

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/31/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345494	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/13/2016
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NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - GASTONIA	STREET ADDRESS, CITY, STATE, ZIP CODE 2780 X-RAY DRIVE GASTONIA, NC 28054
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F 272 SS=E	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p>	F 272		11/10/16
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 10/28/2016
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide Care Area Assessment summaries which included underlying causes, risk factors, and factors to be considered in developing individualized care plan interventions for 4 of 21 sampled residents (Residents #55, #85, #102 and #166) with comprehensive assessments.</p> <p>The findings included:</p> <p>1. Resident #55 had diagnoses which included depression, anxiety disorder, psychotic disorder and bipolar disease. Resident #55's Annual Minimum Data Set (MDS) dated 05/05/2016 indicated his long-term memory was intact but he was moderately cognitively impaired for daily decision making. The MDS specified the resident required extensive staff assistance for bed mobility, transfers, dressing, and toilet use. It indicated the resident was short-tempered and easily annoyed several days during the assessment period. The MDS indicated the resident displayed verbal behaviors like yelling and cursing as well as self-directed behaviors, rejection of care. It also specified the resident had received antipsychotic, antianxiety and antidepressant medications during the week of the assessment. Record review also revealed the resident was being see by a psychiatrist.</p> <p>The 05/05/2016 Behavior Care Area Assessment (CAA) was reviewed. The CAA included an "Analysis of Findings" which indicated there would be a description of the problem, causes and contributing factors, and risk factors related to the</p>	F 272	<p>Filing the plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care.</p> <p>F272</p> <p>For Resident #55, a new comprehensive assessment will be completed to accurately code the Level I PASSR determination and if a CAA is triggered it will contain a clear description of the behaviors, underlying causes, contributing factors, or approaches specific to this resident to consider in developing an individualized care plan. This will be completed by 11/10/2016.</p> <p>For Resident # 166, the discharge Minimum Data Set (MDS) dated 7/18/2016 will be modified (due to resident discharge status) to accurately code the residents choice, based on her being cognitively intact, not to take the Fish Oil dietary supplement rather than a refusal to take the Fish Oil dietary supplement and if a CAA is triggered it will contain a clear description of the underlying causes, contributing factors, if the resident had glasses or not, or approaches specific to this resident to consider in developing an individualized care plan. This will be completed by 11/10/2016.</p>		

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F 272	<p>Continued From page 2</p> <p>care area. The CAA summary stated, "Resident has displayed behavioral symptoms as evidenced of refusal of meds, yelling/cursing at staff. Contributing factors include possible side effects of medications, mental health disorders, and hearing impairment. Staff will need to redirect and encourage compliance as needed."</p> <p>The CAA did not contain a clear description of the behaviors, underlying causes, contributing factors, or approaches specific to this resident to consider in developing an individualized care plan.</p> <p>An interview was conducted on 10/13/16 at 6:01 PM, with Social Worker (SW) #1 who indicated she was responsible for writing the Behavior CAA summary for Resident #55. The SW stated, I thought we were just supposed to summarize what was in the CAA checklist." SW#1 indicated she was aware it did not give a description of Resident #55's concerns, underlying causes or risks related to his behaviors.</p> <p>During an interview on 10/13/2016 at 7:04 PM, the Director of Nursing stated it was her expectation that CAA summaries would include supporting documentation to reflect the resident's status.</p> <p>2. Resident #166 was admitted to the facility on 6/30/2016 and discharged on 7/18/16. The Admission Minimum Data Set (MDS) dated 7/7/2016, indicated the resident was cognitively intact and did not resist care. The MDS specified the resident was visually impaired but did not wear her glasses for the vision assessment.</p>	F 272	<p>For Resident #102, a new comprehensive assessment will be completed and if a CAA is triggered it will contain a clear description of the underlying causes, contributing factors, or approaches specific to this resident to consider in developing an individualized care plan. This will be completed by 11/10/2016.</p> <p>For Resident #85, a new comprehensive assessment will be completed and if a CAA is triggered the Care Area Assessments (CAA) will be modified to contain a clear description of the underlying causes, contributing factors, or approaches specific to this resident to consider in developing an individualized care plan. This will be completed by 11/10/2016.</p> <p>For all residents with the potential to be affected, a new assessment will be completed as directed by Mary Maas RN, MSN, RAI Clinical Coordinator and if a CAA is triggered it will contain a clear description of the underlying causes, contributing factors, or approaches specific to this resident to consider in developing an individualized care plan. This will be completed by 11/10/2016.</p> <p>For the systemic change, MDS Coordinators and Regional MDS consultant were educated by Mary Maas RN, MSN, RAI Clinical Coordinator in person during our survey from 10/10/2016-10/13/2016 on accuracy of coding. All have attempted to sign up for</p>		

