STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING _____ B. WING _____	C 04/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE LANDING NURSING AND REHABILITATION CENTER	1084 US 64 EAST PLYMOUTH, NC 27962

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E 000	Initial Comments An unannounced Recertification survey was conducted on 04/15/19 through 04/18/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ROU311.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey. Event ID #ROU311.	F 000		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to notify a resident representative of a room change for 1 of 1 residents reviewed for room change (Resident #18). The findings included: Resident #18 was admitted to the facility on	F 559	Resident #18 resident representative was notified by the admissions coordinator on 5/6/2019 of the room change on 12/28/2018. 100% audit was completed on 4/30/2019 by the Admissions Coordinator to ensure notification of resident/resident	5/8/19

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

Electronically Signed | 05/08/2019

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F 559	Continued From page 1 5/23/18 with diagnoses that included: Alzheimer's disease, diabetes mellitus and hypertension. Resident #18's most recent Minimum Data Set (MDS) assessment dated 1/15/19 coded him as cognitively impaired. Resident #18 required extensive assistance with bed mobility, transfer, dressing and toilet use. He was assessed as needing total assistance with bathing and personal hygiene. Review of a social work progress note dated 12/27/18 revealed Resident #18 was scheduled to move from a private room to a semi-private room. The note stated the resident representative was notified. Review of a social work progress note dated 12/28/18 indicated the resident representative of Resident #18 was notified Resident #18 was going to remain in a private room. Review of a social work progress note dated 1/4/19 revealed Resident #18 was moved into a semi-private room on 12/28/19. An interview was conducted with the social worker on 4/17/19 at 10:14 AM who stated Resident #18 was moved after she left for the day on 12/28/19. She reported she was unaware Resident #18 changed rooms until she returned on 1/4/19. The social worker stated that the person who facilitated the move should have contacted the resident representative to inform the representative of the move. She indicated she did not contact the resident representative regarding Resident #18's move to a semi-private room.	F 559	representatives are notified of room changes for changes occurring in past 30 days. Any identified concerns were addressed with notification and education provided to ensure notification is completed. In-service was completed on 4/30/2019 by the Administrator with Social Worker, Social Worker Assistant and Admissions Coordinator regarding notification of resident and representative of room changes prior to room change occurring with documentation in electronic medical record. The Social Worker and/or Social Worker Assistant is responsible for documenting notification of room changes in electronic medical record. 100% of all room changes will be audited by the admissions coordinator utilizing the room change audit tool weekly x 8 weeks then monthly x 1 to ensure documentation supports notification of resident and resident representative of room change. The Administrator will review and initial the room change audit tool weekly x 8 weeks then monthly x 1 for completion and any identified area of concerns corrected. The Administrator will forward the QI audit tool for room change notification to executive QA Committee monthly x 3 months. The Executive QA Committee will review the tool monthly x 3 to determine trends and or issues that may need further interventions put into place and to determine the need for further and or frequency of monitoring.	

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F 559	Continued From page 2	F 559		

During an interview with the Admissions Coordinator on 4/17/19 at 10:25 AM she stated she did not contact Resident #18's resident representative regarding his room change on 12/28/18. She further stated she assigned rooms for residents who transferred from the hospital but not for residents who moved within the facility. She indicated nursing staff members were responsible for interfacility room changes.

An interview was conducted with the Director of Nursing (DON) on 4/17/19 at 10:41 AM. She stated nursing staff were not responsible for contacting resident representatives about a room change. The DON stated she would review the staffing schedules to determine Resident #18's assigned nurse on 12/28/18.

An interview was conducted Nurse #2 on 4/17/19 at 1:14 PM who stated she did not notify Resident #18's resident representative regarding a room change on 12/28/18. She reported normally she is notified of a room change by the Admissions Coordinator or the Social Worker. Nurse #2 stated if a resident required an emergent room change she would notify the DON, the resident representative and the physician. She reported she would only contact the resident representative of a room change in an emergency.

An interview was conducted with the Administrator on 4/17/19 at 1:49 PM. She stated it was her expectation resident representative is notified of room changes within the facility. The Administrator indicated the Social Services Assistant should have contact Resident #18's representative.

