

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

PRINTED: 03/27/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345286</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/14/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SALISBURY CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>710 JULIAN ROAD</b> <b>SALISBURY, NC 28147</b>
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E 000	Initial Comments  An unannounced Recertification survey was conducted on 02/11/19 through 02/14/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #BPDS11.	E 000		
F 553 SS=B	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3)  §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.  §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's	F 553		3/14/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>03/08/2019</b>
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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 553	<p>Continued From page 1 strengths and needs.</p> <p>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record reviews, observations, resident and staff interviews, the facility failed to invite three of three residents reviewed for care plan meeting invitations to their care plan meetings (Resident # 28, # 47 and # 60).</p> <p>Findings included:</p> <p>1. Resident # 28 was admitted to the facility on 12/30/2014 with diagnoses that included anemia, chronic pain, major depression, anxiety and symbolic dysfunctions.</p> <p>A quarterly Minimum Data Set (MDS) dated 12/18/2018 revealed that Resident # 28 was cognitively intact and was able to make daily care decisions.</p> <p>On 02/12/2018 at 9:18 AM an interview conducted with Resident # 28 revealed he had not been invited to a care plan meeting in a long time since his sister did not attend the meetings with him anymore.</p> <p>A review of the medical record of Resident # 28 revealed there was no documentation that Resident # 28 had been invited to a care plan meeting.</p> <p>On 12/13/2019 at 9:56 AM an interview with the facility social worker (SW) revealed that she was responsible for care plan meeting invitations given to the residents and mailed to the resident responsible party (RP) based on a list provided to her by the MDS nurse. The SW revealed that she</p>	F 553	<p>F553</p> <ol style="list-style-type: none"> <li>Residents #28, #47 and #60 have been given care plan invites for their Care Plan Meetings to be held on 3/14/19.</li> <li>Social Service Director (SSD) audited all residents who had care plans since January 1, 2019 to ensure they had received invitations to their care plan meetings. Those residents found to not have received an invitation will be issued one for their Care Plan Meetings to be held during the next quarter.</li> <li>Center Executive Director (CED) provided education on 3/5/19 to SSD, Social Service Specialist (SSS) and Interdisciplinary Team (IDT) on Facility Policy on Care Plan invitations and Federal guidelines on inviting residents to care plans. SSD will provide CED / Center Nurse Executive (CNE) with list of scheduled care plans for the upcoming week along with copies of invitations sent to each resident 1x weekly x 3 months to ensure all residents received a care plan invitation. Social Services will document in Point click care who was invited/attended Care Plan Meetings.</li> <li>SSD will submit care plan list and copies of invitations sent to the Quality Assurance (QA) meeting monthly for review. SSD will be responsible for POC.</li> </ol>		

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F 553	<p>Continued From page 2</p> <p>did not have any documentation that included care plan meeting invitations provided to residents or RPs. The SW revealed that she had not invited anyone to a care plan meeting since 11/29/2018 because the facility had been in the process of editing the care plan meeting letter. The SW also revealed that she did not invite any resident that had a memory deficit or was moderately or severely cognitively impaired. The SW could not confirm a date of when Resident # 28 had last been invited to attend a care plan meeting.</p> <p>An interview was conducted with the facility administrator on 02/14/2019 at 3:22 PM. The facility administrator revealed that the expectation that all residents be invited to care plan meetings unless the resident was deemed incompetent by a court of law and that each resident had a quarterly and as needed care plan meeting.</p> <p>2. Resident # 47 was admitted to the facility on 02/01/2016 with diagnoses that included muscle weakness, dementia, Alzheimer's disease, insomnia, anxiety and symbolic dysfunction. A review of a quarterly MDS dated 12/31/2018 revealed that Resident # 47 was cognitively intact and had experienced trouble concentrating and rejected care during the review period.</p> <p>On 02/11/2019 at 12:21 PM an interview conducted with Resident # 47 revealed that Resident # 47 was not certain if she had been invited to a care plan meeting or not and that she would have attended the meeting had she been invited.</p> <p>A review of the medical record of Resident # 47 revealed no documentation that Resident # 47</p>	F 553			

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F 553	<p>Continued From page 3</p> <p>had been invited to a care plan meeting.</p> <p>On 12/13/2019 at 9:56 AM an interview with the facility social worker (SW) revealed that she was responsible for care plan meeting invitations given to the residents and mailed to the resident responsible party (RP) based on a list provided to her by the MDS nurse. The SW revealed that she did not have any documentation that included care plan meeting invitations provided to residents or RPs. The SW revealed that she had not invited anyone to a care plan meeting since 11/29/2018 because the facility had been in the process of editing the care plan meeting letter. The SW also revealed that she did not invite any resident that had a memory deficit or was moderately cognitively impaired. The SW could not confirm a date of when Resident # 47 had last been invited to attend a care plan meeting.</p> <p>An interview was conducted with the facility administrator on 02/14/2019 at 3:22 PM. The facility administrator revealed that the expectation that all residents be invited to care plan meetings unless the resident was deemed incompetent by a court of law and that each resident had a quarterly and as needed care plan meeting.</p> <p>3. Resident #60 was admitted to the facility on 4/30/18 with diagnoses which included: Stroke, diabetes, and generalized weakness.</p> <p>Review of the Minimum Data Set (MDS) assessments for Resident #60 revealed the most recently completed assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 1/1/19. The resident was coded as having been cognitively intact and was able to make daily decisions.</p>	F 553			

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F 553	<p>Continued From page 4</p> <p>During an interview conducted with Resident #60 on 2/11/19 at 3:55 PM the resident stated she had not participated in a care plan meeting.</p> <p>A review of the medical record of Resident #60 revealed no documentation the resident had been recently invited to or participated in a care plan review meeting.</p> <p>An interview was conducted with the facility Social Worker (SW) on 2/12/19 at 4:21 PM. The SW stated the care plan review meeting for Resident #60 would have been on 1/17/19. The SW stated the care plan invite process was going to be revamped between herself and the nurses to get more participation. The SW stated they had been sending out letters and inviting residents to the care plan meetings but had not sent out invitations nor invited residents to care plan meetings since 11/29/18. The SW stated care plan invitations nor were residents invited for the 1/17/19 care plan review. The SW stated Resident #60 had not been invited nor participated in her care plan review which took place on 1/17/19.</p> <p>A second interview was conducted with the SW on 2/13/19 at 3:14 PM. The SW stated the last time Resident #60 had been invited to a care plan was 5/24/18. The SW stated the resident had not responded to the care plan invitation and had not participated in the care plan meeting. The SW stated Resident #60 has had care plan reviews since 5/24/18 and the resident had not participated in the care plan review and she did not have letters regarding the resident having had been invited to the other care plan reviews.</p> <p>An interview was conducted with the facility</p>	F 553			

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F 553	Continued From page 5 administrator on 02/14/2019 at 3:22 PM. The facility administrator revealed that the expectation that all residents be invited to care plan meetings unless the resident was deemed incompetent by a court of law and that each resident had a quarterly and as needed care plan meeting.	F 553			
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)  §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section.  §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.  §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.  §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.  §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced	F 561		3/14/19	

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F 561	<p>Continued From page 6</p> <p>by:</p> <p>Based on observation, record review and staff and resident interviews the facility failed to provide scheduled showers and shaves to 2 of 2 residents, #267 and #266; and 1 of 1 residents, resident #77, was not allowed to leave the 300 Hall as he requested during a quarantine. Findings included:</p> <p>1. Resident #267 admitted to the facility on 1/8/19 with diagnoses of chronic kidney disease, hypertension, dementia, cancer, and weakness.</p> <p>A review of Resident #267's baseline Care Plan dated 1/8/19 revealed he was dependent with activities of daily living such as bathing and personal care.</p> <p>An Admission Minimum Data Set Assessment dated 1/15/19 revealed Resident #267 was dependent for bathing and required limited assistance with personal car</p> <p>A review of Resident #267's Activities of Daily Living Record for February 2019 revealed he had not received a shower during the month of February.</p> <p>On 2/11/19 at 12:14 pm during an interview and observation with Resident #267 he stated he had not been to the shower since he was admitted to the facility on 1/8/19; and he stated he would like to have a shower and be shaved daily. He stated the staff had given him a bed bath but he was told he could not go to the shower because of a quarantine on the 300 Hall due to a stomach virus. Resident #267 had a beard and moustache with approximately one half an inch of hair growth.</p>	F 561	<p>F561</p> <p>1. Residents #267 and #266 where showered and shaved on 2/13/19. Resident #77 was educated on 2/14/19 by Center Executive Director (CED) that he has the right to move freely within the facility during a quarantine situation.</p> <p>2 The nurse management team will complete 100% validation of alert and oriented resident's shower preference by 3/14/19 and update shower schedule and C.N.A. assignment sheet. CED addressed Resident Council on 3/12/19 on their right to move freely around the building during quarantined situations. In the event of future quarantines, CED/Center Nurse Executive (CNE) will remind residents that they can move freely within the facility.</p> <p>3. CNE / Nurse Practice Educator (NPE) re-educated nursing staff regarding giving assigned showers and completing ADL care daily. CNE/NPE will re-educate all nursing staff that all residents have the right to move freely within the building during a quarantine situation by 3/14/19.</p> <p>4. Unit managers/CNE/NPE will complete 3 random showers/ADL audits 2 times week X 3 months to ensure residents are getting scheduled showers and ADL's are being performed as needed. CNE/NPE will submit results of audits to</p>		

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F 561	Continued From page 7  An interview with Nurse Aide #1 on 2/13/19 at 11:21 am revealed she was assigned to Resident #267 on Friday, 2/8/19. She stated Resident #267 had not been shaved or showered because they were not allowed to leave the unit because they were quarantined due to a stomach virus.  An interview with the Director of Nursing on 2/13/19 at 3:41 pm revealed she had reviewed Resident #267's ADL Record and he had not received a shower during the month of February 2019. She stated shaving would be included under personal hygiene but the ADL Record does not specifically document if Resident #267 had been shaved.  On 2/13/19 at 4:00 pm an interview with Nurse Aide #2 revealed he had worked 7:00 am to 7:00 pm on Saturday, 2/9/19. He stated Resident #267 was assigned to him on 2/9/19. Nurse Aide #2 stated he was told by the Nurse the residents were not to be taken to the shower due to sickness, nausea and vomiting, with residents on the 300 Hall. Nurse Aide #2 stated he had not asked Resident #267 if he wanted to be shaved and he had not shaved him. He stated the residents are usually shaved when they are given a shower.  On 2/14/19 at 1:37 pm during a telephone interview with Nurse #1 she stated Resident #267 was assigned to her on 2/9/19 and 2/10/19. She stated they kept the 300 Hall quarantined because there was a stomach virus affecting some of the residents and they were trying to keep it from spreading. She stated she told the Nurse Aides to give "really good bed baths" but did not tell them not to take the residents to the	F 561	the monthly Quality Assurance (QA) meeting for review. CNE will be responsible for POC.		

