**F 000 INITIAL COMMENTS**

No deficiencies were cited as a result of the complaint investigation Event # EYME11.

**F 279 DEVELOP COMPREHENSIVE CARE PLANS**

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on medical record review and staff interviews the facility failed to update the care plan for 1 of 1 sampled residents with pressure sores to reflect the development of a pressure sore.

(Resident #73)

The findings included:

*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal...*
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Resident #73 was admitted to the facility 02/20/15 with diagnoses which included diabetes and after care for a fractured femur.

The nursing initial care plan for Resident #73 developed on admission 02/20/15 identified a problem area, potential for pressure sores. Subsequent care plan reviews were done by the care plan team with a new problem area developed on 03/05/15. The problem area identified for Resident #73 was the potential of pressure sore development related to moisture/incontinence, decreased activity and refusal of care/treatment. The potential for pressure sore problem area was updated on 5/27/15, 06/15/15, 06/18/15, and 08/27/15 with no changes to the problem, noting to "continue plan of care". The goal for this problem area was, resident will have intact skin without signs of skin breakdown through next review. Approaches to this problem area included:

- apply pressure reduction mattress to bed
- apply pressure reduction cushion to chair or wheelchair
- reposition in chair frequently for comfort and pressure reduction
- turn and reposition while in bed frequently for comfort and pressure reduction
- provide incontinence care after each incontinent episode
- complete a full body check weekly and document

Review of the medical record of Resident #73 noted that on 05/25/15 Resident #73 developed unstageable pressure areas on both sides of her outer ankles. Review of the medical record noted these areas remained through the time of the investigation on 10/08/15.

## F 279

and state law."

F279

1. Corrective action was accomplished for the alleged deficient practice in regard to Resident #73’s care plan by correcting care plan to record accurate reflection of change in pressure sore.

2. Residents with wounds have the potential to be affected by the alleged deficient practice. Director of Nursing (DON), Asst. Director of Nursing (ADON), Unit Managers (UM) have completed a 100% skin audit of residents with wounds to ensure care plans accurately reflect wounds.

3. Measures put into place to ensure that the alleged deficient practice does not recur include: Inservice/re-education of RCMD for documenting and updating care plans to capture skin changes; all skin related care plans to be audited by RCMD and updated to reflect resident's current skin condition, treatments and interventions; RCMD to attend wound meetings and update care plans with changes to skin condition, treatments and interventions as appropriate; DON or RCMD will perform random care plan audits of all residents with wounds weekly for 4 weeks and then monthly for 2 months to ensure accurate wound documentation is captured on care plan. DON or RCMD will review and analyze data and report patterns/trends to the
A quarterly Minimum Data Set (MDS) was completed 08/26/15 which assessed Resident #73 with 2 unstageable pressure sores. On 10/08/15 at 4:30 PM the MDS coordinator stated the staff member that completed the 08/26/15 quarterly assessment no longer worked at the facility and was not available for interview. The MDS coordinator stated she could not speak for the former MDS coordinator but when a resident went from being at risk for pressure sore development to the actual development of a pressure sore that should be reflected in the care plan. The MDS coordinator stated she could not explain why the care plan was not updated after the 08/26/15 quarterly assessment to reflect the pressure sores and measures taken to promote healing.

On 10/08/15 at 2:52 PM the Director of Nursing (DON) stated the former MDS coordinator (that completed the 08/26/15 MDS) no longer worked at the facility. The DON stated the care plan should have been reflective of the actual pressure sore and included measures in place to promote wound healing.

F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions.

QAPI committee every month for three months.

4. The QAPI Committee will evaluate the effectiveness of the above plan and will add additional interventions based on identified outcomes to ensure continued compliance.
This REQUIREMENT is not met as evidenced by:

Based on observations, review of the dish machine log, and staff interviews the facility failed to address concerns with the final rinse temperature of the dish machine and failed to clean the ice scoop holder and fans in the kitchen.

The findings included:

The facility undated policy for Dish Machine Temperatures was provided by the food service district manager on 10/05/15 and included the following:

The minimal final rinse temperature of the dish machine should be 180 degrees Fahrenheit.

*Prior to each period of use, record wash and final rinse temperatures on the Dish machine Temperature Record form.

*Immediately bring any substandard temperatures to the attention of management

*If substandard temperatures are identified, determine if the reading is due to a malfunction of the temperature gauge or substandard water temperatures.

*Make management decision concerning adequacy of sanitation of service ware.

Implement disposable service ware if necessary.

*Contact source of repairs.

*Document all actions on the back of the Dish machine Temperature Record Form.

1. During the initial tour of the facility kitchen on 10/05/15 from 9:20 AM-10:50 AM the following observations were made of the dish machine actively in use and staffed with 3 dietary aides.

*Preparation and/or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law."

