STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345537	A. BUILDING ______ B. WING ______	C 07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID 83HN11.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		8/16/18

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

Electronically Signed | 08/07/2018

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

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F 690 Continued From page 1

restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, physician assistant (PA) interview, staff interview, and record review the facility failed to administer an antibiotic to treat a urinary tract infection (UTI) until the twelfth day after the order was given for an urinalysis for 1 of 4 sampled residents (Resident #56) reviewed for catheters and/or UTIs. The facility also failed to anchor the urinary catheter tubing for 1 of 4 sampled residents (Resident #36) reviewed for catheters and/or UTIs. Findings included:

1. Record review revealed Resident #56 was admitted to the facility on 06/28/14. The resident's documented diagnoses included Alzheimer dementia, anxiety, depression, and chronic pain.

The resident's 04/22/18 quarterly minimum data set (MDS) documented his cognition was intact, he exhibited no behaviors including rejection of care, he required extensive assistance from staff with all his activities of daily living except for eating, and he was frequently incontinent of bowel and bladder.

The resident's care plan, revised on 05/03/18 after completion of this quarterly MDS assessment, documented, "(Resident) has bladder incontinence/fecal incontinence r/t (due to) physical limitations." Interventions to this problem included, "Observe/document for s/sx (signs and symptoms of) UTI."

A 04/25/18 physician order requested that an urinalysis (UA), culture and sensitivity (C & S) be

F 690

Ineffective communication regarding physician orders between nursing staff and lack of education regarding purpose and proper use of leg strap as a part of indwelling catheter care has been determined to be the root cause which led to the deficiency.

1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #56, by providing Augmentin 500 MG by mouth, 3 times per day for 7 days as ordered by the physician on 05/07/2018 to 05/14/2018. Resident has no further signs/symptoms of a urinary tract infection.

Corrective action has been accomplished for the alleged deficient practice in regards to Resident #36 by immediately placing the leg strap as required. Director of Nursing provided immediate 1:1 education with NA #1 regarding proper indwelling catheter care, including placement of leg strap.

2. Current residents have the potential to be effected by the same alleged deficient practice and will be identified during the clinical start up meeting. Physician orders written within the last 24-72 hours will be reviewed to ensure ordered treatment has been implemented. The Director of Nursing or Designee will conduct an audit for current residents receiving orders over

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 690 Continued From page 2
collected for Resident #56.

Lab results documented that the resident's urine was collected on 04/27/18, with final results/C & S faxed to the facility on
04/30/18 showing greater than 100,000 colony-forming units (CFU) of Escherichia coli (bacteria) present in the specimen.

Review of progress notes between 04/30/18 and 05/07/18 revealed no documentation of Resident #56 experiencing pain or discomfort.

A 05/07/18 physician order started Resident #56 on Augmentin (antibiotic) 500 milligrams (mg) by mouth (po) three times daily (TID) x 7 days for treatment of an UTI.

Review of the resident's May 2018 medication administration record (MAR) revealed the resident received his first dose of Augmentin at 1:00 PM on 05/07/18.

On 07/17/18 at 2:52 PM Unit Manager #1 stated the facility tried to do a lot of labs through the hospital because they were very good about getting results back to the facility in close to 24 hours. He explained if the hospital lab was utilized the facility collected the specimen immediately, and the facility transported it to the hospital. He commented if the contracted lab company was utilized then the facility immediately collected the urine, refrigerated it, and it was picked up by the company the next morning. He reported the facility had a dedicated computer from which it collected all lab results daily. According to Unit Manager #1, if the facility did not get results in a timely manner then one of the unit managers called the lab or hospital. He

F 690

the last 90 days, to ensure timely treatment. Negative findings will be addressed with the physician if noted. This will be completed by 08/10/2018.

Facility residents who require indwelling catheter care have the potential to be effected by the alleged deficient practice and will be identified upon admission, quarterly, annually and with significant change status via the MDS assessment process. Residents will also be identified in daily clinical start up meetings, if a new order is received for an indwelling catheter. The Director of Nursing or Designee has accomplished an audit of all residents with indwelling catheters to ensure that leg straps are properly secured. Negative findings were corrected if noted. This was completed on 07/19/2018.