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F 559	Continued From page 3 During an interview with the Social Services Assistant on 4/17/19 at 2:23 PM she stated she did not notify Resident #18's resident representative about the room change on 12/28/18. She indicated she was not aware she was responsible for notifications of room changes in the social worker's absence.	F 559		
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 interviews, and record review the facility failed to accurately code the Minimum Data Set (MDS) assessment for the area of functional limitation in range of motion to both upper and lower extremities for 1 of 1 resident reviewed for range of motion. (Resident #102) Findings included: Resident #102 was admitted to the facility on 3/21/11. Review of Resident #102's current diagnoses revealed on 8/1/18 she was diagnosed with a contracture of the right hand. Review of Resident #102's minimum data set assessment dated 4/1/19 revealed the resident was assessed under section G, question G0400A, as having no impairment to her upper extremities and lower extremities. The resident was assessed to be totally dependent on staff for	F 641	Minimum Data Set assessment for resident #102 was modified to include limitation in range of motion to both upper and lower extremities on 4/17/2019 by MDS Coordinator. 100% audit was initiated on 5/3/2019 utilizing the QI Audit Tool Range of Motion by Assistant Director of Nursing (ADON), Quality Improvement nurse QI, Rounds Nurse, Staff Development Coordinator and Nursing Supervisor to include resident #102 to ensure residents with contractures are coded accurately on section G0400 of Minimum Data with completion on 5/7/2019. Any identified concerns will be addressed with Minimum Data Set Coordinator (MDS)/MDS Nurse for modification of Minimum Data Set. In-Service was initiated on 5/3/2019 by the Administrator and DON with MDS Coordinator, MDS Nurse, ADON, QI	5/8/19

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F 641	Continued From page 4 bed mobility, dressing, toilet use, and personal hygiene. She required extensive assistance with eating. During observation on 4/17/19 at 11:11 AM Resident #102 was observed to have a contracture of her right hand. During an interview on 4/16/19 at 2:12 PM Nurse Aide #1 stated Resident #102 was total care. She further stated Resident #102 had limitations to her range motion in both of her hands. During an interview on 4/17/19 at 12:01 PM MDS Nurse #1 stated that Resident #102 had limitations to her range of motion to the upper extremities. She further stated the minimum data set assessment dated 4/1/19 was incorrect and should have indicated that the resident had functional limitations to her range of motion in her upper extremities. During an interview on 4/17/19 at 12:11 PM the Director of Nursing stated she had been the director of nursing for three weeks and was not familiar with how range of motion was captured on the minimum data set assessments but would want the assessments to be accurate regarding the status of the resident. She further stated she agreed the resident had functional limitations to her range of motion in both her upper and lower extremities and if that was an item to be captured in a minimum data set assessment she expected it to be correct.	F 641	Nurse, Rounds Nurse, Staff Development Coordinator and Treatment Nurse regarding coding of section G question G0400 range of motion coding accuracy to include accuracy of resident #102 utilizing Resident Assessment Instrument Manual. In-service was completed on 5/7/2019. 10% of all Minimum Data Set assessments completed will be audited utilizing the QI Audit Tool Range of Motion weekly x 8 weeks, then monthly x 1 to include resident #102 by the Assistant Director of Nursing for Accuracy in section G G0400 range of motion. Any inconsistencies will be addressed with MDS Coordinator with modifications completed as appropriate. The DON will review and initial the Range of Motion Audit tools weekly x 8 weeks, then monthly x 1 for completion and any identified areas of concerns corrected. The DON will forward the QI Audit tool Range of Motion to the executive QA Committee monthly x 3 month. The Executive QA committee will review the tool monthly x 3 to determine trends and or issues that may need further interventions put into place and to determine the need for further and or frequency of monitoring.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		5/8/19