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F 272	<p>Continued From page 3</p> <p>The 07/07/2016 Vision Care Area Assessment (CAA) was reviewed. The CAA included an "Analysis of Findings" which indicated there would be a description of the problem, causes and contributing factors, and risk factors related to the care area. The CAA summary stated, "Resident has impaired vision. Contributing factors include CVA (cerebral vascular accident) and anxiety. Activity department have[sic] large print materials available for use. Staff to assist resident as needed."</p> <p>The CAA did not contain a clear description of the underlying causes, contributing factors, if the resident had glasses or not, or approaches specific to this resident to consider in developing an individualized care plan.</p> <p>An interview with Social Worker (SW) #1 was conducted on 10/13/16 at 6:01 PM. SW #1 stated she had conducted the vision test and coded the portion of the MDS which indicated the resident was not using glasses for the assessment. SW#1 stated Resident#166 told her she had glasses in her room at the facility and that her vision had been affected by the CVA. The Social Worker was asked why the resident had not used her glasses for the vision test. SW#1 said, "I didn't ask her to use them." and wasn't sure how or when the resident used the glasses. After reading the CAA summary she had written, SW#1 stated, "I should have put the information in the summary."</p> <p>During an interview on 10/13/2016 at 7:04 PM, the Director of Nursing stated it was her expectation that the MDS accurately reflect the resident's status.</p>	F 272	<p>the MDS Education Seminar, led by Mary Maas, RN, MSN, RAI Clinical Coordinator but there is currently a waiting list for the class. Education will be provided to the Interdisciplinary Care Plan Team (Social Workers, Activities Director, Certified Dietary Manager and Dietician) by the MDS Coordinators/Regional MDS consultant regarding the assessment process including that the CAA contain a clear description of the underlying causes, contributing factors, or approaches specific to this resident to consider in developing an individualized care plan. This will be completed by 10/31/2016.</p> <p>An audit tool was developed which includes monitoring to make sure the CAA contains a clear description of the underlying causes, contributing factors, or approaches specific to this resident to consider in developing an individualized care plan. The audit tool will be utilized to complete audits of MDS assessments. The MDS Coordinator/Regional MDS consultant/designee will audit 20% of all resident assessments (including new admission assessments) weekly for 8 weeks, then 10% weekly for 4 weeks. Audits will continue quarterly and the results will determine the need for more frequent monitoring.</p> <p>All audit information will be analyzed and reviewed by the Director of Nursing at the QA Committee meetings.</p>		

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F 272	<p>Continued From page 4</p> <p>3. Resident #102 had diagnoses which included, but were not limited to, Alzheimer's disease, and congestive heart failure.</p> <p>A review of the Admission Minimum Data Set (MDS) dated 06/14//2016 revealed Resident #102 was severely cognitively impaired</p> <p>Review of Resident #102's clinical record revealed he received continuous oxygen at 2 liters and staff checked his oxygen saturation level every shift.</p> <p>The 06/14/2016 Cognition Care Area Assessment (CAA) was reviewed. The CAA included an "Analysis of Findings" which indicated there would be a description of the problem, causes and contributing factors, and risk factors related to the care area. The CAA summary stated, "Resident is out of his bed daily to his wheelchair interacting with others. Resident can verbally communicate some of his simple needs. Since admission resident is dependent on staff to cue him to get to his destinations and daily ADL (activities of daily living) care. Resident has a dx (diagnosis) of Alzheimer's disease."</p> <p>The CAA did not contain a clear description of the underlying causes, contributing factors, or approaches specific to this resident to consider in developing an individualized care plan regarding his cognition.</p> <p>An interview was conducted on 10/13/16 at 6:28 PM, with Social Worker (SW) #1. She stated the Social Worker who completed Resident #102's CAA summary no longer worked in the facility. SW#1 did not know why the CAA summary did</p>	F 272			