3. Measures put into place to ensure that the same alleged deficient practice does not recur include: On 08/07/2018, education with current licensed nurses was provided by the Director of Nursing, regarding proper and timely initiation and implementation of physician orders and treatment. Nursing Administration will conduct daily stand down meetings to ensure that ordered treatment is implemented timely.
The Director of Nursing or Designee will conduct daily audits (Monday thru Friday) of physician orders to ensure timely implementation of the orders and proper medication administration protocol is followed. Weekend orders will be

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F 690	Continued From page 3 explained once results were received one of the unit managers called the physician or shared the results with one of the PAs who were in the building frequently. He stated the physician or one of the PAs then wrote an order for an effective antibiotic, and the antibiotic was started immediately that same day. On 07/17/18 at 3:07 PM PA #1 stated lab results were usually relayed to her in person because she was in the building all day on Mondays, Tuesdays, Wednesdays, and Fridays and in the building a half day on Thursdays. However, she explained if she was not present in the facility, results could be placed in her book. She commented the hospital was not always good about sending results over the computer, and often she or a facility nurse had to call them for the results. According to the PA, final UA lab results were usually available 24 - 72 hours after urine collection. She explained as soon as the final lab result was paired with a C & S, then antibiotic treatment should be begun immediately. On 07/17/18 at 5:16 PM the Director of Nursing (DON) stated the nurse who took the order for the UA should write a lab slip, and then the specimen should be collected that shift or next shift, with night shift collecting a lot of specimens. The DON reported the medical records supervisor printed off lab results daily, forwarding them to the unit managers who placed them in the physician books. She commented the unit managers called the labs if they did not get the lab results they were waiting for. 2. Resident #36 was admitted to the facility on	F 690	reviewed on Mondays. Audits will continue daily Monday-Friday for 4 weeks, and then monthly for 2 months and as needed thereafter. On 07/19/2018, education with current licensed nurses and nursing assistants was completed by the Staff Development Coordinator, regarding proper indwelling catheter care, including placement of leg strap. The Director of Nursing or Designee will conduct audits 3 times per week for 4 weeks and then monthly times 2 months to ensure proper indwelling catheter care, including placement of leg straps. 4. The Director of Nursing or Designee will review the results of the above mentioned audits weekly. Data will be analyzed and noted patterns or trends will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. The QAPI Committee will evaluate the effectiveness of the above plan monthly and will develop and implement additional interventions based on negative findings to ensure continued compliance.	

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F 690	Continued From page 4	F 690		

11/24/17. Diagnoses included, in part, obstructive and reflux Uropathy with urinary retention.

The MDS quarterly assessment dated 06/01/18 revealed the resident was cognitively intact. He required extensive assistance with one staff assist with toileting, had an indwelling urinary catheter and was always incontinent of bowel.

A review of the care plan revealed a plan of care for an indwelling urinary catheter with an intervention to anchor the catheter to prevent excess tension.

An interview with Resident #36 was conducted on 07/16/18 at 2:34 PM. Resident #36 stated he has had some problems with bleeding and discomfort.

An observation of catheter care was conducted on 07/18/18 at 9:15 AM with NA #1. The NA provided privacy and informed Resident #36 of each step. He was instructed to remove his slacks after NA #1 washed her hands and applied gloves and prepared the water basins. NA #1 cleansed the peri area with warm soapy water and then rinsed the area. NA #1 proceeded to wash around the penis and the catheter tubing. NA #1 was noted to have rinsed and used clean wash clothes 3 times to cleanse the tubing from the tip of the penis to the bottom of the catheter bag. The catheter was not secured to the resident's leg. NA #1 drained the catheter into a urinal and reconnected the bottom of the catheter.

