed dead bugs behind the toilet. The walls and shelving area was dirty with dried brown matter, liquids and encrusted areas. The corners of bathroom floor at the baseboard area had a heavy buildup of encrusted matter urine like stains. During an interview/observation on 10/24/18 at 3:10 PM, Resident #6 stated the bathroom was worst and housekeeping doesn't do a good cleaning the bathroom around the commode and sink. During an interview on 10/24/18 at 3:25 PM, the Housekeeping Supervisor(HKS) The HK staff responsible for cleaning resident rooms daily. The responsibilities included cleaning bathrooms, dusting, emptying trash, wiping down walls, heating units, emptying trash, sweep and mop entire room. HKS indicated she was unaware the	F 584	F-584 11/22/18 Presbyterian Home of Hawfields will continue to strive to ensure that all residents have a right to a safe, clean, comfortable and homelike environment including receiving treatment and supports for daily living safely. Housekeeping and maintenance cleaned dirty areas and sprayed areas that contained bugs for resident # 6 and will continue to make sure all resident□s room maintain a safe, sanitary, orderly, and comfortable interior. This started on 10/24/2018. Pest control came in on 10/26/2018 to spray and inspect for bugs in resident #6 rooms and for all other surrounding rooms. Pest control will spray and inspect all resident□s rooms that are problematic for bugs at least biweekly until resolved and will resume monthly thereafter. Resident #6 bathroom tile and toilet will be replaced within the next two (2) weeks. Housekeeping supervisor reeducated housekeeping staff on the responsibility for cleaning resident□s room daily which includes clean: bathrooms, dusting, empting trash, wiping down walls, heating units, sweep and mop entire room for all residents daily. DON also reeducated staff on tidy cleaning in resident□s room for all residents. This also started on 10/24/2018.	

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F 584	Continued From page 10 room had not been thoroughly cleaned. During an interview on 10/25/18 at 10:13 AM, Housekeeper #2(HK) stated her responsibilities included dust, mop, sweep, trash, mirrors, commodes, clean shelves walls, floors behind the beds. HK #2 stated she had cleaned Resident #6 ' s room yesterday and saw the two traps filled with bugs on the floor. She further stated she was instructed not to move resident personal belongings unless they had resident ' s permission. She added that did not clean inside the resident ' s drawers, but had cleaned behind the resident's bed, commode, sink and wipe down the walls. HK #2 reported she did not see the ants around the bed area. During an observation of the resident's bathroom, there was still dried matter on the walls around the shelving area and underneath the skink. HK#2 stated she had wiped down the commode, mirror and shelve under the mirror. HK#2 confirmed the shelf with denture cup and mouth swabs, shaving cream had not been cleaned. During an interview on 10/25/18 at 10:28 AM, HK #4 stated the expectation would be to clean the bed room from top to bottom to include dust, mop and sweep under beds, bathrooms, empty trash, clean heating units, deep clean around corners, commodes, sinks, clean mirrors shelves, replace, supplies etc. HK#4 stated the resident room could be cleaned and dusted around the personal items. In bathrooms the items are moved so the cleaning can be done and returned. During an interview on 10/25/18 at 2:52PM, the Director of Nursing(DON) stated resident rooms should be cleaned daily and if there were any concerns it should be reported to housekeeping	F 584	Housekeeping will continue to monitor resident□s room for a safe living environment as well as DON and/or designee will continue to monitor staff for tidy cleaning for all resident□s room to ensure comfort and safety for all residents. A QA audit tool will be used three (3) time per week for one (1) month and reviewed at least weekly by DON, Administrator and/or designee. QA committee will review the QA Action Plan once a month for three (3) months and revise the action plan to ensure continued compliance.	

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F 584	Continued From page 11 supervisor.	F 584		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to discard expired food in the dry storage area and failed to properly label foods in 1 of 1 dry storage area and 1 of 1 walk-in refrigerator. Finding included: 1. An observation of the dry storage on 10/22/18 at 9:45 AM revealed two boxes of chocolate cake mix with a used by date "21 January 2018". 2 a. An observation of the dry storage on	F 812	F-812 11/22/18 Presbyterian Home of Hawfields will continue to thrive to ensure that the facility obtains food for resident consumption from sources approved or considered satisfactory by federal, state, or local authorities. Dietary manager and/or designee will inspect food items, boxes, and containers for dates and expiration dates of products on a regular basis to ensure effectiveness of food service safety.	11/22/18