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F 656	Continued From page 5 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 6 section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to implement a care planned intervention for 1 of 5 residents reviewed for activities of daily living. (Resident #69) Findings included: Resident #69 was admitted to the facility on 02/21/17 with diagnoses that included: Cerebral Vascular Accident, Hemiplegia (paralysis on one side of the body), Depression, Anxiety, Dysphagia (difficulty swallowing) and Hypertension among others. A review of his most recent annual Minimum Date Set (MDS) dated 03/01/19 revealed that a BIMS (brief interview for mental status) was not done as he was rarely or never understood. It further indicated that he did not have any behaviors or rejection of care during the assessment period. The MDS also indicated that resident #69 required the total assistance of 1 staff member for all ADL's (activities of daily living) including bed mobility, dressing, grooming, toileting and personal hygiene. Review of a care plan dated 05/07/18 revealed a focus area of activities of daily living and personal care with a goal of activities of daily living will be completed with staff support as appropriate to maintain or achieve highest practicable level of functioning through next review. Interventions included dependent in high back wheelchair with dycem (a non-slip surface) and pummel cushion, resident up on Tuesday, Thursday and Saturday.	F 656	Resident # 69 was assisted out of bed on 4/17/2019 by assigned certified nursing assistant per the resident care guide/care plan. 100 % audit of all residents care guides to include resident #69 were reviewed by the Quality Improvement Nurse (QI), Staff Development Coordinator, Rounds Nurse, and Nursing Supervisor, Minimum Data Set Coordinator (MDS) and MDS Nurse to determine which residents require specific days to be out of bed. All identified residents were observed on 4/16/2019 and 4/17/2019 to ensure the residents were gotten out of bed as per the resident care plan/care guide interventions. Any identified concerns were addressed and education provided to ensure residents are out of bed as per the resident care plan/care guide by the Quality Improvement Nurse (QI), Staff Development Coordinator, Rounds Nurse, and Nursing Supervisor, Minimum Data Set Coordinator (MDS) and MDS Nurse. An In-service was initiated with all nursing staff on 4/16/2019 by Staff Development Coordinator related to reading and following care guide prior to starting care to determine if the resident requires specific days of the week to be gotten out of bed. If resident refuses or has a change of condition or not able to be gotten out of bed for any reason, the nurse needs to be notified and the nurse	

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F 656	Continued From page 7 On 04/16/19 at 08:27 AM resident #69 was observed in bed wearing a hospital gown. On 04/16/19 at 12:57 PM resident #69 was observed in bed wearing a hospital gown. On 04/16/19 at 04:05 PM resident #69 was observed in bed wearing a hospital gown. In an interview on 04/16/19 at 04:18 PM, Nurse Aide (NA) #3 indicated that resident #69 did not get up out of bed on her shift (3p-11p). She went on to say that resident #69 got up infrequently but not on the 3p-11p shift. In an interview on 04/16/19 at 04:52 PM, NA #2 indicated that resident #69 had not gotten up out of bed yet that day. An interview with Nurse #5 on 04/16/19 at 04:52 PM revealed that she was familiar with resident #69. She further indicated she had been responsible for his care since 07:00 AM that morning. She went on to say resident #69 had not been up out of bed yet that day. She stated that she did not know that resident #69 was supposed to be up in his wheel chair on Tuesdays, Thursdays and Saturdays. On 04/17/19 a review of resident #69's Late Loss ADL sheets dated 03/16/19 through 04/17/19 revealed he was transferred out of bed on 3/18/19, 4/1/19, 4/7/19, 04/15/19 and 04/16/19 at 07:04 PM. A review of nursing progress notes from 03/16/19 through 04/17/19 did not reveal any refusals of care or other information to indicate why resident #69 had not been up in his wheel chair on	F 656	will document refusals in progress notes. This in-service was completed on 5/6/2019. All new hires will receive education during orientation by staff development coordinator. 10% audit of all residents will be observed by the QI Nurse, Staff Development Coordinator, MDS Coordinator, MDS Nurse and Nursing Supervisor to ensure residents are out of bed on the specified days per resident care guide/care plan weekly x 8 utilizing census, then monthly x 1. For any identified areas of concerns resident will be gotten up and staff will be reeducated during audit by the QI Nurse, Staff Development Coordinator, MDS Coordinator, MDS Nurse and Nursing Supervisor. DON will review and initial the audit tools weekly x 8 then monthly x 1 for completion and to ensure any identified areas of concerns were addressed. DON will forward the results to the Executive QA Committee monthly x 3. The Executive QA Committee will review census tools monthly x 3 to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 656	Continued From page 8 Tuesday, Thursday and Saturday during that period. In an interview on 04/17/19 at 08:30 AM MDS Nurse #2 indicated she had initiated the care plan focus area of ADL's for resident #69. She went on to say that she had initiated the intervention for resident #69 to be up on Tuesday, Thursday and Saturday based on a discussion with his family regarding their preferences. She went on to say that resident #69 was not able to speak for himself. She further indicated that the purpose of the care plan was so nursing, and nurse aide staff would know how to safely and effectively provide care for the resident. She went on to say that all nursing and nurse aide staff had access to the care plan on their kiosks. In an interview on 04/17/19 at 08:40 AM the Director of Nursing indicated the care plan contained information that nursing, and nurse aide staff needed to provide care for the resident. She went on to say that nursing and nurse aide staff should be reviewing the information contained in the care plan and implementing the care and interventions in accordance with it. She further indicated that providing care in accordance with the care plan was important for resident health, well-being and safety.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		5/8/19