An interview was conducted with Resident #36 on 07/18/18 at 10:00 AM. Resident #36 reported the staff did not usually secure the catheter tubing. He stated since he has been here, the staff has

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F 690	Continued From page 5 only secured the tubing to his leg a couple of times. An interview with NA #1 on 07/18/18 at 10:03 AM revealed that she did catheter care the same way every time she did care. NA #1 confirmed the catheter tubing was not secured prior to the catheter care and she stated she did not secure it when she was done. She stated the resident did not like it. An interview with Nurse #5 on 07/18/18 at 10:15 AM confirmed the resident had an indwelling urinary catheter. Nurse #5 stated the protocol for urinary catheter care was to check the tubing (entry site), check the bag to be sure it was below the bladder, check for patency and ensure the catheter was draining, check for sediment, bloody or cloudy urine in the catheter bag and check to be sure the bag was secured to the resident's leg. Nurse #5 stated the resident did not refuse care to his catheter or refuse the staff to secure the catheter to his leg. Nurse #5 reported when she did an assessment, she would check to be sure the catheter was in place and secured to the leg. Nurse #5 reported she did not assess it today, but knew he had one on now because the NA just asked for it. An interview with Resident #36 on 07/18/18 at 1:35 PM reported that they put the leg strap on today, but this was maybe the 3rd time they ever put one on. The resident stated "It feels much better with it on." Resident #36 reported he has never refused to wear it nor has staff ever asked if he would like to wear it or not. An interview was conducted with the Director of Nursing (DON) on 07/18/18 at 4:30 PM. The	F 690		

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F 690	Continued From page 6 DON revealed her expectation was for staff to secure the indwelling catheter tubing to the resident's leg at all times per protocol and the care plan.	F 690		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff, and physician interviews the facility failed to provide medication management for 1 of 1 residents (Resident #26) whose physician failed to transcribe an order from the physician progress notes to an order sheet. Findings included: Review of the medical record revealed Resident #26 was admitted to the facility on 08/12/16 and had diagnoses of Alzheimer's disease, non-Alzheimer's dementia, and seizure disorder. Review of the quarterly Minimum Data Set (MDS)	F 711	Ineffective communication between nursing staff and medical providers has been determined the root cause which led to the deficiency. 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #26 by adjusting the medication as ordered by the physician. 2. Current residents have the potential to be affected by the same alleged deficient	8/16/18

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F 711

Continued From page 7

dated 01/13/18 revealed Resident #26 was severely cognitively impaired and had physical and behavioral symptoms.

Review of the Physician Note dated 03/14/18 revealed that Resident #26 was having increased agitation, increased combativeness, and was more difficult to control. The plan was to trial an increase of Risperdal (an antipsychotic medication) to 0.5mg (milligrams) by mouth twice each day.

Review of the Physician Note dated 03/29/18 revealed Resident #26 was assessed as having uncontrolled behavior disturbances and a trial increase of Risperdal to 0.5mg (milligrams) by mouth twice each day would be done.

Review of the March 2018 orders and the March 2018 Medication Administration Record (MAR) revealed no increase to the amount of Risperdal Resident #26 received.

Review of the Psychiatry Follow-Up Note dated 04/10/18 revealed that the most recent physician note indicated Resident #26's Risperdal was to be increased to 0.5mg twice each day but the increased dosage was not reflected on the MAR.

Review of the Physician's Telephone Orders dated 04/18/18 revealed an order to increase Resident #26's Risperdal to 0.5mg twice each day for behavior disturbances.

Review of the April 2018 MAR revealed Resident #26's Risperdal was increased to 0.5mg twice each day on 04/18/18.

In an interview on 07/17/18 at 10:45 AM Resident

F 711

practice. The Director of Nursing or Designee will conduct an audit of current residents with physician assessment notes over the last 90 days. Negative findings will be corrected and addressed with the physician if noted. This will be completed by 08/10/2018.