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F 561	<p>Continued From page 8</p> <p>shower. Nurse #1 stated she was not aware Resident #267 had not been shaved over the weekend.</p> <p>An interview with the Director of Nursing on 2/14/19 at 11:11 am revealed her expectation of staff was Resident #267 should be shaved daily during morning care if he desired and he should be showered during the quarantine of Hall 300 if he desired.</p> <p>An interview with the Administrator on 2/14/19 at 5:39 pm revealed his expectation of staff was the residents would be able to be showered and shaved whenever they requested.</p> <p>2. Resident #266 was admitted to the facility on 1/31/19 with diagnoses of stroke, seizures, repeated falls, diabetes and hypertension. A review of Resident #266's baseline Care Plan dated 1/31/19 revealed he required extensive assistance with transfers and personal care.</p> <p>The resident's most recent Minimum Data Set assessment was an admission assessment dated 2/14/19 and it revealed Resident #266 was cognitively intact and required extensive assistance with bathing and personal care, such as shaving.</p> <p>A review of Resident #266's ADL Record for February 2019 revealed he had not received a shower during the month of February.</p> <p>An interview and observation of Resident #266 on 2/11/19 at 11:50 am revealed he had facial hair that was approximately one fourth inch long and thick. He stated he had been at the facility for a week and had not been to the shower yet or been</p>	F 561			

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F 561	<p>Continued From page 9 shaved.</p> <p>On 2/12/19 at 9:05 am Resident #266 was observed to have thick facial hair that was approximately one fourth inch long to his mustache and lower face.</p> <p>On 2/13/19 at 8:05 am an observation and interview with Resident #266 revealed he continue to have facial hair to his mustache and lower face area. He stated he still had not had a shower and had not been shaved.</p> <p>An interview with Nurse Aide #3 on 2/13/19 at 8:10 am revealed she was told residents that were not sick or did not have roommates that were sick could go to the shower, but Resident #266's roommate had been sick so he was not taken to the shower.</p> <p>During an interview with Nurse #2 on 2/13/19 at 9:06 am she stated the residents are shaved on their shower days and in-between if they need to be shaved. She stated residents should be showered and shaved any time they request.</p> <p>During an interview with Nurse Aide #1 on 2/13/19 at 11:21 am she stated she was assigned to Resident #266 on Friday 2/8/19. She stated Resident #267 had not been shaved or showered on 2/8/19 because they were not allowed to leave the unit due to a quarantine of 300 Hall because some of the residents had nausea, vomiting, and diarrhea.</p> <p>An interview with the Director of Nursing on 2/13/19 at 3:41 pm revealed she had reviewed Resident #266's ADL Record and he had not received a shower during the month of February</p>	F 561			

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F 561	<p>Continued From page 10</p> <p>2019. She stated shaving would be included under personal hygiene but the ADL Record does not specifically document if Resident #266 had been shaved.</p> <p>An interview with Nurse Aide #2 on 2/13/19 at 4:00 pm revealed he had been assigned to Resident #266 on Saturday, 2/9/19, and Sunday 2/10/19. He stated he was told by the Nurse the residents were not to be taken to the shower because residents on the 300 Hall had nausea, vomiting, and diarrhea. He stated he had not shaved Resident #266 on 2/8/19. He stated the residents are shaved on their shower days and when they request a shave.</p> <p>An interview with Nurse #1 on 2/14/19 at 1:37 pm revealed she had cared for Resident #266 on 2/9/19 and 2/10/19. She stated the 300 Hall was quarantined because there was a stomach virus involving some of the residents. She stated she told the Nurse Aides to give the residents "really good bed baths" but did not tell them they could not go to the shower. She stated she had not noticed Resident #266 had not been shaved over the weekend.</p> <p>On 2/14/19 at 11:11 am an interview with the Director of Nursing revealed he expectation was Resident #266 should be asked daily if they would like to be shaved during morning care. She stated it was also her expectation that Resident #266 be showered during the time the 300 Hall was quarantined if he wanted to be showered.</p> <p>An interview with the Administrator on 2/14/19 at 5:39 pm revealed his expectation of staff was the residents would be showered and shaved</p>	F 561			

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F 561	<p>Continued From page 11 whenever they requested.</p> <p>3. Resident #77 was admitted to the facility on 6/11/15 with diagnoses of Parkinson's Disease, Dementia, Stroke, Depression, and Anxiety. His most recent Minimum Data Set Assessment dated 1/7/19 revealed he was cognitively intact and required supervision with moving about in the facility.</p> <p>On 2/11/19 at 9:53 am an interview with Resident #77 revealed he was upset because he could not leave the 300 hallway. He stated there were people that were sick on the 300 Hall and he was not allowed to leave. Resident #77 stated he had asked to leave the hall since the quarantine had started last week.</p> <p>During an interview with Nurse Aide #4 on 2/12/19 at 2:51 pm she stated the 300 Hall had been quarantined because some of the residents had been sick with nausea, vomiting, and diarrhea. She stated the quarantine had started last week during the middle of the week. She stated the residents had not been allowed to leave the hall.</p> <p>During a second interview with Resident #77 on 2/12/19 at 3:01 pm he stated he had not been off the 300 Hall for 6 days. He stated he was told there was a flu bug and he could not leave the hall by the Nurses.</p> <p>An interview with Nurse Aide #6 on 2/13/19 at 9:57 am revealed the 300 Hall had been on quarantine since last week and the residents were not allowed to go off the hall.</p> <p>On 2/13/19 at 10:25 am the Director of Nursing stated the 300 Hall had been quarantined for a</p>	F 561			

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F 561	Continued From page 12 week because there was a virus causing nausea, vomiting, and diarrhea. She stated they had not let residents leave the hall to contain the virus. She stated she had spoken with the Health Department regarding the virus and was advised to have the residents on 300 Hall eat their meals in their rooms and to not have activities on the hallway. The Director of Nursing stated even with the quarantine the residents should have been allowed to leave 300 when they requested, and Resident #77 should have been allowed to leave the hall when he requested.  An interview with the Administrator on 2/14/19 at 5:39 pm revealed his expectation of staff was the resident would be able to move about the facility whenever they requested and the staff should have allowed Resident #77 to leave the unit when he requested.	F 561			
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)  §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F 655		3/14/19	

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F 655	<p>Continued From page 13</p> <p>(C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to develop a baseline discharge care plan in the baseline care plans for 5 of 5 residents reviewed for discharge care plans (Residents # 31, # 166, # 168, # 169 and Resident # 117).</p> <p>Findings included:</p> <p>1. Resident # 31 was readmitted to the facility on 01/25/2019 with diagnoses that included</p>	F 655	<p>F655</p> <p>1. Discharge care plans were developed for residents #31, #166, #168, #169 and #117 on 3/14/19 by Social Service Director (SSD).</p> <p>2. SSD and Social Service Specialist (SSS) completed a 100% audit of all Resident care plans who were admitted in the last 60 days, on 3/14/19 to ensure all</p>		

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F 655	<p>Continued From page 14</p> <p>cardiomyopathy, lupus erythematosus, pain, anemia, paranoid schizophrenia, seizures and behaviors.</p> <p>A review of a significant change Minimum Data Set (MDS) dated 02/01/2019 revealed that Resident # 31 had unclear speech and was rarely understood or understands and was not able to participate in a cognition test because she had both short- and long-term memory deficits. Resident # 31 was total care for bed mobility, transfers, eating and toileting. Resident # 31 was incontinent of bladder and bowel and Resident # 31 had no active discharge plan in place.</p> <p>A review of the care plans initiated on readmission date of 01/25/2019 revealed that a baseline care plan for discharge plans for Resident # 31 was not included in the care plans. MDS nurse # 1 was interviewed at 9:33 AM on 02/13/2019 and revealed that the facility social worker (SW) was responsible to develop baseline discharge care plans for residents and that the care plans were to be initiated in 24 hours of admission or readmission.</p> <p>On 02/13/2019 at 9:56 AM an interview was conducted with the facility SW. The SW revealed that she was responsible for completion of section Q of the MDS that was coded for resident discharge plans at the time of the MDS. The SW explained that sometimes the facility-initiated discharge plans on admission or readmission and that at times the resident and the family did not share the same discharge plans and sometimes resident discharge plans changed over time. The SW revealed that she did not develop a discharge care plan for any resident except one currently in the facility. The SW revealed that she was not</p>	F 655	<p>residents had a Discharge Care Plan in place. Any resident found without a Discharge Care Plan in place, one was added.</p> <p>3. Center Executive Director (CED) re-educated SSD and SSS on 3/6/19 regarding Discharge Care Planning for all residents, per regulation. New admits will be initiated within 72 hours after admission and will be revised/updated every 90 days or as residents needs change by SSD / SSS. Current Residents Discharge Care Plans will be revised/updated every 90 days or as residents needs change by SSD / SSS.</p> <p>4. Center Executive Director will complete random Care Plan Audits using the Care Plan Audit Tool 1x weekly x 3 months to ensure Discharge Care Plans were completed. CED will submit Care Plan Monitoring tool to Quality Assurance (QA) meeting monthly for review. SSD/SSS will be responsible for this POC.</p>		

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F 655	<p>Continued From page 15</p> <p>aware that an actual discharge care plan needed to be written and included with a resident's baseline care plan.</p> <p>On 02/14/2019 at 3:22 PM an interview with the facility administrator was conducted and revealed that it was his expectation that each resident was to have a discharge care plan that was initiated with the baseline care plan and the care plan was to be updated or revised as needed and at least every quarter to reflect each resident's current discharge plans.</p> <p>2. Resident # 166 was admitted to the facility on 01/02/2019 with diagnoses that included left knee pain, right knee pain, depression, vertigo, anxiety, dementia and muscle weakness.</p> <p>A review of an admission Minimum Data Set (MDS) dated 01/09/2019 revealed that Resident # 166 was cognitively intact and had 1 to 3 days of physical behaviors toward others and verbal behaviors toward others. Resident # 166 had 4 to 6 days of rejecting care. Resident # 166 required extensive assist of one to two staff for bed mobility, transfers, toileting and eating. Resident # 166 was always incontinent of bladder and her bowel status was recorded as not rated (resident had an ostomy or did not have a bowel movement for the entire 7day review period). Resident # 166 received 7 days of an antidepressant medication and 7 days of a diuretic medication. Resident # 166 was coded to have had no active discharge plans in place.</p> <p>A review of the Care Area Assessments (CAAs) for Resident # 166 did not reveal that Resident # 166 had triggered for discharge plans.</p>	F 655			

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F 655	<p>Continued From page 16</p> <p>A review of the baseline care plans for Resident # 166 initiated on admission date of 01/02/2019 revealed that a care plan for the discharge plans of Resident # 166 was not included in the baseline care plans for Resident # 166.</p> <p>MDS nurse # 1 was interviewed at 9:33 AM on 02/13/2019 and revealed that the facility social worker (SW) was responsible to develop baseline discharge care plans for residents and that the care plans were to be initiated in 24 hours of admission or readmission.</p> <p>On 02/13/2019 at 9:56 AM an interview was conducted with the facility SW. The SW revealed that she was responsible for completion of section Q of the MDS that was coded for resident discharge plans at the time of the MDS. The SW explained that sometimes the facility-initiated discharge plans on admission or readmission and that at times the resident and the family did not share the same discharge plans and sometimes resident discharge plans changed over time. The SW revealed that she did not develop a discharge care plan for any resident except one currently in the facility. The SW revealed that she was not aware that an actual discharge care plan needed to be written and included with a resident's baseline care plan.</p> <p>On 02/14/2019 at 3:22 PM an interview with the facility administrator was conducted and revealed that it was his expectation that each resident was to have a discharge care plan that was initiated with the baseline care plan and the care plan was to be updated or revised as needed and at least every quarter to reflect each resident's current discharge plans.</p>	F 655			