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F 677	Continued From page 9 Based on observations, family and staff interviews, and record review the facility failed to keep fingernails trimmed for 1 of 3 dependent residents reviewed for activities of daily living care. (Resident #99) Findings included: Resident #99 was admitted to the facility on 3/26/19. His active diagnosis included heart failure, hypertension, and diabetes mellitus. Review of Resident #99's admission minimum data set assessment dated 4/2/19 revealed he was assessed as severely cognitively impaired. He was assessed to have no behaviors of rejection of care. Resident #99 required extensive assistance with bed mobility, transfers, dressing, and personal hygiene. Review of Resident #99's care plan dated 3/26/19 revealed he was care planned to need assistance with activities of daily living and personal care. The interventions included to provide total care to resident for personal hygiene and grooming. During observation on 4/15/19 at 10:35 AM Resident #99's fingernails were observed to be long. During an interview on 4/15/19 at 10:36 AM Resident #99's family member stated his fingernails were very long and needed to be trimmed. She stated he usually liked his nails trimmed and she had mentioned it to staff but the nails were still long. During observation on 4/16/19 at 11:43 AM Resident #99's fingernails were observed to be	F 677	Nail Care was provided to resident #99 by hall nurse on 4/16/2019. 100 % audit of all residents nails to include resident #99 completed on 4/19/2019 by Minimum Data Set (MDS) Coordinator, MDS Nurse, Quality Improvement (QI) nurse, Charge Nurse and staff development coordinator using resident census. All nails were cut during the audit for any identified areas of concerns. An In-service was initiated with all nursing staff on 4/16/2019 related to proper nail care by the staff development coordinator. This in-service was completed on 5/2/2019. All new hires will receive education during orientation by staff development coordinator. 10% Nail Care Audit will be completed by MDS Coordinator, MDS Nurse, QI nurse, Charge Nurse and staff development coordinator utilizing the resident Census weekly x 8 weeks then monthly x 1. Any identified areas of concerns care will be provided and CNA and nurse will be retrained during audit by MDS Coordinator, MDS Nurse, QI nurse, Charge Nurse and staff development coordinator. The DON will review and initial the Nail Care Audit tools weekly x 8 weeks, then monthly x 1 for completion and any identified areas of concerns corrected. DON will forward the Nail Care Audit tool results to the Executive QA Committee	