3. Measures put into place to ensure that the same alleged deficient practice does not recur include: On 08/07/2018, current medical providers and current licensed nurses will be educated by the Director of Nursing, regarding the requirement for physician recommendations to be written as orders in the medical record. The Director of Nursing or Designee will review all physician progress notes to ensure recommendations have been transcribed as orders and have been properly communicated to nursing staff. Audits will continue daily Monday-Friday for 4 weeks, and then monthly for 2 months and as needed thereafter. Audits for Saturday and Sunday will be completed by Director of Nursing or Designee on Monday.

4. The Director of Nursing or Designee will review audits weekly. Data will be analyzed and noted patterns or trends will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. The QAPI Committee will evaluate the effectiveness of the above plan monthly and will develop and implement additional interventions based on negative findings to ensure continued compliance

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F 711	Continued From page 8 #26's physician indicated an order for a medication change should be provided to the facility as an order. He stated that writing the change in the progress note did not constitute an order. He stated the medication change should have been transcribed onto an order sheet so the medication could be increased. The physician did not feel Resident #26 was harmed although the behaviors continued. In an interview on 07/18/18 at 4:45 PM the Director of Nursing stated it was the responsibility of the physician to write an order for medication management and not to just write the information in a progress note. She indicated she expected physicians to accurately assess residents at each visit and to document accordingly.	F 711		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide laboratory services as ordered for 1 of 6 Residents (Resident #27) whose laboratory orders were reviewed. Findings included: Review of the medical record revealed Resident #27 was re-admitted to the facility on 02/28/18	F 770	Lack of reconciliation of the orders to ensure timely lab draws has been determined to be the root cause which led to the deficiency. 1. Corrective action has been accomplished for the alleged deficient	8/16/18

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F 770	Continued From page 9 and had diagnoses of kidney cancer, anemia, and Clostridium Difficile colitis. Review of the annual Minimum Data Set (MDS) dated 05/14/18 revealed Resident #27 was cognitively aware and did not reject care. Review of the Physician's Telephone Orders dated 05/07/18 revealed an order for a Complete Blood Count (CBC) with differential and a Basic Metabolic Panel (BMP) to be drawn STAT (right away) on 05/14/18. Review of the laboratory result report revealed the STAT CBC ordered for 05/14/18 was not collected until 05/16/18. There was no result available for the STAT BMP ordered to be collected on 05/14/18. Review of the Physician's Telephone Orders dated 05/15/18 revealed an order for a BMP lab test. There was no result available for the BMP laboratory test. In an interview on 07/19/18 at 9:30 AM the District Director of Clinical Services (DDCS) stated the STAT CBC with differential ordered for 05/14/18 was not collected until 05/16/18. She indicated the STAT BMP ordered for 05/14/18 was not performed at all. She stated the BMP was re-ordered to be drawn on 05/15/18 but that test was not done. She indicated the laboratory results were not followed up on by the staff or the physician and they should have been. She stated the laboratory tests just got missed. In an interview on 07/19/18 at 10:00 AM Unit Manager (UM) #2 stated STAT meant to complete the order for the date ordered. She indicated if an order was written on 05/07/18 for a STAT laboratory test on 05/14/18 the test needed to be completed on 05/14/18. In an interview on 07/19/18 at 12:17 PM UM #1 stated the process for laboratory tests was to write the orders, write the order in the laboratory	F 770	practice in regards to Resident #27 by obtaining the ordered lab and updating the physician with the results. 2. Current residents have the potential to be affected by the same alleged deficient practice. The Director of Nursing or Designee has accomplished an audit of current residents with lab orders over the last 90 days. Negative findings will be corrected and addressed with the physician if noted. This will be completed by 08/10/2018. 3. Measures put into place to ensure that the same alleged deficient practice does not recur include: On 08/07/2018, current licensed nurses will be educated by the Director of Nursing, regarding lab management procedures and expectations. The Director of Nursing or Designee will review the lab book for each unit during the clinical start-up meeting to ensure proper completion of labs per physician orders. Negative findings will be investigated and reported on during the daily stand down meeting. Audits will continue daily Monday-Friday for 4 weeks, and then monthly for 2 months and as needed thereafter. Audits for Saturday and Sunday will be completed by Director of Nursing on Monday. 4. The Director of Nursing or Designee will review audits weekly. Data will be analyzed and noted patterns or trends will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. The	