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F 655	<p>Continued From page 17</p> <p>3. Resident # 168 was admitted to the facility on 02/08/2019 with diagnoses that included right hip pain, alcohol dependence, anemia and diabetes mellitus type 2 (DM 2).</p> <p>A review of the medical record for Resident # 168 revealed that an admission MDS dated 02/08/2019 was in progress.</p> <p>A review of the baseline care plans for Resident # 168 initiated on 02/09/2019 revealed that Resident # 168 did not have a discharge care plan initiated on admission.</p> <p>MDS nurse # 1 was interviewed at 9:33 AM on 02/13/2019 and revealed that the facility social worker (SW) was responsible to develop baseline discharge care plans for residents and that the care plans were to be initiated in 24 hours of admission or readmission.</p> <p>On 02/13/2019 at 9:56 AM an interview was conducted with the facility SW. The SW revealed that she was responsible for completion of section Q of the MDS that was coded for resident discharge plans at the time of the MDS. The SW explained that sometimes the facility-initiated discharge plans on admission or readmission and that at times the resident and the family did not share the same discharge plans and sometimes resident discharge plans changed over time. The SW revealed that she did not develop a discharge care plan for any resident except one currently in the facility. The SW revealed that she was not aware that an actual discharge care plan needed to be written and included with a resident's baseline care plan. The SW confirmed that Resident # 168 did not have a baseline care plan in place.</p>	F 655			

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F 655	<p>Continued From page 18</p> <p>On 02/14/2019 at 3:22 PM an interview with the facility administrator was conducted and revealed that it was his expectation that each resident was to have a discharge care plan that was initiated with the baseline care plan and the care plan was to be updated or revised as needed and at least every quarter to reflect each resident's current discharge plans.</p> <p>4. Resident # 169 was admitted to the facility on 01/24/2019 with diagnoses that included pulmonary hypertension, atrial fibrillation, muscle weakness, emphysema, osteoarthritis and emphysema.</p> <p>A review of an admission MDS dated 01/31/2019 for Resident # 169 revealed that Resident # 169 was cognitively intact, had clear speech and was usually understood and required extensive staff assist for bed mobility and total staff assist for transfers, eating and toileting. Resident # 169 was always incontinent of bladder and bowel and had shortness of breath at rest. Resident # 169 was coded to have uncertain discharge plans and that an active discharge plan was not in place.</p> <p>A review of the baseline care plans initiated for Resident # 169 on 01/24/2019 revealed that a baseline care plan for discharge had not been developed.</p> <p>MDS nurse # 1 was interviewed at 9:33 AM on 02/13/2019 and revealed that the facility social worker (SW) was responsible to develop baseline discharge care plans for residents and that the care plans were to be initiated in 24 hours of admission or readmission.</p>	F 655			

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F 655	<p>Continued From page 19</p> <p>On 02/13/2019 at 9:56 AM an interview was conducted with the facility SW. The SW revealed that she was responsible for completion of section Q of the MDS that was coded for resident discharge plans at the time of the MDS. The SW explained that sometimes the facility-initiated discharge plans on admission or readmission and that at times the resident and the family did not share the same discharge plans and sometimes resident discharge plans changed over time. The SW revealed that she did not develop a discharge care plan for any resident except one currently in the facility. The SW revealed that she was not aware that an actual discharge care plan needed to be written and included with a resident's baseline care plan. The SW confirmed that Resident # 168 did not have a baseline care plan in place.</p> <p>On 02/14/2019 at 3:22 PM an interview with the facility administrator was conducted and revealed that it was his expectation that each resident was to have a discharge care plan that was initiated with the baseline care plan and the care plan was to be updated or revised as needed and at least every quarter to reflect each resident's current discharge plans.</p> <p>5. Resident #117 was admitted to the facility on 11/20/18 with diagnoses of malignant brain cancer, diabetes, and weakness.</p> <p>A Hospital Discharge Summary dated 11/20/18 revealed Resident #117 had refused palliative radiation and surgical resection of the brain tumor and wanted to pursue rehabilitation to return home and then eventually hospice services when appropriate.</p>	F 655			

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F 655	<p>Continued From page 20</p> <p>Resident #117's Minimum Data Set Admission Assessment dated 11/27/18 revealed she was cognitively intact and required limited assistance with personal care. The assessment also revealed Resident #177's discharge plan was to return to the community.</p> <p>A review of the medical record for Resident #117 revealed a Discharged Resident Transfer Record dated 12/4/18 and signed by the Family Member/Health Care Power of Attorney. The record showed the Family Member was educated on the medications for Resident #117; the plan for Home Health Services; and the follow up appointment with Resident #117's primary physician. Resident #117 discharged hom with family support and home health services on 12/4/18.</p> <p>A review of Resident #117's Care Plan dated 11/20/18 revealed she did not have a care plan in place for discharge plans on admission or throughout her stay.</p> <p>On 2/14/19 at 1:09 pm an interview with the Social Worker revealed Resident #117 came to the facility for therapy to gain strength to enable her to discharge home with family support. She stated the Family Member was aware Resident #117 would eventually need hospice services. The Social Worker stated she did not do a Care Plan for discharge for Resident #117. She stated she just failed to put the discharge care plan in place.</p> <p>An interview with the Administrator on 2/14/19 at 3:22 pm revealed his expectation was all residents should have a discharge care plan that is initiated on admission and updated and revised</p>	F 655			

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F 655	Continued From page 21	F 655			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interviews, the facility failed to review and revise the care plan for a hand splint for one of three residents reviewed for position and	F 657	F657  1. Care Plan was revised for Resident #57 on 3/6/19 by Social Worker to reflect	3/14/19	

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F 657	<p>Continued From page 22 mobility (Resident #57).</p> <p>The findings included:</p> <p>Resident #57 was admitted to the facility 4/17/12. The resident's cumulative diagnoses which included: stroke, functional quadriplegia (weakness of the entire body), generalized weakness, aphasia (difficulty speaking), dysphagia (difficulty swallowing), heart failure, presence of a feeding tube, heart disease, and arthritis.</p> <p>A review completed of the Minimum Data Set (MDS) assessments for Resident #57 revealed the most recent completed assessment was a comprehensive annual assessment with an Assessment Reference Date (ARD) of 1/1/19. Review of the assessment revealed the resident was coded as having been unable to complete the cognitive assessment due to have been rarely or never understood. The resident was coded as having been totally dependent on 1-2 staff members for all activities of daily living (ADLs). The resident was coded as having had impairment on one side of the upper extremity (shoulder, elbow, wrist, hand) and lower extremity (hip, knee, ankle, foot). The resident was not coded as having had received therapy services or restorative nursing for splint or brace assistance during the assessment period.</p> <p>A review was completed of Resident #57's care plan. The review revealed the resident had a care plan focus for the resident having demonstrated poor body alignment requiring the use of an adapted wheelchair. The goal listed for the focus was the resident would maintain proper body alignment and skin integrity. An intervention</p>	F 657	<p>residents current care plan regarding hand splint.</p> <p>2. Center Nurse Executive (CNE), Nursing Unit Managers, Nurse Practice Educator (NPE) and Licensed Nurses completed a 100% audit on 3/14/19 of all care plans for residents with Orthopedic Devices to ensure residents' care plans are reflective of current devices.</p> <p>3. CNE re-educated all Nursing Administration on 3/7/19 regarding the care planning of Orthopedic Devices.</p> <p>4. CNE, NPE, Assistant Director of Nursing (ADON) will complete random Care Plan Audits using A Care Plan Audit Tool 1x weekly x 3 months to ensure all orthopedic devices are reflected on resident's care plan. CNE/NPE will submit Care Plan Audit Tool to month Quality Assurance (QA) meeting for review. CNE will be responsible for this POC.</p>		

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F 657	<p>Continued From page 23</p> <p>listed for the goal was the resident's left upper extremity resting hand splint and elbow splint to be applied at 10:30 AM and off at 6:30 PM. The intervention initiation and creation dates were 9/9/16.</p> <p>An observation conducted of Resident #57 on 2/11/19 at 4:22 PM revealed the resident to be resting in bed with a visibly contracted left hand and elbow and there was no splint observed on the resident or in the bed near the resident.</p> <p>During an interview conducted with Nurse #8 on 2/13/19 at approximately 11:45 AM he stated Resident #57 used to wear a splint on her left hand, but the resident kept taking the splint off her left hand with her right hand. The nurse stated the splint often had to be placed back on the resident about every 15 minutes before it was discontinued.</p> <p>During an interview conducted with the Restorative Nursing Assistant (RNA) on 2/14/19 at approximately 2:00 PM she stated Resident #57 had never been on caseload for Restorative Nursing to have placed a splint on her left hand and that she had not worked with Resident #57.</p> <p>An interview was conducted with the Rehabilitation Manager (RM) on 2/14/19 at 2:05 PM. The RM stated she was familiar with the contracture of Resident #57's left elbow and hand and therapy had worked with the resident regarding the contractures. The RM stated most recently the resident was receiving therapy regarding the contractures from 3/22/18 to 5/11/18. The RM stated they continue to do quarterly screens of the resident's contracture to monitor for changes. The RM stated the most</p>	F 657			

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F 657	Continued From page 24 flexion therapy was able to get out of her left elbow was maybe 10 degrees and that was not enough range to apply a splint to her arm and elbow. She also stated the resident's hand was also contracted and when they had attempted to work with the right hand the resident would squeeze her left hand more and they were unable to apply a splint or have a splinting program for the resident's left hand. The RM stated there was no discharge plan to Restorative Nursing for splint placement due to the resident's limited range from contracture and the application of a splint would have been uncomfortable and not beneficial for the resident in her current condition.	F 657			
F 658 SS=E	During an interview with the Administrator on 2/14/19 at 4:38 PM he stated it was his expectation for care plans for residents to have been updated and accurate. Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)  §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify a physician and family member for a resident whose intravenous access was pulled out and intravenous fluid was not administered as the physician ordered for 1 of 1 residents reviewed for notification of physician and family (Resident #84) and failed to accurately document the bowel movement status for 1 of 1 resident reviewed for accurate bowel movement	F 658	F658  Element 1: The process of providing appropriate notification to physician and family of any status change was in place before February 11, 2019. The nurse failed to provide appropriate/timely notification to physician and family member when IV was pulled out and IV	3/14/19	

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F 658	<p>Continued From page 25 status documentation (Resident # 166).</p> <p>Findings included:</p> <p>1. Resident #84 was admitted to the facility on 9/17/2017 with the most recent readmission date of 2/9/2019 with diagnoses to include osteoarthritis, chronic obstructive pulmonary disease, and muscle weakness. The most recent quarterly Minimum Data Set (MDS) assessment dated 1/9/2019 assessed the resident to be cognitively intact with no behaviors.</p> <p>The medical record was reviewed, and a physician order dated 1/24/2019 for Dextrose solution 5% half-normal saline (D5 ½ NS) 1 liter to be infused intravenously every shift for dehydration. The order clarified to run the D5 ½ NS solution at 50 milliliters (ml) per hour to administer 1 liter of intravenous (IV) solution.</p> <p>A nursing note written by Nurse #3 dated 1/24/2019 at 10:00 PM documented the IV access site was dislodged and attempts to reinsert the IV were not successful. The note did not document the physician (MD) or Resident #84 's family were notified that staff were unable to restart the IV and administer the IV solution.</p> <p>A nursing note written by Nurse #3 dated 1/24/2019 at 10:31 PM noted Resident #84 received 350 ml of IV solution out of the 1,000 ml (1 liter) she was ordered to receive. The note did not document the MD or Resident 's family were notified that staff were unable to restart the IV and administer the IV solution.</p> <p>An interview was conducted via a phone call to Nurse #3 on 2/14/2019 at 11:34 AM. Nurse #3</p>	F 658	<p>fluids not administered for resident #84. The process of accurately documenting the bowel movement status was in place before February 11, 2019. The nursing staff failed to accurately document the bowel movement status for resident #166.</p> <p>Element 2: The nurse management team will complete 100% audit of any current/new change of conditions to ensure appropriate notification was made to the physician and family member by 3-14-2018.</p> <p>The nurse management team will complete 100% audit of all current residents <input type="checkbox"/> flowsheet to ensure accurate documentation for bowel movements is recorded. All residents noted to not have bowel movement in three days will be assessed, bowel protocol initiated, physician notified as indicated.</p> <p>Element 3: Director of Nursing/Nurse Practice Educator re-educated licensed nursing staff by 3-14-19. Education included that nurses will ensure that they are notifying families of any change of condition, falls, new orders at time of incident/change in status. If condition happens in the middle of night, we needs to notify at that time unless family has requested you wait until first thing in a.m. If instructed to call in a.m. (7 a.m.) ensure we call at the end of shift and document. Nurses will ensure that they are notifying physician and family when resident has had an interruption of treatment (intravenous therapy filtrating/pulled out). All appropriate attempts should be made</p>		