F371

1. A. Corrective action was accomplished for the alleged deficient practice, in regard to the failure to address concerns with the final rinse temperature of the dish machine, were corrected by taking the machine out of service, washing and sanitizing all breakfast dishes and utilizing disposable products immediately. Ecolab was contacted and has changed current dish machine to a low temp dish machine.

B. All residents have the potential to be affected by the alleged deficient practice.

C. Measures put into place to ensure that the alleged deficient practice does not recur include: In-service/re-education of all dietary staff and new staff including Dietician and Food Service Director regarding procedure and notification of response to incorrect final rinse temperatures of the dish machine by

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The final rinse temperature of the dish machine was observed and the highest temperature of the final rinse was observed as follows:
1. The highest temperature of the final rinse of a rack containing a food preparation pan was 172 degrees Fahrenheit (F).
2. The highest temperature of the final rinse of a rack containing plate covers was 172 degrees F.
3. The highest temperature of the final rinse of a rack containing a plastic storage tub was 172 degrees F.
4. The highest temperature of the final rinse of a rack containing a plastic storage tub was 170 degrees F.
5. The highest temperature of the final rinse of a rack of plates was 170 degrees F.
6. The highest temperature of the final rinse of a rack of plates was 170 degrees F.
7. The highest temperature of the final rinse of a rack of plates was 170 degrees F.
8. The highest temperature of the final rinse of a rack of plates was 170 degrees F.
9. The highest temperature of the final rinse of a rack of silverware was 170 degrees F.
10. The highest temperature of the final rinse of a rack of trays was 170 degrees F.
11. The highest temperature of the final rinse of a rack of trays was 170 degrees F.
12. The highest temperature of the final rinse of a rack of cups was 172 degrees F.
13. The highest temperature of the final rinse of a rack of trays was 170 degrees F.

At 9:38 AM Dietary Aide #1 stated either he or another dietary aide recorded the final rinse temperature of the dish machine on the log and that he usually looked for a final rinse temperature between 180-190 degrees F. Review District Manager; and dish machine and sanitizer log will be completed prior to use for each of the 3 meal periods. Food Service Director or Cook Supervisor will complete daily monitoring tool x30 days and then weekly x4 weeks and then monthly ongoing. District Manager will complete sanitation inspection weekly x4 weeks and then monthly thereafter. Food Service Director and District Manager will review and analyze data and report patterns/trends to the QAPI committee every month.

D. THE QAPI Committee will evaluate the effectiveness of the above plan and will add additional interventions based on the identified outcomes to ensure continued compliance.

2. A. Corrective actions were accomplished for the alleged deficient practice, in regard to the ice machine scoop holder, exhaust fans and the air conditioning unit. They were corrected by immediately cleaning of all items and removal of the air conditioning window unit.
B. All residents have the potential to be affected by the alleged deficient practice.
C. Measures put into place to ensure that the alleged deficient practice does not recur include:
In-service/re-education for all dietary staff regarding daily cleaning assignments completed by Food Service Director, FSD will complete daily monitoring using the cleaning assignment checklist and analyze data and report findings/trends to
Continued From page 5

of the dish machine log noted the morning final rinse temperature of the dish machine had not been recorded for 10/05/15. Dishware that had been observed run through the dish machine was stored for use by the dietary aides.

14-the highest temperature of the final rinse of a rack of trays was 170 degrees F.
15-the highest temperature of the final rinse of a rack of plate covers was 170 degrees F.
16-the highest temperature of the final rinse of a rack of plate covers was 170 degrees F.
17-the highest temperature of the final rinse of a rack of plate bottoms was 170 degrees F.

At 9:45 AM Dietary Aide #2 observed the final rinse temperature of the dish machine and commented to Dietary Aide #3 that the temperature was 170 degrees F. Nothing was done in response to this comment and the dietary aides continued to run racks of dishes through the dish machine.

18-the highest temperature of the final rinse of a rack of plate covers was 170 degrees F.
19-the highest temperature of the final rinse of a rack of plate covers was 168 degrees F.
20-the highest temperature of the final rinse of a rack of scoop plates and divided plates was 165 degrees F.
21-the highest temperature of the final rinse of a rack of plates was 165 degrees F.

At 9:50 AM the Food Service Director (FSD) was asked if she was aware of any problems with the dish machine. The FSD (who had been putting stock away at the time of the observations) responded that she was not aware of any concerns and that the machine was checked

the QAPI Committee every month.
D. The QAPI Committee will evaluate the effectiveness of the above plan and will add additional interventions based on the
identified outcomes to ensure continued compliance.
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Continued From page 6

Every couple weeks by a service company. The FSD stated on the last visit the service company had not reported any problems. At the time of the interview the FSD went to the dish machine and observed a rack of bowls run through the dish machine. The highest temperature of the final rinse of the rack of bowls was 175 degrees F. The FSD commented the temperature was low and reported when the machine had last been checked by the service company no problems had been reported. After this observation the FSD left the area of the dish machine and the three dietary aides resumed use of the dish machine. The FSD did not provide any instruction to the dietary aides prior to leaving the area of the dish machine. The dietary aides continued to wash and store dishes that had been run through the dish machine in the dish storage areas within the kitchen.