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F 272	<p>Continued From page 5</p> <p>not consider the resident's use of oxygen, medications or other factors impacting cognition.</p> <p>During an interview on 10/13/2016 at 7:04 PM, the Director of Nursing stated it was her expectation that CAA summaries would include supporting documentation to reflect the resident's status.</p> <p>4. Resident #85 was admitted to the facility 7/28/2011 with diagnoses which included depression, anxiety disorder, non-Alzheimer's dementia, and dissociative /conversion disorder. Resident #85's annual Minimum Data Set (MDS) dated 6/9/2016 indicated he was moderately cognitively impaired. The MDS specified the resident required extensive assistance with activities of daily living including bed mobility, transfers, dressing, and toileting. The MDS indicated the resident displayed behaviors such as yelling and cursing as well as hitting and spitting at staff. It also indicated that the resident had received antipsychotic, antianxiety, and antidepressant medications during the assessment review date.</p> <p>Medical record review also revealed the resident was being seen by a psychiatrist.</p> <p>Resident #85 was observed on 10/12/2016 at 6:30 AM, lying in bed yelling, "I am ready to get up" and cursing at times.</p> <p>The 6/9/2016 Behavior Care Area Assessment (CAA) was reviewed. The CAA included an "Analysis of Findings" which indicated there would</p>	F 272			

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F 272	Continued From page 6 be a description of the problem, causes and contributing factors, and risk factors related to the care area. The CAA summary stated, "Resident has displayed behavioral symptoms as evidenced by yelling/cursing, contributing factors include hearing/vision impairments, mental health problems and use of antihypertensive medication, staff to redirect and encourage resident to display appropriate behavior. " The CAA did not contain a clear description of the behaviors, underlying causes, contributing factors, or approaches specific to this resident to consider in developing an individualized care plan. An interview was conducted on 10/13/16 at 6:20 PM, with Social Worker (SW) #1 who indicated she was responsible for writing the Behavior CAA summary for Resident #85. The SW stated, " I thought we were just supposed to summarize what was in the CAA checklist." SW#1 indicated she was aware it did not give a description of Resident #85's concerns, underlying causes, or risks related to his behaviors. During an interview on 10/13/2016 at 7:04 PM, the Director of Nursing stated it was her expectation that CAA summaries would include supporting documentation to reflect the resident's status.	F 272			
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate	F 278		11/10/16	

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F 278	<p>Continued From page 7</p> <p>each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to code the Minimum Data Set accurately for 3 of 21 sampled residents regarding Preadmission Screening and Resident Review level (Resident #55), and behaviors (Residents #65 and #166).</p> <p>The findings included:</p> <p>1. Resident #55 had diagnoses which included depression, anxiety disorder, psychotic disorder and bipolar disease.</p>	F 278	<p>F278</p> <p>For Resident #55, a new comprehensive assessment will be completed to accurately code the Level I PASSR determination. Resident #55 did not experience any adverse effects related to MDS coding inaccuracy. This will be completed by 11/10/2016.</p> <p>For Resident #166, the discharge Minimum Data Set (MDS) dated</p>		

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F 278	<p>Continued From page 8</p> <p>Review of a letter dated 7/02/15, from the Division of Medical Assistance revealed Resident #55 had PASRR Level I determination.</p> <p>Resident #55's annual Minimum Data Set (MDS) dated 5/5/2016, indicated he had been evaluated by the State level Preadmission Screening and Resident Review (PASRR) authority, and determined to have a serious mental illness and/or intellectual disability. The MDS specified Resident #55 had a PASRR Level II determination.</p> <p>An interview with Social Worker (SW)#1 was conducted on 10/13/16 at 4:32 PM. SW #1 indicated the SW who had completed the PASRR portion of Resident #55's MDS, was no longer working at the facility. She could not explain why the other SW had coded the resident as Level II PASRR, but it was not correct. SW#1 stated she had checked the database and Resident #55 had a Level I determination.</p> <p>During an interview on 10/13/2016 at 7:04 PM, the Director of Nursing stated it was her expectation that the MDS accurately reflect the resident's status.</p> <p>2. Resident #166 was admitted to the facility on 6/30/2016 and discharged on 7/18/16. The Admission dated 7/7/2016, indicated the resident was cognitively intact and did not resist care.</p> <p>Record review of a nursing notes dated 7/2/2016, revealed Resident #166 had refused to take a Fish Oil dietary supplement because it was too</p>	F 278	<p>7/18/2016 will be modified (due to resident discharge status) to accurately code the residents choice, based on her being cognitively intact, not to take the Fish Oil dietary supplement rather than a refusal to take the Fish Oil dietary supplement. Resident #166 did not experience any adverse effects related to MDS coding inaccuracy. This will be completed by 11/10/2016.</p> <p>For Resident #65, a new comprehensive assessment will be completed to accurately code any behaviors documented in the resident's medical record within the 7 day look back period. Resident #65 did not experience any adverse effects related to MDS coding inaccuracy. This will be completed by 11/10/2016.</p> <p>For all current residents with the potential to be affected, a new assessment will be completed as directed by Mary Maas, RN, MSN, RAI Clinical Coordinator. This will be completed by 11/10/2016.</p> <p>For the systemic change, MDS Coordinators and Regional MDS consultant were educated by Mary Maas, RN, MSN, RAI Clinical Coordinator in person during our survey from 10/10/2016-10/13/2016 on accuracy of coding. All have attempted to sign up for the MDS Education Seminar, led by Mary Maas, RN, MSN, RAI Clinical Coordinator but there is currently a waiting list for the class. Education will be provided to the Interdisciplinary Care Plan Team (Social</p>		