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F 658	<p>Continued From page 26</p> <p>reported she was working 2nd shift (3:00 PM to 11:00 PM) on 1/24/2019 and was assigned to Resident #84. Nurse #3 went on to explain Resident #84 pulled out the IV access and she had only received a portion of the IV fluid she was ordered, and several attempts were made to restart the IV access without success. Nurse #3 concluded by reporting that she did not call the MD or the family to notify them that Resident #84 had pulled out the IV access and staff were unsuccessful at starting another site, and was not certain why she did not call the MD or the family.</p> <p>The facility MD was interviewed on 2/14/2019 at 4:02 PM. He reported he was not notified by the facility on 1/24/2019 the IV access had been pulled out and the staff were unable to get IV access for Resident #84. The MD reported he did not feel that Resident #84 suffered adverse consequences from not receiving the IV fluid as he had ordered.</p> <p>The Director of Nursing (DON) was interviewed on 2/14/2019 at 4:32 PM. The DON reported neither the MD nor the family was not notified on 1/24/2019 that Resident #84 had pulled out her IV access. The DON reported it was her expectation that nursing staff notified the MD and family for any interruption of treatment.</p> <p>The Administrator was interviewed on 2/14/2019 at 5:53 PM and he reported it was his expectation that the MD and resident family were notified of any change or interruption of treatment.</p> <p>2. Resident # 166 was admitted to the facility on 01/2/2019 with diagnoses that included left knee pain, right knee pain, depression, vertigo, anxiety, dementia and muscle weakness.</p>	F 658	<p>to restart intravenous therapy. If unable, notify physician to obtain appropriate orders (Peripherally Inserted Central Catheter (PICC), midline, discontinue intravenous therapy, change to by mouth meds, etc.) regardless of time of day/night. Document all attempts and any new orders.</p> <p>Director of Nursing/Nurse practice educator re-educated licensed nurses and certified nursing assistants. Education included that each certified nursing assistant is to document bowel movements for each shift. They are notify nurse of any issues with bowel movements, complaints of abdominal cramping/distention, problems having bowel movements. Night shift nurses are to review flow books for assigned halls to ensure appropriate bowel movement documentation is recorded. If resident has not had bowel movement in three days, bowel assessment to be complete, bowel protocol to be initiated as ordered by the assigned night shift nurse and resident added to acute board for appropriate follow-up for the on-coming shifts.</p> <p>Element 4: Unit managers/nurse manager designee will complete audit of 3 random residents for appropriate notification of physician and family member for any change of conditions on each unit 3 times weekly X 4 weeks, then weekly X 4 weeks, then monthly X 4 months. . Director of Nursing will submit results of audits to the monthly Quality Assurance (QA) meeting for review. Director of Nursing is responsible for</p>		

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F 658	<p>Continued From page 27</p> <p>A review of an admission Minimum Data Set (MDS) dated 01/09/2019 revealed that Resident # 166 was cognitively intact and had 1 to 3 days of physical behaviors toward others and verbal behaviors toward others. Resident # 166 had 4 to 6 days of rejecting care. Resident # 166 required extensive assist of one to two staff for bed mobility, transfers, toileting and eating. Resident # 166 was always incontinent of bladder and her bowel status was recorded as not rated (resident had an ostomy or did not have a bowel movement for the entire 7day review period). Resident # 166 received 7 days of an antidepressant medication and 7 days of a diuretic medication.</p> <p>A review of the Care Area Assessments (CAAs) for Resident # 166 did not reveal that her bowel status was addressed.</p> <p>A care plan initiated on 01/19/2019 for Resident # 166 revealed that Resident # 166 exhibited or was at risk for gastrointestinal symptoms or complications related to constipation with the goal that Resident # 166 would pass a soft formed stool every 3 days. Interventions included in part to obtain laboratory work as ordered, assess and report abdominal distention, decreased bowel movements, decreased bowel sounds and abdominal pain, to monitor and record bowel movements, to provide a bowel regimen and to encourage fluids.</p> <p>A review of a form titled Bowel Retraining Evaluation dated 01/09/2019 for Resident # 166 revealed that she had a daily elimination pattern and did not have a history of constipation.</p>	F 658	<p>implementing the acceptable plan of correction. Date of compliance will be on 3-14-2019. Director of Nursing will bring to QA on a monthly</p> <p>Unit managers will complete audit of 2 random residents for accurate documentation of bowel movement status and appropriate interventions as indicated on each unit 2 times weekly X 4 weeks, then weekly X 4 weeks, then monthly X 4 months. Director of Nursing will submit results of audits to the monthly QA meeting for review. Director of Nursing is responsible for implementing the acceptable plan of correction. Date of compliance will be on 3-14-2019. Director of Nursing will bring to QA on a monthly basis X 6 months.</p>		

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F 658	<p>Continued From page 28</p> <p>A form titled ADL (activity of daily living) Record dated for January 2019 revealed that Resident # 166 was documented as incontinent of bowel from 01/02/2019 until 01/22/2019 but that Resident # 166 was documented in the areas of bowel movement consistency, size and number as either Resident # 166 had no bowel movement, had a line drawn in those areas or was left blank in those areas( boxes) for 01/02/2019 through 01/22/1029.</p> <p>On 01/03/2019 at 11:55 AM a history and physical progress note completed by the facility Nurse Practitioner (NP) revealed in part that Resident # 166 denied any belly pain. The NP revealed that Resident # 166 was to receive a Dulcolax Suppository 10 MG (Bisacodyl) Insert 1 suppository rectally as needed for constipation If no bowel movement (BM) in 4 days, administer a fleet enema 7-19 GM/118ML (Sodium Phosphates) Insert 1 dose rectally as needed for constipation If no BM in 5 days and if Resident # 166 had no result from the fleet enema the physician (MD) was to be called. On physical exam Resident # 166's abdomen was soft, non-tender and Resident # 166 had active bowel sounds.</p> <p>A review of a nurse progress noted dated 01/03/2019 at 12:57 PM revealed in part that Resident # 166 was fed by nurse staff and that Resident # 166 required the nurse staff to reposition her and to provide incontinent care to Resident # 166.</p> <p>An MD history and physical note dated 01/05/2019 revealed in part that Resident # 166 abdomen was soft and non-tender. The MD added to administer milk of magnesia suspension</p>	F 658			

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F 658	<p>Continued From page 29</p> <p>(MOM) 400 mg/5 ml, give 30 ml orally (po) as needed for constipation and no BM in 3 days. On physical exam the MD recorded that Resident # 166 had no abdominal pain and that Resident # 166 denied abdominal pain and that her abdomen was soft and non-on examination the abdomen of Resident # 166 was soft and non - tender.</p> <p>An NP progress note dated 01/10/2019 included in part that nurse staff reported Resident # 166 was eating and taking oral fluids and that on examination, Resident # 166 had no abdominal pain and the abdomen was soft and non - tender. With active bowel sounds.</p> <p>On 01/13/2019 at 1 :50 PM a nurse medication administration note revealed that the nurse administered MOM 30 ml orally to Resident # 166 as ordered by the MD for no BM in 3 days and that Resident # 166 had bowel sounds in all 4 quadrants.</p> <p>The Medication Administration Record (MAR) for Resident # 166 dated for January 2019 revealed that Resident # 166 received MOM 400mg(milligram)/5 ml (milliliters) 30 ml orally (po) as needed for constipation for no bowel movement in 3 days one time on 01/13/2019.</p> <p>On 02/14/2019 at 8:32 AM an interview was conducted with MDS nurse # 1.MDS nurse #1 revealed that she did not complete the admission MDS dated 01/09/2019 for Resident # 166 and the MDS had been completed by MDS nurse #2 (MDS nurse # 2 was out of town). MDS nurse # 1 confirmed that during the MDS review period, Resident # 166 was coded correctly as not rated in the area of bowel movements after she reviewed the ADL record for Resident # 166 dated from 01/02/2019 through 01/22/2019 and</p>	F 658			

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F 658	<p>Continued From page 30</p> <p>the AD record did not reflect that Resident # 166 had a bowel movement. MDS nurse # 1 could not explain the lines or blank boxes for Resident # 166's bowel movements on the ADL record for the MDS review period through 01/22/2019.</p> <p>On 02/14/2019 at 8:35 AM MDS nurse # 1 asked the Director of Nurses (DON) to please review the ADL record form for Resident # 166 dated from 01/02/2019 through 01/22/2019. The DON reviewed the ADL record form and revealed that the ADL form, which was completed by nurse assistants (NAs) had not been coded as listed in the directions on the form and the DON was unable to explain why there were blanks or lines recorded on the form. The DON was not able to confirm if Resident # 166 had a bowel movement during the MDS review period and then through 01/22/2019.</p> <p>On 02/14/2019 at 9:16 AM nurse # 4 was interviewed and revealed that she worked part time in the nurse department and that on 01/03/2019 she did work from 3:00 PM to 7:00 PM as the nurse for the 300 hall where Resident # 166 resided. Nurse # 4 revealed that she was certain that the NA that also was assigned to Resident # 166 at the same time had not reported any bowel movement or bowel movement concerns for Resident # 166 and that nurse # 4 did not review the ADL record form on that day for Resident # 166. Nurse # 4 revealed that it was not her usual routine to review the ADL record for her assigned residents. Nurse # 4 revealed that on observation of the ADL record for Resident # 166 dated 01/02/2019 through 01/22/2019 she was unable to identify what the documentation coded or blanks on the form meant. Nurse # 4 revealed that in the nurse progress notes when</p>	F 658			

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F 658	<p>Continued From page 31</p> <p>the nurse documented that Resident # 166 was incontinent of bowel that it did not mean that Resident # 166 had an actual BM, but it was a blanket statement to record that Resident # 166 was incontinent of bowel.</p> <p>On 02/14/2019 at 9:57 AM a further review of Resident # 166's medical record revealed facility standing orders signed by the MD that included if Resident # 166 did not have a BM for 3 days the nurse was to administer 30 mls of milk of magnesia (MOM) orally (po) for one dose, if Resident # 166 had no BM in 4 days the nurse was to administer a Dulcolax suppository rectally times one and if Resident # 166 had no BM for 5 days the nurse was to administer a fleet enema one time and to notify the MD for further orders if there was no BM after the fleet enema.</p> <p>An interview was conducted with nurse # 2 on 02/14/2019 at 10 :17 AM. Nurse # 2 revealed that she had been the nurse for Resident # 166 on 01/03/2019, 01/04/2019, 01/07/2019 and 01/09/2019 on the day shift (7:00 AM to 3:00PM). Nurse # 2 confirmed this on review of the nurse progress notes for Resident # 166. Nurse # 2 revealed that she was not aware of the BM activities of Resident # 166. Nurse # 2 revealed that the NAs were responsible to record resident BM status on the ADL record forms. Nurse # 2 confirmed that she never reviewed the NA documentation on the ADL record form and that it was her expectation that the NAs report to the nurse any changes of bowel status for any resident to the nurse. Nurse # 2 revealed that Resident # 166 had never complained of abdominal pain and nurse # 2 knew that Resident # 166 was incontinent of BM, but that nurse # 2 had not administered a laxative to Resident # 166</p>	F 658			