22-the highest temperature of the final rinse of a rack of bowls was 170 degrees F.
23-the highest temperature of the final rinse of a rack of trays was 170 degrees F.

At 9:55 AM the FSD walked through the dish machine area and commented she was taking a snack to a resident and that she would be right back. On her return the FSD asked Dietary Aide #1 how the final rinse temperature of the dish machine looked that morning. Dietary Aide #1 stated he had not looked at the final rinse temperature that morning. The FSD left the area of the dish machine and the dietary aides resumed washing dishes.

24-the highest temperature of the final rinse of a rack of trays was 170 degrees F.
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At 9:57 AM Dietary Aide #1 looked at the final rinse temperature gauge of the dish machine, commented "that ain't right" and recorded 170 in the designated area to record the final rinse temperature on the dish machine log book.

25-the highest temperature of the final rinse of a rack of plate covers was 170 degrees F.

At 10:05 AM Dietary Aide #1 was asked about the 170 degree temperature that he had recorded for the final rinse. Dietary Aide #1 stated he would inform the FSD of any concerns and indicated he needed to inform the FSD of the low final rinse temperature. Nothing was done at the time of the conversation and the dietary aides resumed washing dishes.

26-the highest temperature of the final rinse of a rack of plate covers was 172 degrees F.
27-the highest temperature of the final rinse of a rack of silverware was 170 degrees F.
28-the highest temperature of the final rinse of a rack of plate bottoms was 170 degrees F.

At 10:15 AM the FSD was asked if she had any concerns about the dish machine. The FSD stated she was aware the final rinse temperature of the dish machine should reach 180 degrees F. The FSD stated she was going to call the company that serviced the dish machine. Nothing was done or said to the dietary aides and they continued to run dishes through the dish machine.

29-the highest temperature of the final rinse of a rack of plates was 170 degrees F.
30-the highest temperature of the final rinse of a rack of bowls was 170 degrees F.

At 10:15 AM the FSD was asked if she had any concerns about the dish machine. The FSD stated she was aware the final rinse temperature of the dish machine should reach 180 degrees F. The FSD stated she was going to call the company that serviced the dish machine. Nothing was done or said to the dietary aides and they continued to run dishes through the dish machine.

29-the highest temperature of the final rinse of a rack of plates was 170 degrees F.
30-the highest temperature of the final rinse of a rack of bowls was 170 degrees F.
At 10:20 AM the FSD reported she spoke to a representative from the service company and they told her as long as the final rinse temperature was between 120-180 degrees F it was okay. The FSD was asked what she thought about that and she noted the final rinse temperature should be 180 degrees as the dish machine was designed to use heat to sanitize dishware. Nothing was done or said to the dietary aides and they continued to run racks of dishes through the dish machine.

31-the highest temperature of the final rinse of a rack of silverware was 170 degrees F.

At 10:21 AM the FSD was asked if anything should be done if the final rinse temperature of the dish machine did not reach 180 degrees F. The FSD stated they should use bleach to sanitize dishware. The FSD stated she was awaiting a return call from the service company. Nothing was done or said to the dietary aides and they continued to run racks of dishes through the dish machine.

32-the highest temperature of the final rinse of a rack of plate covers was 170 degrees F.

33-the highest temperature of the final rinse of a rack of trays was 170 degrees F.

At 10:22 AM the consultant dietitian entered the kitchen. The consultant dietitian was asked if she was aware of any problems with the dish machine and the consultant dietitian stated she was not aware of any concerns. The consultant dietitian was informed of the multiple observations of the final rinse temperature not reaching 180 degrees F during the final rinse cycle. The consultant
**F 371** Continued From page 9
dietitian stated she would talk to the FSD and left the area of the dish machine without looking at the dish machine or saying anything to the three dietary aides working at the dish machine.

34-the highest temperature of the final rinse of a rack of trays was 170 degrees F.
35-the highest temperature of the final rinse of a rack of pitchers and trays was 170 degrees F.
36-the highest temperature of the final rinse of a rack of bowls was 170 degrees F.
37-the highest temperature of the final rinse of a rack of bowls was 168 degrees F.

At 10:25 AM the consultant dietitian left the kitchen and did not look at the dish machine or speak to the dietary aides as they continued to run dishes through the dish machine.

38-the highest temperature of the final rinse of a rack of bowls was 170 degrees F.
39-the highest temperature of the final rinse of a rack of bowls was 170 degrees F.
40-the highest temperature of the final rinse of a rack of bowls was 170 degrees F.