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F 770	Continued From page 10 book and then the night shift nurses would write the requisition form for the laboratory tests. UM #1 stated if a test was marked STAT for a specific date then that was when the test needed to be done. He indicated if a physician ordered a laboratory test and it was missing from the record the physician should ask for the results. He stated the missing test and the late STAT tests should have been caught during the 24 hour chart check done by the night nurses. In a follow-up interview on 07/19/18 at 1:50 PM the DDCS stated she expected quality care from the staff and physicians in the facility. She stated she expected laboratory tests to be done timely as ordered. The DDCS indicated she expected the nurses to review and validate that laboratory tests were completed.	F 770	QAPI Committee will evaluate the effectiveness of the above plan monthly and will develop and implement additional interventions based on negative findings to ensure continued compliance.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		8/16/18

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	345537	A. BUILDING ______ B. WING ______	C 07/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER STREAM HEALTH AND REHABILITATION CENTER	2305 SILVER STREAM LANE WILMINGTON, NC 28401

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F 812 Continued From page 11

standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview the facility failed to replace an empty bottle of sanitizing solution which fed into the low-temperature dish machine. The facility also failed failed to maintain final rinse temperatures at or above 120 degrees Fahrenheit during the operation of the low-temperature dish machine.
Findings included:

1. During observation of the dish machine process, beginning at 8:49 AM on 07/18/18, six trays of kitchenware were run through the dish machine.

At 9:07 AM on 07/18/18 a test strip which was used to check the strength of the sanitizing solution feeding into the dish machine did not register the presence of any sanitizer. Observation revealed the jug of sanitizing solution feeding into the low-temperature dish machine was empty. The jug was completely dry. Review of the dish machine log revealed a dietary employee documented a test strip used to check the strength of the sanitizing solution feeding into the dish machine before beginning the cleaning of the breakfast dishes on 07/18/18 registered 200 parts per million (PPM) of sanitizer. On the log during the month of July 2018 it was documented 37 times that the test strip registered 200 PPM.

At 10:40 AM on 07/18/18 the dish machine service representative stated there was no way a test strip could have registered 200 PPM before the washing of breakfast dishes started at 8:49 AM on 07/18/18 because the jug of sanitizer was completely dry. He also reported the sanitizing

F 812

Ineffective interdepartmental communication regarding dishwasher temperature irregularities along with infrequent monitoring of sanitizer levels has been determined to be the root cause which led to the deficiency.

1. Corrective action has been accomplished for the alleged deficient practice. Initially, all kitchen operations related to sanitization of dishware were immediately stopped upon identification of the deficiency. Dishware that had gone through the machine following meal service did not leave the kitchen until properly sanitized per guidelines. Ecolab immediately arrived at the facility to inspect the dish machine and found it to be working properly.

2. Current residents have the potential to be affected by the same alleged deficient practice. On 07/18/2018, the District Director of Clinical Services accomplished an audit of all discharges to the hospital over the last 60 days. None of the residents discharged to the hospital were diagnosed with foodborne illness.

3. Measures put into place to ensure that the same alleged deficient practice does not recur include: On 07/18/2018, current dietary staff were immediately educated by the Certified Dietary Manager regarding proper temperature and sanitizer levels. Dishwasher temperature

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F 812

Continued From page 12

dispensing system on the dish machine had been recently serviced and calibrated so no test strips would have registered as high as 200 PPM any time during July 2018. He commented the dispensing system was calibrated to dispense enough sanitizer to register 50 - 75 PPM on a continuous basis. He explained this was the optimal range that maximized the sanitizing potential of the low-temperatures dish machine.

At 10:47 AM on 07/18/18 the District Director of Clinical Services reviewed all discharges from the facility to the hospital in the past two months, and reported that none of the residents discharged to a hospital were diagnosed with foodborne illness.