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F 658	<p>Continued From page 32</p> <p>and that if there was a concern about Resident # 166 being constipated that nurse # 2 would have telephoned the MD to report it.</p> <p>On 02/14/2019 at 10:501 AM an interview with nurse # 6 revealed that she had been the nurse for Resident # 166 on 01/02/1019 and 01/03/2019. Nurse # 6 revealed that the NAs documented resident BMs on the ADL record form and the NAs were expected to report changes in any resident's BM status to the nurse. Nurse # 6 was not able to recall that Resident # 166 had complained of abdominal pain or constipation.</p> <p>NA # 5 was interviewed on 02/14/2019 at 12: 06 PM. NA # 5 revealed that she had taken care of Resident # 166 and that all ADL activities for Resident # 166 were recorded on the ADL record for Resident # 166 which included BMs. NA # 5 confirmed that she had taken care of Resident # 166 on 01/02/2019 and had recorded that Resident # 166 had been reported to her as incontinent of BM and that the NA recorded an "I" on the BM status of Resident # 166 and that NA # 5 drew a line under the "I" to indicate that Resident # 166 had not had a BM. NA # 5 revealed that on observation of the instruction for BM documentation on the ADL record that the form had not been completed as instructed. NA # 5 revealed that she would notify the nurse if a resident had no BM in at least 2 days in a row or if a resident had a change in their normal BM status she would also report that to the nurse. NA # 5 revealed that she was almost certain that Resident # 166 did not have a BM on 01/02/2019.</p> <p>A telephone interview conducted with NA # 9 on 02/14/2019 at 12:23 PM revealed that she had</p>	F 658			

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F 658	<p>Continued From page 33</p> <p>taken care of Resident # 166 but that she was not able to recall if Resident # 6 had a BM when NA # 9 was assigned to her. NA # 9 revealed that BMs were recorded on the ADL record a line in the BM column of the ADL record reflected that the resident did not have a BM to record. NA # 9 reported that she would report to the nurse if Resident # 166 or any other resident did not have a BM in a week or so.</p> <p>On 02/14/2019 at 12:29 PM a telephone interview conducted with NA # 10 revealed that the BM status for Resident # 166 was recorded by the NAs on the ADL Record. NA # 10 revealed that she was unable to recall if Resident # 166 had a BM when NA # 10 was assigned to her. NA # 10 revealed that she did not always have time to document in the ADL record at the end of her shift and that sometimes the boxes were left blank. NA # 10 reported that she did know that if Resident # 166 had blood in her BM or loose BMs that she would notify the nurse.</p> <p>On 02/14/2019 at 2:35 PM an interview and record review was conducted with the facility MD and the DON. The MD revealed that on review of the documentation by the NP and MD in the medical record of Resident # 166 it clearly explained that Resident # 166 did not experience any constipation or change in her BM status from 01/02/2019 through 01/22/2019. The MD revealed that he examined Resident # 166 on multiple occasions and determined at those times that Resident # 166 did not present with any BM concerns. The MD stated that he did use a bowel protocol, that he signed, and it was present in each resident's chart and that the MD had never had any concern that the protocol had not been followed by the nurse staff. Resident # 166 was</p>	F 658			

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F 658	Continued From page 34 per the MD, very elderly and in active health decline. The MD added he knew that the nurse staff could identify and reporting to him or the NP if there were any chronic constipation concerns for Resident # 166 or any other resident. The MD concluded the interview with an observation of the ADL record for Resident # 166 dated from 01/02/2019 through 01/22/2019 and revealed that the form was incomplete and the documentation was poor and that any conclusion could not be made from the ADL form and that he believed that facility did not have a clinical concern related to Resident # 166 , but on review of the ADL record " there most definitely is a documentation issue, not a clinical issue."  On 02/14/2019 at 2:43 PM an interview conducted with the DON revealed that it was expected that all licensed nurses check each resident ADL record at the end of each shift to monitor for any clinical changes or missed documentation. The DON revealed that she also expected that all forms be completed entirely and that the directions on the form be followed as written on the form.	F 658			
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)  §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 732		3/14/19	

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F 732	<p>Continued From page 35</p> <p>resident care per shift:</p> <p>(A) Registered nurses.</p> <p>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).</p> <p>(C) Certified nurse aides.</p> <p>(iv) Resident census.</p> <p>§483.35(g)(2) Posting requirements.</p> <p>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.</p> <p>(ii) Data must be posted as follows:</p> <p>(A) Clear and readable format.</p> <p>(B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to accurately report care hours provided by licensed and unlicensed personnel for 9 out of 10 daily posted nurse staffing sheets reviewed.</p> <p>Findings included:</p> <p>Review of the facility ' s daily nursing staffing</p>	F 732	<p>F732</p> <p>Element 1: The process of accurately posting/reporting nurse staffing information that was in place before February 11, 2019. The facility failed to post accurate staffing information. Staffing Information form updated on 2-14-2019.</p> <p>Element 2: The Nurse Staffing form was</p>		

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F 732	Continued From page 36 forms and daily nursing schedules for the dates 11/22/2018, 11/23/2018, 11/24/2018, 12/18/2018, 12/19/2018, 12/20/2018, 1/2/2019, 1/8/2019, and 2/11/2019 revealed the daily nursing staffing forms were not accurate on the following 9 of 9 days:  a. The nursing schedule for the facility dated 11/22/2018 was reviewed and it was noted 1 medication aide (MA) was scheduled to work 1st shift (7:00 AM to 3:00 PM) on the assisted living side of the facility. The daily nurse staffing sheet indicated the MA had provided 8 hours of skilled care. The nursing schedule for the facility dated 11/22/2018 was reviewed and it was noted 1 MA was scheduled to work 2nd shift (3:00 PM to 11:00 PM) on the assisted living side of the facility. The daily nurse staffing sheet indicated the MA had provided 8 hours of skilled care.  b. The nursing schedule for the facility dated 11/23/2018 was reviewed and it was noted 1MA was scheduled to work 1st shift on the assisted living side of the facility. The daily nurse staffing sheet indicated the MA had provided 8 hours of skilled care. The nursing schedule for the facility dated 11/23/2018 was reviewed and it was noted 1 MA was scheduled to work 2nd shift on the assisted living side of the facility. The daily nurse staffing sheet indicated the MA had provided 8 hours of skilled care.  c. The nursing schedule for the facility dated 11/24/2018 was reviewed and it was noted 1 MA was scheduled to work 1st shift on the assisted living side of the facility. The daily nurse staffing sheet indicated the MA had provided 8 hours of skilled care. The nursing schedule for the facility dated 11/24/2018 was reviewed and it was noted	F 732	updated to exclude medication aide for assisted living and orientees on 2-14-19.  Element 3: Director of Nursing/Nurse Practice Educator re-educated scheduling coordinator, licensed nurses, and nursing administration to be completed by 3-14-19. Education included that the scheduling coordinator, nursing administration and licensed nurses will ensure that the Staffing Information form will be filled out accurately with the appropriate staff working skilled care for appropriate shifts and hours. Scheduling coordinator will complete form for 1st and 2nd shift Monday through Friday, 3rd shift 200 hall nurse will complete Monday through Friday, and 200 hall weekend Day & Night Baylor nurses will complete the form for Saturday and Sunday. Nursing Administration will help ensure form is completed.  Element 4: Director of Nursing will complete audit of form 3 X weekly X 4 weeks, then weekly X 4 weeks, then monthly X 4 months. Director of Nursing will submit results of audits to the monthly QAPI meeting for review. Director of Nursing is responsible for implementing the acceptable plan of correction. Date of compliance will be 3-14-2019. Director of Nursing will bring to QAPI on a monthly basis X 6 months.		

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F 732	<p>Continued From page 37</p> <p>1 MA was scheduled to work 2nd shift on the assisted living side of the facility. The daily nurse staffing sheet indicated the MA had provided 8 hours of skilled care.</p> <p>d. The nursing schedule for the facility dated 12/18/2018 was reviewed and it was noted 1 MA was scheduled to work 1st shift on the assisted living side of the facility and 2 Registered Nurses (RN) were scheduled to work 1st shift 12/18/2018. The daily nurse staffing sheet indicated the MA had provided 8 hours of skilled care for 1st shift and that 3 RN ' s had provided 24 hours of care on 1st shift 12/18/2018. The nursing schedule for the facility dated 12/18/2018 was reviewed and it was noted 1 MA was scheduled to work 2nd shift on the assisted living side of the facility. The daily nurse staffing sheet indicated the MA had provided 8 hours of skilled care for 2nd shift.</p> <p>e. The nursing schedule for the facility dated 12/19/2018 was reviewed and it was noted 1 MA was scheduled to work 1st shift on the assisted living side of the facility. The daily nurse staffing sheet indicated the MA had provided 8 hours of skilled care. The nursing schedule for the facility dated 12/19/2018 was reviewed and it was noted 1 MA was scheduled to work 2nd shift on the assisted living side of the facility and 12.5 Nursing Assistants (NA) were scheduled to work. The daily nurse staffing sheet indicated the MA had provided 8 hours of skilled care and 13 NA had provided 97.5 hours of care on 2nd shift for 12/19/2018.</p> <p>f. The nursing schedule for the facility dated 12/20/2018 was reviewed and it was noted 1 MA was scheduled to work 1st shift on the assisted</p>	F 732			

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F 732	<p>Continued From page 38</p> <p>living side of the facility and 11 NA were scheduled to work 1st shift. The daily nurse staffing sheet indicated the MA had provided 8 hours of skilled care and 12 NA had provided 90 hours of care for 1st shift on 12/20/2018. The nursing schedule for the facility dated 12/20/2018 was reviewed and it was noted 1 MA was scheduled to work 2nd shift on the assisted living side of the facility. The daily nurse staffing sheet indicated the MA had provided 8 hours of skilled care. The nursing schedule for 3rd shift (11:00 PM to 7:00 AM) dated 12/20/2018 revealed 9.5 NA were scheduled to work 3rd shift. The daily nursing staffing sheet indicated 10 NA had provided 75 hours of care on 3rd shift 12/20/2018.</p> <p>g. The nursing schedule for the facility dated 1/2/2019 was reviewed and it was noted 1 MA was scheduled to work 1st shift on the assisted living side of the facility and 2 RN were scheduled to work 1st shift on 1/2/2019. The daily nurse staffing sheet indicated the MA had provided 8 hours of skilled care and 3 RNs provided 24 hours of care on 1st shift that date. The nursing schedule for the facility dated 1/2/2019 was reviewed and it was noted 1 MA was scheduled to work 2nd shift on the assisted living side of the facility and 4 Licensed Practical Nurses (LPN 's) were scheduled for 2nd shift on 1/2/2019. The daily nurse staffing sheet indicated the MA had provided 8 hours of skilled care and 5 LPNs had provided 40 hours of care on 2nd shift on 1/2/2019.</p> <p>h. The nursing schedule for the facility dated 1/8/2019 was reviewed and it was noted 1 MA was scheduled to work 1st shift on the assisted living side of the facility and 2 RNs were</p>	F 732			