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F 812	Continued From page 12 10/22/18 at 9:45 AM revealed an opened box , individually wrapped with "Oatmeal Cream Pies" printed on it and an opened plastic container with "Light Corn Syrup- 1 Gallon" printed on it with no label indicating the open date and expiration date. b. An observation of the walk- in refrigerator on 10/22/18 at 9:45 AM revealed an opened plastic container with "Mayonnaise - 1 Gallon " printed on it, an opened plastic container with "Sweet Relish -1 Gallon" printed on it and an opened plastic container with " Dill Spears- 1 Gallon " printed on it with no labels indicating the open dates and expiration dates of these products. During an interview on 10/22/18 at 9:50 AM, the dietary manager was unsure of the expiration dates. The dietary manager further stated that the dietary supervisor was responsible for ordering the food products and labeling the food products. c. An observation of the walk- in refrigerator on 10/24/18 at 10:55 AM, revealed a plastic container half filled with a light yellowish sauce, with "Honey Mustard Sauce - 1 gallon" printed on it , a half filled plastic container with brownish liquid with "Soy sauce - 1 gallon" printed on it and a half filled plastic container with brownish liquid with" Worcestershire sauce - 1 gallon printed on it with no labels indicating a use by dates or expiration dates on them. Observation also revealed a tray containing 21 individually wrapped sticks of butter with no expiration date or no use by date on them. The rack also contained eight 16 oz tubs with "Knorr roasted chicken base " printed on them. These tubs had no label indicating the use by or expiration date. During an interview on 10/24/18 at 10:55 AM, the	F 812	Boxes and/or containers of dry storage items are dated when opened. Items are used or discarded by the use by, best by dates. The facility□s food storage guide is used to determine the products expiration date if items don□t have use by or best by label on it. Canned items are removed from boxes and individually dated with date received. All refrigerated and frozen boxes/containers are dated when opened and same guidelines are applied. Dietary staff has ensured that all food items have met the requirements. The dietary manager and/or designee will randomly audit labels for dates and expirations on all food products. A QA audit will be utilized. A QA audit tool will be used three (3) times per week for one (1) month and reviewed at least weekly by the dietary manager and/or designee. QA committee will review the AW Action Plan once (1) per month for three (3) months and revise the action plan to ensure continued compliance.	

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F 812	Continued From page 13 dietary supervisor acknowledged the individually wrapped sticks of butter placed on the tray had no dates to indicate the expiration or use by date. The dietary supervisor stated all the food products ordered came in cardboard boxes that indicated the date in Julian format (code that consist of series of numbers and/or letter applied by manufactures to identify the date and time of production). He was unable to state how the staff would know about the expiration dates. During an interview on 10/25/18 at 10:00 AM, the dietary cook #1 indicated based on the menu, the food was removed from the freezer and labeled before placing it in the refrigerator for thawing. The cook further indicated the boxes had packed date. The cook# 1 indicated she was unsure how to read the Julian date on the boxes. During an interview on 10/25/18 at 10:05 AM, the dietary cook # 2 indicated she was not sure when the product was placed in the walk -in refrigerator as it was not labelled. The dietary cook #2 also indicated she did not know how to read the Julian dates. During an interview on 10/25/18 at 11:00 AM. the dietary manager indicated it was her expectation that the food was placed in original boxes with appropriate dates and if removed from the original box be labelled appropriately. She also stated the expired food should be discarded appropriately.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		11/22/18

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F 867	Continued From page 14 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's Quality Assessment an Assurance Committee failed to effectively maintain implemented procedures and effectively monitor the interventions that the committee put into place in September 2017. This was for three recited deficiencies, which were originally cited on 9/21/17 during the recertification survey and on the current recertification survey. The deficiencies were in the area of, Homelike Environment, Food Procurement and Quality Assessment and Assurance improvement. The continued failure of the facility during three federal surveys of record show an isolated pattern of the facilities inability to sustain an effective quality assurance program. The Findings included: This tag is cross-referred to: 1. F584-Based on observation and staff interview the facility failed to discard expired food in the dry storage area and failed to properly label foods in 1 of 1 dry storage area and 1 of 1 walk-in refrigerator. The facility was cited during the 9/21/17 recertification survey for failure to clean, wax or strip dark accumulated residue along the edges of the walls, in all doorways along halls A, B, C and D. 2. F812 - Based on observation and staff interview the facility failed to discard expired food	F 867	F-867 11/22/18 Presbyterian Home of Hawfields will continue to strive to ensure that procedures put into place in September of 2017 will effectively be monitored and evaluated to ensure interventions are properly being maintained. Administrator and/or designee will evaluate improvement projects conducted by the facility on a regular basis to assure quality assessment and assurance to develop and implement appropriate plan of action. Dietician manager reeducated dietary staff on safe storage and labeling of foods. Housekeeping supervisor reeducated housekeeping on cleaning in all doorways along halls, cleaning floors and cleaning dark accumulated residue on edges of the walls. The administrator and/or designee will regularly review and analyze data, including data collected under the QAPI program and act on available data to make improvements. Labeling of foods and cleanliness of the facility will be monitored on a regular basis to ensure quality assurance. The administrator and/or designee will randomly audit the QAPI program for performance improvements to identify	