At 4:22 PM on 07/18/18 the Dietary Manager (DM) stated she in-serviced the dietary staff about a month ago about the dish machine process. She reported at that time it was explained to the dietary staff that a low-temperature dish machine sanitized kitchenware via a sanitizing solution that fed into the machine, and white strips that turned different shades of purple were to be used when checking the strength of the sanitizer. She commented dietary staff were told that these strips were supposed to register 50 - 75 PPM of sanitizing solution. According to the DM, the test strips were a mechanism for detecting problems with the sanitizer dispensing system, and it was her expectation that test strips be used every time the dish machine was started up for use. She stated staff should be notifying her immediately when the test strips registered above or below 50 - 75 PPM.

At 4:34 PM on 07/18/18 a dietary aide stated she always wanted the dish machine test strips to

F 812

will be checked and recorded on the temperature log by dietary staff each shift. Negative findings will be immediately reported to the Certified Dietary Manager or Maintenance Director and will be resolved prior to the use of the machine. Maintenance Director or Designee will review the temperature log to ensure that the proper temperature is maintained. Audits will continue daily Monday-Friday for 4 weeks, and then monthly for 2 months and as needed thereafter. Audits for Saturday and Sunday will be completed by or Maintenance Director or Designee on Monday.

4. Sanitizer levels will be checked and recorded by dietary staff prior to each use of the dishwasher. Negative findings will be immediately reported to the Certified Dietary Manager and will be resolved prior to use of the machine. Certified Dietary Manager or Designee will review the sanitizer log to ensure that the proper levels are maintained. Audits will continue daily Monday-Friday for 4 weeks, then monthly for 2 months and PRN thereafter. Audits for Saturday and Sunday will be completed by Certified Dietary Manager on Monday.

4. The Maintenance Director and Certified Dietary Manager will review their assigned audits weekly. Data will be analyzed and noted patterns or trends will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. The QAPI Committee will evaluate the effectiveness of the above

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F 812	Continued From page 13	F 812		

Continued From page 13

register about 75 PPM of sanitizer in order to kill germs and bacteria on kitchenware. She commented if the strips were below 50 PPM or above 100 PPM she let the DM or the maintenance manager know immediately so the problem could be fixed. She also reported that when she was assigned to work at the dish machine, before running kitchenware through, she always checked the jugs of washing agent, drying agent, and sanitizer to make sure there was solution inside them.

2. Between 8:49 AM and 9:08 AM on 07/18/18 six racks of kitchenware were run though the dish machine. The final rinse gauge of the low-temperature dish machine did move above the minimum temperature of 100 degrees Fahrenheit. The two dietary employees operating the dish machine were not monitoring the temperature gauges.

At 10:40 AM on 07/18/18 the dish machine service representative stated during this observation the water feeding into the dish machine in the final rinse cycle was not above 100 degrees Fahrenheit. He reported there was nothing wrong with the dish machine gauges themselves, and they were accurately capturing water temperatures. He commented the final rinse gauge should read at least 120 degrees Fahrenheit in order for kitchenware to be sanitized.

At 4:22 PM on 07/18/18 the Dietary Manager (DM) stated dietary employees had been made aware that it was their responsibility to monitor the dish machine gauges during the entire process of cleaning kitchenware. She reported the ideal temperature range for water in the final

Provider's Plan of Correction (F 812):

plan monthly and will develop and implement additional interventions based on negative findings to ensure continued compliance.

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F 812	Continued From page 14 rinse cycle was 120 - 140 degrees Fahrenheit. She commented when the final rinse temperature was below 120 degrees it was her expectation that the dietary staff notify her immediately. According to the DM, final rinse temperature below 120 degrees placed resident health in jeopardy. At 4:34 PM on 07/18/18 a dietary aide stated the staff was supposed to notify the DM anytime the final rinse temperature of the dish machine was below 120 degrees Fahrenheit. She explained final rinse water below this temperature was not hot enough to fully activate the sanitizing solution, and the germs and bacteria on kitchenware might not be destroyed.	F 812		