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F 732	<p>Continued From page 39</p> <p>scheduled to work 1st shift on 1/8/2019. The daily nurse staffing sheet indicated the MA had provided 8 hours of skilled care and 3 RNs had provided 24 hours of care on 1/8/2019 for 1st shift. The nursing schedule for the facility dated 1/8/2019 was reviewed and it was noted 1 MA was scheduled to work 2nd shift on the assisted living side of the facility and 9 NA were scheduled for 2nd shift on 1/18/2019. The daily nurse staffing sheet indicated the MA had provided 8 hours of skilled care and 11 NA had provided 82.5 hours of care on 1/8/2019 for 2nd shift.</p> <p>i. The nursing schedule for the facility dated 2/11/2019 was reviewed and it was noted 1 MA was scheduled to work 1st shift on the assisted living side of the facility, 14 NA were scheduled to work, 3 LPN were schedule to woke and no RN were scheduled to work 1st shift on 2/11/2019. The daily nurse staffing sheet indicated the MA had provided 8 hours of skilled care, 15 NA provided 112.5 hours of care and 2 RNs provided 16 hours of care. The nursing schedule for the facility dated 2/11/2019 was reviewed and it was noted 1 MA was scheduled to work 2nd shift on the assisted living side of the facility, 12.5 NA were scheduled to work and 4 LPNs were scheduled to work 2nd shift on 2/11/2019. The daily nurse staffing sheet indicated the MA had provided 8 hours of skilled care, 12 NA provided 90 hours of care and 5 LPNs provided 40 hours of care for 2nd shift on 2/11/2019.</p> <p>An interview was conducted with the scheduling coordinator on 2/14/2019 at 2:26 PM. She reported she was not aware that staff who provided care on the assisted living part of the building were not be counted towards skilled care hours provided. The scheduling coordinator went</p>	F 732			

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F 732	Continued From page 40 on to explain she was including orienting and training staff towards the care hours. The scheduling coordinator reported the posted nurse staffing sheets were updated by her at the change of shift to document call-outs or call-in, census changes and the 3rd shift charge nurse will adjust the posted nursing schedule for the facility on 3rd shift.  The Administrator was interviewed on 2/14/2019 at 5:53 PM and he reported it was his expectation the posted nurse staffing was accurate and did not count orienting staff or the medication aide ' s hours toward the total amount of care hours provided.	F 732			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)  §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  §483.45(c)(2) This review must include a review of the resident's medical chart.  §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		3/14/19	

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F 756	<p>Continued From page 41</p> <p>minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.</p> <p>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, pharmacist and staff interviews the facility failed to act upon a pharmacist reported recommendations for 1 of 5 residents reviewed for unnecessary medications (Resident #94).</p> <p>Findings included:</p> <p>Resident #94 was admitted to the facility 10/4/2017 with diagnoses to include cerebral vascular accident (stroke), depression, anxiety and dizziness.</p> <p>A review of the medical record for Resident #94 revealed a physician order dated 10/18/2017 for mirtazapine 15 milligrams 1 tablet by mouth at bedtime for mood, sleep and appetite.</p> <p>The annual Minimum Data Set (MDS) dated 10/12/2018 assessed Resident #94 to be</p>	F 756	<p>F756</p> <p>Element 1: The process of reviewing and processing monthly drug reviews per pharmacy before February 11, 2019. The facility failed to act upon a pharmacist reported recommendations. Current pharmacy recommendations have been printed and placed in physician's box for review.</p> <p>Element 2: The nurse management team will complete 100% audit of pharmacy consults to ensure each has been addressed by physician and hard copy in the chart by 2-14-19.</p> <p>Element 3: The Director of Nursing/Nurse Practice Educator re-educated nursing administration and physicians/nurse</p>		

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F 756	<p>Continued From page 42</p> <p>cognitively intact without physical behaviors, wandering or rejection of care. Section D (mood) of the MDS dated 10/12/2018 revealed Resident #94 had answered D0200 B. "feeling down, depressed or hopeless" as 1. Yes, 1 day for a cumulative score of 2, "minimal depression".</p> <p>The most recent quarterly MDS assessment dated 1/11/2019 assessed Resident #94 to be cognitively intact without physical behaviors and with rejection of care 4-6 days. Section D of the MDS question D0200 B "feeling down, depressed or hopeless" was answered as 1. Yes for 1 day and D "feeling tired or having little energy" 1. Yes 7-11 days. The cumulative score for section D was 3 "minimal depression".</p> <p>The pharmacist medication regimen review dated 11/21/2018 was reviewed and the box indicating a report on irregularities or recommendations was in the chart.</p> <p>The medical record of Resident #94 was reviewed, and no pharmacist recommendations or report of irregularities dated 11/21/2018 was found in the chart.</p> <p>The Pharmacist for the facility was interviewed via a phone call on 2/12/2019 at 4:05 PM. The Pharmacist reported he had recommended a gradual dose reduction (GDR) of mirtazapine for Resident #94 on 11/21/2018 but had not received a report of the outcome. The Pharmacist went on to explain after he reviewed medications for a resident, he would type up a recommendation and this form was faxed to the facility and placed in the hard chart for physician review. The Pharmacist concluded by reporting the physician responded to his recommendations by agreeing</p>	F 756	<p>practitioners by 3-12-19. Education includes that nursing administration is to ensure that monthly pharmacy recommendations are being addressed each month, order is entered into computer if applicable and consult is filed in chart. Director of Nursing/Assistant Director of Nursing will distribute pharmacy recommendations to appropriate provider for review after pharmacist has visited for the month. Copy of monthly recommendation will be kept in a notebook in the nursing office. Notebook is to be checked weekly to verify if recommendation has been completed. If recommendation has been completed and filed, copy can be taken out of notebook.</p> <p>Element 4: Director of nursing will audit 10 medical records each month to ensure that pharmacy recommendations have been addressed by physician and filed on the chart according to plan and regulation X 6 months. Director of nursing will submit results of audits to the monthly QAPI meeting for review. Director of Nursing is responsible for implementing the acceptable plan of correction. Date of compliance will be 2-16-2018. Director of Nursing will bring to QAPI on a monthly basis X 6 months.</p>		

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F 756	Continued From page 43 to order the changes to medications or declining to change medications.  The physician (MD) for the facility was interviewed on 2/14/2019 at 4:02 PM. The MD reported he was not aware of a pharmacist recommendation to attempt a GDR for mirtazapine for Resident #94.  The Director of Nursing (DON) was interviewed on 2/14/2019 at 4:32 PM. The DON reported the pharmacist recommendations were to be filed in the resident ' s hard chart for MD review. The DON reported she was unable to locate the pharmacist recommendations for Resident #94 dated 11/21/2018. The DON concluded by reporting it was her expectation the pharmacist recommendations were filed in the hard chart for MD review and response to the recommendations.  The Administrator was interviewed 2/14/2019 at 5:53 PM and he reported it was his expectation the pharmacist recommendations were filed in the hard chart for the MD provider to review.	F 756			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)  §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		3/14/19	

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F 758	Continued From page 44  Based on a comprehensive assessment of a resident, the facility must ensure that---  §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;  §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;  §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and  §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.  §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the	F 758			
			F758		

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F 758	<p>Continued From page 45</p> <p>facility failed to ensure a pharmacy recommendation for gradual dose reduction for 1 of 5 residents, reviewed for unnecessary medications Resident #77.</p> <p>Findings included:</p> <p>Resident #77 was admitted to the facility on 6/11/15 with diagnoses of Parkinson's Disease, dementia, depression, insomnia, and anxiety. A review of his most recent Minimum Data Assessment dated 1/7/19 revealed he was cognitively intact and received antianxiety medication during the assessment period.</p> <p>During an interview with the Pharmacist on 2/12/19 at 4:00 pm he stated he had requested a gradual dose reduction in November 2018 for Lorazepam 0.5 milligram, an antianxiety medication, and had not received a response from the physician. The Pharmacist stated his expectation was the facility would ensure the physician reviewed the Pharmacy Recommendations.</p> <p>An interview with the Director of Nursing (DON) on 2/14/19 at 4:52 pm revealed she could not find a pharmacist request for gradual dose reduction of Resident #77's antianxiety medication in the medical record. She stated the Pharmacy Recommendations should come to her and she distributes them to the physicians. The DON stated after the recommendations were reviewed by the physician and he writes the orders they are filed on the medical record. She stated there had been an issue since November 2018 with the Pharmacy Recommendations being misplaced and she was putting a plan into place to correct the issue. The DON stated she instructed the</p>	F 758	<p>Element 1: The process of ensuring pharmacy recommendation for gradual dose reduction reviewed and processed before February 11, 2019. The facility failed to ensure pharmacy recommendation for gradual dose reduction was reviewed and processed upon a pharmacist reported recommendations. Resident # 77 recommendations have been addressed by the physician.</p> <p>Element 2: The nurse management team will complete 100% audit of pharmacy consults for the last 30 days to ensure each has been addressed by physician and hard copy in the chart by 3-14-19.</p> <p>Element 3: The Director of Nursing/Nurse Practice Educator re-educated nursing administration and physicians/nurse practitioners. Education includes that nursing administration is to ensure that monthly pharmacy recommendations are being addressed each month, order is entered into computer if applicable and consult is filed in chart. Director of Nursing/Assistant Director of Nursing will distribute pharmacy recommendations to appropriate provider for review after pharmacist has visited for the month. Copy of monthly recommendation will be kept in a notebook in the nursing office. Notebook is to be checked weekly to verify if recommendation has been completed. If recommendation has been completed and filed, copy can be taken out of notebook.</p>		

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F 758	Continued From page 46 Pharmacist to give the Pharmacy Recommendations to her or the Assistant Director of Nursing to ensure they were not misplaced again.  During an interview with the Administrator on 2/14/19 at 5:44 pm he stated his expectation was the gradual dose reductions of psychotropic medications would be done as required. He stated the issue with pharmacy recommendations being misplaced would be corrected.	F 758	Element 4 Director of nursing will audit 10 medical records each month to ensure that pharmacy recommendations have been addressed by physician and filed on the chart according to plan and regulation. Director of nursing will submit results of audits to the monthly QAPI meeting for review. Director of Nursing is responsible for implementing the acceptable plan of correction. Date of compliance will be 2-16-2018. Director of Nursing will bring to QAPI on a monthly basis X 6 months.		
F 804 SS=C	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)  §483.60(d) Food and drink Each resident receives and the facility provides-  §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;  §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations the facility failed to serve food that was attractive and had a palatable appearance for two of three observed pureed plates.  Findings Included:  An observation was conducted on 2/11/19 at 12:56 of the lunch meal for Resident #12. Resident #12 was observed to have received his	F 804	F804 1- The inconsistent puree items were pulled from the tray line and thickened to the proper consistency by Dietary District Manager (DDM) on 2/13/19.  2- The DDM re-educated the dietary staff on 3/7/19 on how to prepare puree items to the proper consistency.	3/14/19	

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F 804	Continued From page 47 lunch meal on an undivided pureed plate and the pureed food was watery in consistency. Due to the watery consistency and the pureed food not having been on a divided plate the pureed foods were observed to have blended together resulting in an unappetizing and unattractive appearance.  An observation was conducted of the plating and traying of the lunch meal on 2/12/19 at approximately 2/12/19. The lunch meal for puree consisted of pureed meatballs, pureed vegetables, and mashed potatoes. A randomly observed pureed meal for a resident revealed the pureed foods to have been plated on an undivided plate and due to the watery consistency of the pureed meat and pureed vegetables the three foods were observed to have blended together resulting in an unappetizing and unattractive appearance.  During an interview conducted with the Administrator on 2/14/19 at 4:38 PM he stated it was his expectation for food to palatable and presentable.	F 804	3- The Dietary Manager (DM) / designee will complete Palatability Monitoring Tool for all 3 meals daily x 3 months to ensure that all puree items has been prepared to the proper consistency prior to each meal service. The Center Executive Director (CED) will complete random audits of palatability of pureed meals 1 X week for 3 months.  4- DM and CED will bring the Palatability Monitoring Tool to monthly Quality Assurance (QA) meeting for review. DM will be responsible for POC		
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	F 812		3/14/19	