At 10:30 AM Dietary Aide #2 was asked about the final rinse temperature and Dietary Aide #2 stated she thought the final rinse temperature was supposed to be between 165-180 degrees F and that the dish machine log book indicated what the minimal temperature should be. Dietary Aide #2 located the dish machine log book and noted the final rinse temperature should be 180 degrees.
Dietary Aide #2 stated if the final rinse temperature did not reach 180 degrees she would inform the FSD.

At 10:32 AM the FSD stated she spoke with the
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<td>41 - the highest temperature of the final rinse of a rack of plates was 170 degrees F.</td>
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<td>At 10:35 AM the FSD stated she had relayed the concerns of the dish machine to the consultant dietitian and the consultant dietitian told her to call the service company. The FSD stated no other recommendations had been given by the consultant dietitian to address the dish machine.</td>
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<td>On 10/05/15 at 11:25 AM the concern with the dish machine was shared with the administrator. The administrator stated she would immediately deal with the concern.</td>
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<td>On 10/05/15 at 5:00 PM disposable dishware was observed in use at meal service and dishes used for food preparation and meal service were washed in the three compartment sink which was set up with chemical sanitation.</td>
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<td>On 10/07/15 at 10:50 AM the consultant dietitian stated when she spoke to the FSD about the dish machine she was told the service company had been informed of the issues with the dish machine. The consultant dietitian stated she felt the FSD was taking care of the problems with the dish machine. The consultant dietitian stated she did not have an opinion regarding how dietary staff should have responded to the concern with</td>
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<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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<td>On 10/08/15 at 2:43 PM the FSD and district manager stated the service representative reported he misspoke when giving guidance to the FSD on 10/05/15. The FSD stated the service representative thought the facility dish machine was a low temperature machine when he informed the FSD the final rinse temperature was acceptable between 120-180 degrees F. The FSD stated she was so concerned with getting the food delivery put away on 10/05/15 she could not think about what to do with the concern of the dish machine. The district manager stated an inservice was done with all dietary staff on 10/05/15 to discuss the proper steps to take if the dish machine final rinse temperatures did not reach a minimum temperature of 180 degrees F. The district manager stated the booster heater on the dish machine was not functioning and it was still being serviced by an outside contractor. The district manager stated the dietary aides should have checked the final rinse temperature at the start of use of the dish machine and immediately reported any concerns to the FSD. The district manager stated staff should not have continued to use the dish machine when the final rinse temperature was known to be less than 180 degrees F.</td>
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<td>2. On 10/07/15 from 10:15 AM-11:00 AM observations were made of the facility kitchen.</td>
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<td>a. The ice machine in the kitchen was noted to be located inside a small closet. There was a large exhaust fan at ceiling height in this closet that was adjacent to the ice machine. The exhaust fan was operating and the grill of the fan had a thick coating of brown dust covering the entire surface area. A blue plastic ice scoop</td>
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### SUMMARY STATEMENT OF DEFICIENCIES

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**F 371**

holder was observed on the wall of the room, adjacent to the ice machine. The ice scoop was stored inside the ice scoop holder with the scoop portion touching the bottom interior of the holder. The bottom interior of the ice scoop holder was observed and small, brown pellet sized matter was observed inside the ice scoop holder.

b. Two fans were observed in operation in the area of the kitchen which housed the steam table. One was a window air conditioner with the filter removed and located on the window sill, in front of the unit. The filter had a thick layer of dust covering the entire surface area. The grill of the window unit (where air flow discharged) had a thick black sludge covering the entire surface area. An exhaust fan at ceiling height had a thick coating of dust which covered the entire surface area of the grill.

c. The grill on the fan in the walk in refrigerator had a thick coating of black matter covering the entire surface area.

At 11:00 AM the ice scoop holder was observed with the FSD. The brown pellet matter on the interior bottom was easily removed with gentle touch. The FSD was unable to identify the source of the matter but stated the ice scoop holder should be removed and cleaned every day. The FSD stated the ice scoop holder needed to be cleaned. The FSD stated she had recently placed a maintenance work order to have the grills cleaned on the fans because she noted how dirty the exhaust fans and window air conditioning were. The FSD stated she was not aware who was responsible for cleaning the grill of the fan in the walk in refrigerator.
BRIAN CTR HLTH & REHAB BREVARD

On 10/07/15 at 1:20 PM the assistant maintenance director stated the maintenance department relied on work orders for any cleaning that was needed in the kitchen. The assistant maintenance director stated he was not aware of any outstanding work orders in the kitchen. The assistant maintenance director stated he had been contacted a couple hours prior about fans that needed to be cleaned in the kitchen.

On 10/07/15 at 2:10 PM the administrator stated the dietary department and staff were managed by an outside contractor and the contract district manager provided oversight to the dietary department, including the FSD.