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F 278	<p>Continued From page 9 big and was difficult to swallow.</p> <p>Review of the July 2016 Medication Administration Record revealed the resident continued to refuse the Fish Oil dietary supplement, with the same explanation, until her discharge on 7/18/2016.</p> <p>The Discharge MDS dated 7/18/2016, specified Resident #166 rejected care 4-6 days during the assessment period.</p> <p>An interview with Social Worker (SW) #1 was conducted on 10/13/16 at 6:01 PM. SW #1 stated she had coded the portion of the MDS which indicated the resident was rejecting care She stated the rejection of care coding was based on the refusal of medication and that Resident #166 had no other behaviors. SW #1 indicated it was an error in coding because the resident was cognitively intact and could make her own choices. SW #1 said, "I understand that it was her choice."</p> <p>During an interview on 10/13/2016 at 7:04 PM, the Director of Nursing stated it was her expectation that the MDS accurately reflect the resident's status.</p> <p>3. Resident #65 had the diagnoses which included anxiety, and depression. Resident #65's annual Minimum Data Set (MDS) dated 4/8/16 indicated the resident was cognitively impaired. The MDS specified the resident did not have any behavior or verbal symptoms directed towards others.</p>	F 278	<p>Workers, Activities Director, Certified Dietary Manager and Dietician) by the MDS Coordinators/Regional MDS consultant regarding the assessment process and coding the MDS accurately. This will be completed by 10/31/2016.</p> <p>An audit tool was developed which includes MDS coding accuracy. The audit tool will be utilized to complete audits of MDS assessments to verify that MDS assessments are coded accurately. The MDS Coordinator/Regional MDS consultant/designee will audit 20% of all resident assessments (including new admission assessments) weekly for 8 weeks, then 10% weekly for 4 weeks. Audits will continue quarterly and the results will determine the need for more frequent monitoring.</p> <p>All audit information will be analyzed and reviewed by the Director of Nursing at the QA Committee meetings.</p>		

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F 278	Continued From page 10 Review of a progress note from 4/2/16 revealed the resident as very agitated and was cursing at a male resident and calling him offensive names. The progress note also revealed the resident acted out aggressively with a female resident. Review of a progress note dated 4/5/16 revealed a behavior team meeting was conducted related to the episodes of agitation, cursing, and aggressive behaviors towards other residents. An interview with Social Worker (SW) #1 was conducted on 10/13/16 at 6:00 PM. SW #1 indicated the SW who had completed the Behavior portion of Resident #65's MDS, was no longer working at the facility. She could not explain why the other SW had not captured the resident's behavior on the MDS. During an interview on 10/13/2016 at 7:04 PM, the Director of Nursing stated it was her expectation that the MDS accurately reflect the resident's status.	F 278			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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: Based on observation, record review, and staff interviews, the facility failed to provide perineal care based upon the facility's perineal care	F 312	F312 Resident # 102, as a result of being	11/10/16	