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F 812	<p>Continued From page 48</p> <p>gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interviews the facility failed to clean food service equipment and failed to sanitize cookware and food preparation surfaces. The facility failed to maintain, clean, sanitize three of three food preparation and storage areas including the kitchen, A side pantry, and B side pantry.</p> <p>Findings Included:</p> <p>1. An observation of the kitchen and interviews conducted on 2/11/19 at 9:22 AM revealed the following:</p> <p>a. Knobs were dirty with a debris build up on three of five appliances including the flat top grill/stove/oven combination unit, the convection oven, and the steam table.</p> <p>b. There was food and debris in two of two floor drain traps one located to the rear of the cook line and one located in the front of the cook line.</p> <p>c. Food, debris, dishware, and plasticware were observed on the floor in three of three areas of the kitchen including the main kitchen area, stock room, and the dish room.</p> <p>d. Food and debris were observed under, around, and on the front lift access door for one of one dish machines in the dish room.</p> <p>e. One of one exhaust fan grill was observed to have a dust build up in the dish room.</p>	F 812	<p>F812</p> <p>1- Flat top grill/stove/oven combination unit, convection oven and steam table knobs were cleaned on 2/13/19 by Dietary District Manager (DDM) / dietary designee.</p> <p>Both floor drain traps were cleaned on 2/13/19 by Dietary District Manager (DDM) / dietary designee.</p> <p>All debris from the main kitchen area, stock room and dish room were removed and cleaned on 2/13/19 by Dietary District Manager (DDM) / dietary designee.</p> <p>All debris under and around the front lift access door of the dish machine were cleaned on 2/13/19 by Dietary District Manager (DDM/ dietary designee).</p> <p>The exhaust fan grill located in the dish room were cleaned on 2/13/19 by Maintenance Department.</p> <p>The trash can and carts located in front of the handwashing sink were moved by Dietary District Manager (DDM) / dietary designee on 2/11/19.</p>		

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F 812	Continued From page 49 f. Two of two handwash sinks had carts and or trash cans in front of them impairing ease of access for handwashing. Staff members were not observed moving items impairing access nor washing their hands at the handwash sinks during the observation period. g. An interview of a dietary staff member and an observation of the three-compartment sink in the dish room revealed three compartments with the following labels, the compartment on the left was labeled-wash, the compartment in the center was labeled rinse, and the compartment on the right was labeled sanitize. The wash compartment was approximately 2/3 full with sudsy water. The rinse compartment had the faucet running into the compartment which contained 2 steam table pans both facing up and the water was immediately draining out of the sink. The sanitize compartment had no liquid in it. A staff member was observed to have washed a large frying pan and a steam table in the wash compartment sink, then rinse the two items off under the running water in the rinse sink, and then place the two items on a drying rack above the three-compartment sink. The cook was observed to have washed a steam table pan in the wash compartment of the three-compartment sink, rinse the pan under the running water, and then return to the kitchen with the pan. During an interview with Dietary Aide #3 she stated the items on the drying rack above the three-compartment sink were ready to be used to prepare and or serve food with. h. An unlabeled spray bottle with a clear liquid was observed hanging on a rack in the dish room. An interview with Dietary Aide #1 revealed she did not know what was in the spray bottle and an interview with Dietary Aide #2 revealed it was bleach.	F 812	The 3 Compartment Sink was drained and correctly refilled according to labels Wash, rinse and sanitize and all pans were properly washed on 2/13/19 by Dietary District Manager (DDM) / dietary designee.  All unlabeled spray bottles were labeled on 2/13/19 by Dietary District Manager (DDM) / dietary designee.  The space were the missing tile grout was located was cleaned on 2/13/19 by Dietary District Manager (DDM) / dietary designee The missing tile grout was repaired on 3/7/19 by the Maintenance Department at the entrance to the dish room.  The drain line under drink line was cleaned on 2/13/19 by Dietary District Manager (DDM).  Heater over the drink line was cleaned by Maintenance Department on 2/13/19.  Coffee urn was cleaned out and debris on top of machine was cleaned on 2/13/19 by Dietary District Manager (DDM) / dietary designee.  Ice Machine deflector was cleaned on 2/13/19 by Dietary District Manager (DDM) / dietary designee.  All cereal storage containers were emptied and cleaned on 2/13/19 by Dietary District Manager (DDM) / dietary designee.		

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F 812	Continued From page 50 i. An observation of the tile floor at the entrance to the dish room revealed missing grout between the tiles for one of one dish room and food and debris was observed in the space where grout should have been. j. Dust and debris were observed on one of one heater observed over the drink line. k. Under the drink line, one of one drain line was observed to have had a dirt and debris build up which traveled through shelves containing stored pitchers. l. One of one coffee urn was observed to have had coffee grounds and other debris on the top of the machine. m. A pinkish color buildup was observed on the deflector in one of one ice machines. n. Dust, dirt, debris were observed on four of four containers containing cereal on a storage rack across from the drink line. o. Multiple pieces of adaptive silverware and multiple spill proof cups and tops were observed in various positions including several cups and tops were stacked food contact side up in 4 of 4 bins of the storage rack they were observed in. Several cups and tops in four of the four bins were observed to have had moisture in them due to having been placed in the bins still wet after having been washed. In addition, the bottom of the bins were observed to have had food, dust, and debris in 4 of 4 bins. p. The inside top of the was observed to have had food and debris in one of one microwave observed. q. On the dish rack next to the prep sink six of six steam table pans were observed to have been stacked with moisture. r. The cook was observed to have been wiping off two of two oven mitts at the prep sink with a dish cloth she had rinsed from water from the	F 812	All adaptive silverware and multiple spill proof cups and tops were rewashed on 2/13/19 by Dietary District Manager (DDM) / dietary designee. Storage Bins were cleaned of debris on 2/13/19 by Dietary District Manager (DDM) / dietary designee.  The plate warmer was cleaned of debris on 2/13/19 by Dietary District Manager (DDM) / dietary designee.  The kitchen steam table water was drained and steam table was cleaned. Underside of the tip shelf of the steam table were cleaned on 2/13/19 by Dietary District Manager (DDM) / dietary designee.  All Dining Room Steam tables pans were cleaned on 2/14/19 by Housekeeper.  Microwave was cleaned on 2/13/19 by Dietary District Manager (DDM) / dietary designee.  All 6 steam table pans observed to have moisture was rewashed and allowed to completely dry before use on 2/13/19 by Dietary District Manager (DDM) / dietary designee.  The wet dish cloth was placed in dirty linen to be washed and a new one was used on 2/13/19 by Dietary District Manager (DDM) / dietary designee.  The bowls stacked in the bus pans were		

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F 812	Continued From page 51 faucet from the prep sink. The cook was then observed to have placed the wet dish cloth draped on the prep sink. s. Two of two bus pans were observed to have multiple bowls stacked in the bus pans with the food contact surface up on the bowls in each pan. t. The protective guard of the commercial mixer was observed to have had food and debris on it. u. Four of four observed food storage containers under the prep table were observed to have had a brown stain to the clear container. v. Food and debris were observed on the bottom of the inside of one of one plate warmer. w. Food and debris were observed around the hinges and on the bottom of one of one of the pellet warmer. x. The cook was observed rinsing her hands in the prep sink without using soap. The runoff from her hands went into a pot with grits in the prep sink which had been soaking. y. The front side of one of one steam table and the underside of the top shelf of the steam table were observed to have had a buildup of debris. z. Water was observed leaking from one of one 4 way connection for water supply behind the drink line.  2. An observation of the kitchen and interviews conducted on 2/12/19 at 11:31 AM revealed the following: a. Knobs were dirty with a debris build up on three of five appliances including the flat top grill/stove/oven combination unit, the convection oven, and the steam table. b. There was food and debris in two of two floor drain traps one located to the rear of the cook line and one located in the front of the cook line. c. Food, debris, dishware, and plasticware were observed on the floor in three of three areas of	F 812	removed and re washed on 2/13/19 by Dietary District Manager (DDM) / dietary designee.  The protective guard of the mixer was cleaned of food and debris on 2/13/19 by Dietary District Manager (DDM) / dietary designee.  The food storage containers under the prep table were cleaned on 2/13/19 by Dietary District Manager (DDM) / dietary designee.  The pellet warmer was cleaned including the hinges on 2/13/19 by Dietary District Manager (DDM) / dietary designee.  Leak from water supply to the drink line was repaired on 2/13/19 by Maintenance Department.  Leak from the Booster Heater was repaired on 2/13/19 by Maintenance Department.  The 2 16 quart plastic containers were rewashed and allowed to air dry on 2/13/19 by Dietary District Manager (DDM) / dietary designee.  The dietary aide #4 was made to put on a beard guard and hair net on 2/12/19 by Dietary District Manager (DDM) / dietary designee.  The prep table were re-cleaned with a clean dish towel on 2/13/19 by Dietary District Manager (DDM) / dietary		

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F 812	Continued From page 52 the kitchen including the main kitchen area, stock room, and the dish room. d. Food and debris were observed under, around, and on the front lift access door for one of one dish machines in the dish room. e. One of one exhaust fan grill was observed to have a dust build up in the dish room. f. An unlabeled spray bottle with a red colored liquid was observed hanging on a rack in the dish room. g. An observation of the tile floor at the entrance to the dish room revealed missing grout between the tiles for one of one dish room and food and debris was observed in the space where grout should have been. h. Dust and debris were observed on one of one heater observed over the drink line. i. Under the drink line, one of one drain line was observed to have had a dirt and debris buildup which traveled through shelves containing stored pitchers. j. One of one coffee urn was observed to have had coffee grounds and other debris on the top of the machine. k. Dust, dirt, debris were observed on four of four containers containing cereal on a storage rack across from the drink line. l. Multiple pieces of adaptive silverware and multiple spill proof cups and tops were observed in various positions including several cups and tops were stacked food contact side up in 4 of 4 bins of the storage rack they were observed in. Several cups and tops in four of the four bins were observed to have had moisture in them due to having been placed in the bins still wet after having been washed. In addition, the bottom of the bins were observed to have had food, dust, and debris in 4 of 4 bins. During the lunch meal tray assembly, a dietary staff member was	F 812	designee.  The 6 plastic spice containers were re-cleaned with a clean dish towel on 2/13/19 by Dietary District Manager (DDM) / dietary designee.  All dish dirty dish cloths were put in a container and taken to the laundry to be cleaned 2/13/19 by Dietary District Manager (DDM) / dietary designee.  Side B nourishment room/pantry cabinet under sink was cleaned, and all items were removed and doors secured on 2/14/19 by Maintenance Director (MD).  The inside of the microwave located in the side B nourishment/pantry room was cleaned by Environmental Director (ED) on 2/14/19.  Debris behind the side B ice machine was cleaned out by housekeeping on 2/14/19.  Side A nourishment room/pantry cabinet under sink was cleaned, and all items were removed and doors secured on 2/14/19 by Maintenance Director (MD).  The two makers in the side A nourishment room/pantry was cleaned by housekeeper on 2/14/19.  Debris behind the side A nourishment room/pantry ice machine was cleaned out by housekeeping on 2/14/19.		