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F 867	Continued From page 15 in the dry storage area and failed to properly label foods in 1 of 1 dry storage area and 1 of 1 walk-in refrigerator. The facility was cited during the 9/21/17 recertification survey for failure to label/identify with preparation date or the use-by date food in walk-in freezer: the fifteen plastic bowls filled with a pudding-like substance, two oblong metal pans covered with foil; in walk-in refrigerator, foil-covered tray labeled "lunch", three small bowls covered with plastic and two small plastic glasses covered with plastic lids; in nourishment room refrigerator: unopened ready-to-eat frozen dinner, store-bought clear plastic food container with no name on it. 3. F520 - Based on record review and staff interviews, the facility's Quality Assessment an Assurance Committee failed to effectively maintain implemented procedures and effectively monitor the interventions that the committee put into place in September of 2017. The facility was cited during the 9/21/17 recertification survey for failure to effectively maintain implemented procedures and effectively monitor the interventions that the committee put into place for plan of care development in August of 2016. On 10/25/18 at 1:20 PM, during an interview, the Director of Nursing (DON) indicated that the Quality Assessment and Assurance Committee meetings occurred monthly and based on the results of the several previous surveys the facility created and implemented the plan of correction. The facility constantly worked on quality improvement projects and conducted multiple	F 867	quality deficiencies and deviations routinely to ensure implementations of the QAPI program are met. A QA audit tool will be used three (3) times per week or one (1) month and reviewed at least weekly by Administrator and/or designee. QA committee will review the QA Action Plan once a month for three (3) months and revised the action plan to ensure continued compliance.	

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F 867	Continued From page 16 audits in different areas of care.	F 867		
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to maintain an effective pest control program for 1 of 6 resident rooms (Resident #6). The findings included: An observation on 10/24/18 at 2:13 PM, of Resident #6 ' s room revealed beside Resident #6 ' s bed there was an ant hill of ants crawling on the floor from the baseboard near a cracked wall and heating unit. There were dead bugs and roaches in resident drawers where computer was located. During an observation of Resident #6 ' s room on 10/24/18 at 3:10 PM, with the Maintenance Director included two filled bug traps on the floor near the closets, the ant hill located at the side of bed near heating system with ants crawling, dead roaches/bugs in resident drawers at computer station. The computer desk drawers had several dead roaches and bugs. Resident #6 stated "I don't see why I have to live and sleep with bugs and roaches crawling all over me at night. I get up around 5 AM every morning and you can see them crawling all over the placed. The bathroom was worst, housekeeping doesn't do a good cleaning in the bathroom around the commode or	F 925	F-925 11/22/18 Presbyterian Home of Hawfields will continue to strive to ensure that the facility maintain an effective pest control program so that the facility is free of pests and rodents. Housekeeping and maintenance cleaned dirty areas and sprayed areas that contained bugs and will continue to make sure resident #6 maintains a sanitary, orderly, and comfortable interior as well as all other residents. Pest control was called on 10/24/2018 and came in on 10/26/2018 to spray and inspect for bugs in resident #6 room and floor all other surrounding rooms. Pest control will spray and inspect all residents rooms that are problematic for bugs at least biweekly until resolved and will resume monthly thereafter. Resident #6 bathroom tile and toilet will be replaced within the next two (2) weeks. Housekeeping supervisor reeducated housekeeping staff of the responsibility for cleaning resident□s room daily which includes cleaning: bathrooms, dusting, empting trash, wiping down walls, heating units, sweep and mop	11/22/18

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F 925	Continued From page 17 sink. It ' s very upsetting to see all these bugs coming from my computer as I try to work. I have kill and swat them away." During an interview on 10/24/18 at 3:25 PM, the Housekeeping Supervisor(HKS) The HK staff responsible for cleaning resident rooms and reporting to maintenance if they see any bugs to report to maintenance and complete the maintenance slip. During an interview on 10/25/18 at 10:13 AM, Housekeeper #2(HK) stated she had cleaned Resident #6 ' s room yesterday and saw the two traps filled with bugs on the floor. She further stated she was instructed not to move resident personal belongings unless they had resident ' s permission. She added that did not clean inside the resident ' s drawers, but had cleaned behind the resident's bed, commode, sink and wipe down the walls. HK #2 reported she did not see the ants around the bed area. During an interview on 10/25/18 at 10:28 AM, HK #4 stated when she observed any bugs, ants/ rodents or needed repairs in resident rooms, the expectation would be to report to HKS and maintenance director. HK #4 stated when she had seen them she would just kill them or sweep them up and put in trash. During an 10/25/18 at 2:52PM, the Director of Nursing indicated stated a discussion had been held in morning meeting a few months ago regarding bugs in resident rooms. It was reported in the meeting the issue had been resolved. The DON further stated she was unaware there was bugs in Resident #6 ' s room. The expectation would be for staff to report any observations of	F 925	entire room for all residents daily. Housekeeping will continue to monitor resident□s room for a safe living environment and will continue to monitor measures to eradicate and contain common household pests for all resident□s to ensure the facility is free of pests and rodents for all residents. A QA audit tool will be used three (3) times per week for one (1) month and reviewed at least weekly by DON, Administrator and/or designee. QA committee will review the QA Action Plan once a month for three (3) months and revise the action plan to ensure continued compliance.	

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F 925	Continued From page 18 bugs and pest to maintenance director immediately.	F 925		