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NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - GASTONIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2780 X-RAY DRIVE GASTONIA, NC 28054		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	<p>Continued From page 11</p> <p>guidelines for 1 of 3 residents (Resident #102) reviewed, who required extensive assistance for incontinence care.</p> <p>Findings included:</p> <p>The facility policy, revised May 2007, entitled "Perineal Care" read in part, "For a male resident" "g. Rinse washcloth and apply soap or skin cleansing agent. h. Wash and rinse the rectal area thoroughly"</p> <p>Resident #102 had diagnoses which included, but were not limited to, Alzheimer ' s disease, congestive heart failure, and renal insufficiency.</p> <p>A review of the Minimum Data Set Admission Assessment (MDS) dated 06/14/2016 revealed Resident #102 was severely cognitively impaired and required extensive assistance with toileting and personal hygiene. The MDS specified the resident was incontinent of bowel and bladder.</p> <p>The Care Plan, most recently revised on 09/13/16, specified the resident should receive assistance with the activities of daily living which he could not perform independently. The Care Plan also indicated the resident was at risk for skin breakdown due to incontinence of bowel and bladder.</p> <p>On 10/10/16 at 2:18 PM, NA #1 was observed providing incontinent care to Resident #102, who had been incontinent of stool. The NA used the incontinent brief to remove most of the stool. She took a wet towel and wiped the resident's rectal area three times, using a clean area of the towel with each swipe. NA #1 then applied a clean brief, and covered the resident with a blanket so he could nap.</p>	F 312	<p>unable to carry out ADLs is receiving necessary services to maintain good nutrition, grooming and personal and oral hygiene. The employee has received appropriate follow up as well as education.</p> <p>For the systemic change, education will be provided to Nursing staff by the Director of Nursing/ SDC regarding proper incontinence care to include the use of soap or some kind of cleansing agent during incontinence care. This will be completed by 10/31/2016.</p> <p>For all residents with the potential to be affected, an audit tool was developed for observing incontinence care to include the use of soap or some kind of cleansing agent during incontinence care. The DON/designee will observe 20% of residents receiving incontinence care. This will be completed by 11/10/2016.</p> <p>Audits will be completed by the DON/designee weekly for 4 weeks, then monthly for 3 months. Audits will continue monthly and the results will determine the need for more frequent monitoring.</p> <p>All audit information will be analyzed and discussed by the DON at the QA Committee Meetings.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345494	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/13/2016
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F 312	Continued From page 12 Immediately following the observation, on 10/10/16 at 2:23 PM, NA#1 was interviewed about cleansing and rinsing the resident's skin when he had been incontinent of stool. NA#2 stated she didn't need to rinse soap from the skin because she had not used soap when cleaning him. She pulled open the top drawer of the resident's bedside table and said, "See, he doesn't have any soap." When asked what she usually did when a resident had no soap at the bedside, NA#1 stated, "When they're out, their out. We are supposed to have all the supplies we need but if we don't have the supplies.." The NA didn't finish her sentence but shrugged her shoulders. After checking to see if the resident's oxygen tubing was properly placed, NA#1 left the room to provide care for another resident. During an interview on 10/13/16 at 7:10 PM, the Director of Nursing indicated it was her expectation that soap or some kind of cleansing agent would be used when incontinent care was performed.	F 312			
F 371 SS=F	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	F 371		11/10/16	

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F 371	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interviews, the facility failed to air dry dishware prior to stacking them on top of one another in storage, during 2 of 2 observations of dishware in the kitchen.</p> <p>Findings included:</p> <p>During review of the kitchen on 10/10/16 at 10:57 AM, staff were observed removing items from the dishwasher. There were 30 of 30 plates stacked on top of one another in the plate warmer while still wet. There were 47 of 47 bowls and 5 of 5 plates with guards that were stacked on top of one another while wet, and they were sitting at the tray service line.</p> <p>Dietary Staff #1, who indicated she had removed the plates and bowls from the dishwasher, was interviewed on 10/10/16 at 11:10 AM. Dietary Staff #1 said, "We are told to let them dry but I have to keep up with the dishwasher. I should probably stack them upside down so they dry."</p> <p>On 10/11/16 at 7:59 PM the kitchen was reviewed again and 9 of 15 bowls were found stacked on top of one another with moisture inside them.</p> <p>During an interview on 10/13/16 at 9:00 AM, the District Dietary Manager indicated it was his expectation that dishware be allowed to dry because when stacked wet there is increased risk of bacteria growth.</p>	F 371	<p>F371</p> <p>For all residents affected and having the potential to be affected, education was provided to dietary staff by the Dietary Manager & Administrator regarding drying kitchenware prior to stacking them in a storage unit. This was completed on 10/28/2016. Furthermore, on 10/19/2016, Ecolab technician inspected the dish machine and recalibrated it to optimize performance of rinse/dry chemicals.</p> <p>An audit tool was developed for kitchen sanitation to include observing that all kitchenware is dry prior to stacking and that dietary employees understand wet nesting. Audits will be completed by the Dietary Manager/designee for 4 weeks, then weekly for 4 weeks. Audits will continue monthly and the results will determine the need for more frequent monitoring.</p> <p>All audit information will be analyzed and discussed by the Dietary Manager at the QA Committee Meetings.</p>		