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F 677	Continued From page 10 long. During observation on 4/16/19 at 2:12 PM Resident #99's fingernails were observed to be long. During an interview on 4/16/19 at 2:12 PM Nurse Aide #1 stated Resident #99 was total care for all activities of daily living besides eating. She further stated because the resident was diabetic the nurses would clip the resident's fingernails. During an interview on 04/16/19 at 3:07 PM Nurse #1 stated the nurses cut resident fingernails who were diabetic, and she had cut Resident #99's nails right after he was admitted. She further stated she did not notice his fingernails being long recently and she would usually check when providing blood sugar checks. Upon observation of Resident #99's fingernails she stated his fingernails should have been cut but she did not notice them when she took his blood sugar this morning and should have. She concluded she would cut them as soon as possible. During an interview on 4/16/19 at 3:20 PM the Director of Nursing stated the facility staff cut fingernails for diabetic residents after being evaluated and she was not 100% sure who was responsible. She further stated she would expect that residents who had been evaluated would have their nails cut as needed by staff. Upon observing the resident's nails, she stated the nails were a little long and needed to be cut and if the nurse was the one responsible she should have noticed and clipped them in the morning during his blood sugar check.	F 677	monthly x 3. The Executive QA Committee will review Nail Care Audit tool x 3 months to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 684	Continued From page 11	F 684		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to follow the physician's order to check fasting blood sugars three times a week for 1 of 1 resident (Resident #19) reviewed for medication administration. Findings included: Resident #19 was admitted on 10/11/2018 with the active diagnoses of acute respiratory failure with hypoxia, type 2 diabetes, essential hypertension, cerebral infarction, aphasia, and paraplegia. A review of the most recent Minimum Data Sheet (MDS) dated 1/15/2019 revealed that he was severely cognitively impaired, received total assistance with all activities of daily living, was unable to make himself understood and received enteral feedings. The care plan initiated on 3/7/2019 revealed that an active plan was in place for diabetes mellitus with the intervention to check fasting blood sugars as ordered by the physician, monitor for hyperglycemia/hypoglycemia and medications as ordered by the physician.	F 684	Resident #19 finger stick blood sugar was completed on 4/19/2019 as per physicians orders. Physician was notified of the 4/5/2019 and 4/25/2019 fasting blood sugar omissions by the Resident Care Liaison on 4/18/2019. 100 % audit of all residents Medication Administration Records to include residents #19 were reviewed for blood glucose monitoring by finger stick blood sugars and insulin administration. Audit was completed by Assistant Director of Nursing (ADON), Quality Improvement (QI) Nurse, Staff Development Coordinator, Minimum Data Set (MDS) Coordinator, MDS Nurse, and Nursing Supervisor utilizing the medication administration audit tool and daily census to ensure all orders insulin were administered per physician order. Any area of concern was address during the audit by the Director of Nursing and ADON by notifying the physician. Audit was completed on 5/3/2019.	5/8/19

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F 684	Continued From page 12 Resident #19 was observed on 4/15/2019 at 8:00am resting in the bed with his eyes closed and there were no signs of hyperglycemia or hypoglycemia observed. The physician's order dated 1/22/2019 stated fasting blood sugar was to be decreased to 3 times a week every morning with no sliding scale coverage. A review of the medication administration record (MAR) revealed that on 4/5/2019 and 4/17/2019 the MAR had blanks where the results or an indication that it was not done were to be placed. The electronic record was reviewed, and those results were not found to be in the system. Nurse #3 that worked the night shift on the 200 hallway on 4/5/2019 and 4/17/2019 was not available for an interview. An interview with Nurse #4 on 4/18/2019 at 4:00 pm revealed that resident #19 was scheduled for finger sticks three times a week on Mondays, Wednesdays, and Fridays. The results were to be put on the MAR and put in the electronic record under the vital sign section. Nurse #4 further revealed that resident #19 does not normally refuse finger sticks. During an interview with the administrator on 4/18/2019 at 10:30 am she revealed that she was unaware that the fasting blood sugars had not been done, and that the physician orders should have been followed.	F 684	An In-service was initiated with all nurses on 4/20/2019 by Director of Nursing regarding following physician orders including checking finger stick blood sugars and insulin administration as per physicians orders. In-service was completed on 5/3/2019. All newly hired nurses will receive education during orientation by staff development coordinator. 10% audit of all residents Medication Administration Records will be reviewed by QI Nurse, Staff Development Coordinator, MDS Coordinator, MDS Nurse and Nursing Supervisor to ensure physicians orders are followed with documentation on medication administration record for blood glucose monitoring and insulin administration including resident #19 by the ADON weekly for 8 weeks and then monthly x 1 month utilizing the medication administration audit tool and resident census. For any identified areas of concerns the physician will be notified and nurse will be reeducate during audit by the QI Nurse, Staff Development Coordinator, MDS Coordinator, MDS Nurse and Nursing Supervisor. DON will review and initial the audit tools weekly x 8 then monthly x 1 for completion and to ensure any identified areas of concerns were addressed. DON will forward the results of the medication administration audit tools to	

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F 684	Continued From page 13	F 684	the Executive QA Committee monthly x 3 months. The Executive QA Committee will review the results of the medication administration tools monthly x 3 to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain 1 of 1 dietary ice machine free from black mold and failed to maintain the low temperature dish machine wash temperature at 120 degrees Fahrenheit or higher during 2 of 3 kitchen observations.	F 812	Ice machine cleaned by dietary manager on 4/18/2019 and is free of black mold. On 5/8/2019 dishwasher was checked by Dishwasher Leasing Company to ensure machine functioning properly. Dishwasher Leasing Company increased	5/8/19

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F 812	Continued From page 14 The findings included: 1. During an observation of the kitchen on 4/15/49 at 10:35 AM an area 3 inches long by 1 inch wide of black spotted mold was observed on the ice deflector guard of the ice machine. During an observation on 4/17/19 at 11:20 AM the ice machine deflector guard continued to have the area of black spotted mold. An interview was conducted with the Dietary Manager on 4/17/19 at 11:20 AM during the observation of the ice machine. The Dietary Manager removed the ice guard and stated the ice guard needed to be cleaned. 2. During an observation of the low temperature dish washing machine on 4/15/19 at 10:40 AM the wash temperature registered 108 degrees Fahrenheit during 2 observed wash cycles. The observation of the temperature gauge revealed the temperature should register 120 degrees Fahrenheit. During an interview with the Dietary Manager on 4/15/19 at 10:40 AM she stated the machine had not been used very much that morning so the temperature was lower than it should be. During an observation of the low temperature dish machine on 4/19/19 at 9:45 AM revealed the temperature registered 118 degrees Fahrenheit during 4 wash cycles of the machine. An interview was conducted with the Dietary Manager during the observation on 4/19/19 at 9:45 AM. During the interview the Dietary Manager stated the machine's thermometer was	F 812	hot water heater temperature and insulated hot water lines to meet demands of kitchen. 100% Audit was completed on 5/3/2019 by the maintenance director to ensure ice machines were free of black mold. Trial run of dishwasher was conducted on 5/8/2019 by Dietary Manager with oversight by Administrator to ensure dishwasher cycle is at 120 degrees Fahrenheit. No concerns were identified. In-service was completed on 5/2/2019 by the Administrator related to cleaning of ice machines to include cleaning of ice deflector guard and cleaning schedule. In service was provided to Dietary Manager, Maintenance Director, and Maintenance Assistant. In-service was completed on 5/2/2019 by the Administrator to Dietary Manager related to monitoring of dish machine wash temperature. Temperatures are to be checked prior to each dish cycle to ensure temperature at 120 degrees Fahrenheit if temperature is not at 120 degrees Fahrenheit maintenance will be notified and then multiple cycles will continue to be run through dish machine to reach temperature of 120 degrees F prior to beginning dish cycle with =>50ppm hypochlorite (chlorine) on dish cycle in final rinse. Maintenance will audit ice machines for signs of black mold using Ice Machine Audit tool 5 x week x 8 weeks then	

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F 812	Continued From page 15 old so it may not be accurate. The Dietary Manager then used a different thermometer to check the temperature of the water inside the machine. The temperature of the water inside the machine again registered 118 degrees Fahrenheit using the other thermometer. The Dietary Manager stated the dish machine wash temperature should be a minimum of 120 degrees Fahrenheit.	F 812	monthly x 1 with identified concerns addressed immediately with Dietary Manager for corrective actions. Dietary Manager will audit low temperature dish machine to ensure dish water temperature is =>120 degrees F utilizing the low temperature audit tool monitored daily 5 days a week x 8 weeks, then monthly x 1 with identified concerns addressed immediately for corrective actions. The administrator will review and initial the low temperature audit tools weekly x 8 weeks, then monthly x 1 for completion and any identified areas of concerns corrected. The Administrator will forward the QI Audit Tool (Low Temperature Dish Machine) and Ice Machine Audit Tool to the executive QA Committee monthly x 3. The executive QA committee will review the Low Temperature Audit Tool and Ice Machine Audit Tool monthly x 3 to determine the need for further and or frequency of monitoring.	