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F 812	Continued From page 53 observed to have removed a spill proof cup from the 4 bin container and place it on a resident tray. m. An interview with and observation of the cook obtaining temperature of the food on the steam table was conducted. The cook was observed to get the temperature of the green peas with a probe thermometer and wipe the thermometer off with a paper towel. The cook was then observed to have used the same paper towel in between obtaining the temperature for mashed potatoes. The cook pulled the mashed potatoes from the steam table and placed them in the convection oven and she stated the mashed potatoes were not warm enough. The cook then proceeded to use the same thermometer probe after wiping it with a paper towel and in between obtaining temperature for the remaining items on the steam table including: rice, pureed meat, mechanical soft meat, meatballs, carrots, tomato sauce, and pureed vegetables. The cook stated that was how she obtained the temperature for the foods from the steam table prior to the food being plated and trayed. n. Two of two bus pans were observed to have multiple bowls stacked in the bus pans with the food contact surface up on the bowls in each pan. o. Four of four observed food storage containers under the prep table were observed to have had a brown stain to the clear container. p. Food and debris were observed on the bottom of the inside of one of one plate warmer. q. Food and debris were observed around the hinges and on the bottom of one of one of the pellet warmer. r. The front side of one of one steam table and the underside of the top shelf of the steam table were observed to have had a buildup of debris. s. Water was observed leaking from one of one 4 way connection for water supply behind the	F 812	2- All dietary staff were educated on 3/7/19 by DDM on hand washing procedure, proper method for cleaning and sanitizing, wet nesting, proper ware washing procedures, temping food, general cleaning and sanitation, restraining facial hair and proper labeling of chemicals. All Housekeeping staff was re-educated on 3/13/19 by the ED on making sure that when cleaning the side A & B Pantries, that they clean behind the ice machines, clean the inside of the microwaves and coffee makers.  3- The Food Contact Surface Monitoring Tool, Handwashing Observation Tool, Pantry Monitoring Log and Wet Nesting Monitoring Tool will be completed by DDM, Dietary Manager (DM) or dietary designee 5x weekly x 3 months to ensure that the food service equipment is clean, the cookware and food preparation surfaces are clean and sanitized.  The DM, ED, or designee will check side A and B pantries 1x daily x 3 months to ensure cleanliness.  The designated dietary staff will complete cleaning assignments daily per shift to ensure that the equipment, food preparation areas, serving areas are kept clean.  The Center Executive Director (CED) will audit the kitchen utilizing a Sanitation Check list, 1 X weekly x 90 days. The CED or designee will audit side A & B	

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F 812	Continued From page 54 drink line. t. Two of two clear 16 quart plastic containers were observed to have been stacked wet on the rack next to the prep sink. u. Dietary Aide #4 was observed to be in the tray preparation area, was observed going into the walk-in cooler, was observed pouring salad dressing into a souffle cup, and was observed pushing tray carts out of the kitchen with unrestrained facial hair. The dietary aide was also observed to have been wearing a hat with unrestrained hair on his head. Unrestrained facial hair for one of two male dietary staff members. v. The booster heater for the one of one dish machine in the dish room was observed to have been leaking. w. An interview with and observation of Dietary Aide #5 was conducted. The dietary aide was observed to have rinsed a dish towel in the prep sink and proceeded to wipe down the prep counter. The dietary aide was observed to have put the dish towel in a green bucket labeled detergent removed the dish towel, wiped down the prep counter, returned the dish towel to the bucket labeled detergent, and put a loaf of bread and an empty pot on the prep counter. The dietary aide was then observed opening cans of tomatoes and poured them into the pot on the prep counter. The dietary aide stated the green buckets had sanitizer in them and the green buckets meant the dish towels were good, green for good, and the red buckets were for dirty towels. She stated they do not remove dish towels from the red buckets and dip them in the green buckets.  3. An observation of the kitchen and interviews conducted on 2/13/19 at 10:12 AM revealed the	F 812	pantries 1x weekly x 3 months to ensure pantries are clean.  4- DM and CED will bring all monitoring tools to the monthly Quality Assurance (QA) meeting for review. DM will be responsible for POC.		

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F 812	Continued From page 55 following: a. An interview with and observation of the cook and Dietary Manager (DM) was conducted. The cook was observed removing raw chicken from the right sink of the prep sink, placing it on a baking try, and applying seasoning/spices from 6 different 32-ounce plastic spice containers. After completing seasoning the chicken the cook was observed wiping down the 6 seasoning/spice containers with a dishtowel she had ran under the water from the prep sink faucet and then wiped down the prep sink with same dish towel and set the 6 seasoning/spice containers on the prep sink. The cook also wiped down a prep table with the dish cloths she had rinsed in water from the faucet of the prep sink. The cook then hung two dish cloths on the front edge of the prep sink. The Dietary Manager was then observed moving an ambrosia fruit salad from one stainless pan to another on the prep table which had been wiped down with the wet dish cloth. The Dietary Manager left the ambrosia fruit salad on the prep counter and left the area. The cook was then observed to rinse out a large stainless bowl at the prep sink, invert the bowl, and placed the inverted bowl over the smaller bowl with the ambrosia fruit salad. The bowl covering the ambrosia fruit salad had visible water droplets on the exposed side, facing up. The Dietary Manager returned with a red bucket marked sanitizer and placed the dish towels which were hanging on the sink in the red bucket marked sanitizer. The cook was then observed to have gone into the walk in cooler and proceeded to dump two boxes of raw zucchini into the prep sink where the raw chicken had been previously. During an interview with the cook she stated she had wiped down the sink with sanitizer and pointed to the red bucket marked sanitizer. The cook pointed to the bucket	F 812			

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F 812	<p>Continued From page 56</p> <p>the Dietary Manager had brought and placed into the sink after she had wiped down the sink. The cook then proceeded to take the red bucket marked sanitizer and dump it down the drain in the left side of the prep sink. An interview with the Dietary Manager revealed it was his expectation for the sink and other applicable items such as the counter, dishes/bowls, and the seasonings/spices to have been properly sanitized to prevent cross contamination. The Dietary Manager also stated the zucchini would be rinsed and was to be cooked as part of the lunch meal for the day.</p> <p>b. Knobs were dirty with a debris build up on three of five appliances including the flat top grill/stove/oven combination unit, the convection oven, and the steam table. An interview conducted with the District Manager (DM) revealed her expectation was for knobs on appliances to have been cleaned.</p> <p>c. An observation revealed there was food and debris in two of two floor drain traps one located to the rear of the cook line and one located in the front of the cook line. The District Manager (DM) stated the floor drain traps had been cleaned the night before and they became that dirty in one day.</p> <p>d. Food, debris, dishware, and plasticware were observed on the floor in three of three areas of the kitchen including the main kitchen area, stock room, and the dish room. The DM stated it was her expectation for the floor area to be clean in the kitchen, dish room, and stock room.</p> <p>e. Food and debris were observed under, around, and on the front lift access door for one of one dish machines in the dish room. The DM stated it was her expectation for the dish machine to be cleaned and wiped down after each use.</p> <p>f. One of one exhaust fan grill was observed to</p>	F 812			

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F 812	Continued From page 57 have a dust build up in the dish room. The DM stated it was her expectation for the exhaust fan to be clean. g. An observation of the tile floor at the entrance to the dish room revealed missing grout between the tiles for one of one dish room and food and debris was observed in the space where grout should have been. The DM stated she would turn in a work order to maintenance regarding the grout and tiles. h. Dust and debris were observed on one of one heater observed over the drink line. The DM stated it was her expectation for the heater to be clean. i. Under the drink line, one of one drain line was observed to have had a dirt and debris buildup which traveled through shelves containing stored pitchers. The DM stated it was her expectation for storage areas for pitchers and other wares be clean. j. One of one coffee urn was observed to have had coffee grounds and other debris on the top of the machine. The DM stated it was her expectation for the coffee urn to be clean. k. Dust, dirt, debris were observed on four of four containers containing cereal on a storage rack across from the drink line. The DM stated it was her expectation for storage containers for food to be clean. l. Multiple pieces of adaptive silverware and multiple spill proof cups and tops were observed in various positions including several cups and tops were stacked food contact side up in 4 of 4 bins of the storage rack they were observed in. Several cups and tops in four of the four bins were observed to have had moisture in them due to having been placed in the bins still wet after having been washed. In addition, the bottom of the bins were observed to have had food, dust,	F 812			

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F 812	Continued From page 58 and debris in 4 of 4 bins. During the lunch meal tray assembly, a dietary staff member was observed to have removed a spill proof cup from the 4 bin container and place it on a resident tray. The DM stated the 4 bin container was actually designed for silverware and not cups. The DM stated it was her expectation for the spill proof cups to be stacked so they could dry. m. Two of two bus pans were observed to have multiple bowls stacked in the bus pans with the food contact surface up on the bowls in each pan. The DM stated items such as plates or bowls do not have to be covered or exposed food surfaces on plates or bowls be inverted. n. Four of four observed food storage containers under the prep table were observed to have had a brown stain to the clear container. The DM stated the containers looked to have a brown color because they had been stained with tea but the containers were clean. o. Food and debris were observed on the bottom of the inside of one of one plate warmer. The DM stated it was her expectation for the plate warmer to have been clean. p. Food and debris were observed around the hinges and on the bottom of one of one of the pellet warmer. The DM stated it was her expectation for the pellet warmer to have been clean. q. The front side of one of one steam table and the underside of the top shelf of the steam table were observed to have had a buildup of debris. The DM stated it was her expectation for the steam table to have been clean. r. Six of six steam table wells were observed to have had food and debris in the well water. The DM stated it was her expectation for the well water to be changed when it had food and debris in it.	F 812			

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F 812	<p>Continued From page 59</p> <p>s. Water was observed leaking from one of one 4 way connection for water supply behind the drink line and water was also observed leaking from the booster heater for the dish machine. The DM stated she would complete work orders to address the leaks.</p> <p>t. An interview with the DM revealed it was her expectation for the thermometer probe to be cleaned and sanitized between checking temperatures on different foods to prevent cross contamination, for chemicals to be properly labeled including sanitizer being placed in the sanitizer bucket, for dietary staff to have their facial hair restrained, for wet dish towels to be stored in sanitizer, for wares to be properly washed in the three compartment sink, for appliances to be clean, and for oven mitts to be properly laundered when dirty or to dispose and order more mitts if necessary.</p> <p>4. An observation of the B side pantry conducted on 2/13/19 at 4:44 PM revealed the following:</p> <p>a. An observation in the cabinet under the sink revealed a box of honey thickener containing 31 packets, a box of nectar thickener containing 16 packets, the bottom shelf of the cabinet appeared to have been damaged due to a water leak due to the presence of exposed particle board and parts of the wood had turned black in color.</p> <p>b. An observation of the top of the inside of the microwave revealed food and debris on it.</p> <p>c. An observation behind the ice machine revealed four sleeves of white foam cups, bowl with a plastic cover with an unidentifiable substance in it, and other debris on the floor.</p> <p>5. An observation of the A side pantry conducted on 2/13/19 at 5:20 PM revealed the following:</p> <p>a. An observation in the cabinet under the sink</p>	F 812			

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F 812	<p>Continued From page 60</p> <p>revealed the bottom shelf of the cabinet appeared to have been damaged due to a water leak due to the presence of exposed particle board and parts of the wood had turned black in color. There was a wash basin under the sink and a bath blanket which had become affixed to the to particle board shelf.</p> <p>b. An observation of the two coffee makers in the pantry revealed dried coffee grounds in the filter compartment with a white cotton like matter in both coffee makers.</p> <p>c. An observation behind the ice machine revealed three sleeves of white foam cups and other debris on the floor.</p> <p>6. An observation conducted in conjunction with an interview with the Administrator was conducted on 2/13/19 at 5:38 PM.</p> <p>a. An observation in the cabinet under the sink in the B side pantry revealed a box of honey thickener containing 31 packets, a box of nectar thickener containing 16 packets, the bottom shelf of the cabinet appeared to have been damaged due to a water leak due to the presence of exposed particle board and parts of the wood had turned black in color. An observation in the cabinet under the sink revealed the bottom shelf of the cabinet appeared to have been damaged due to a water leak due to the presence of exposed particle board and parts of the wood had turned black in color. There was a wash basin under the sink and a bath blanket which had become affixed to the to particle board shelf. The Administrator stated it was his expectation for no items to be stored under the sink and for the area under the sink to be clean.</p> <p>b. An observation of the top of the inside of the microwave in the B side pantry revealed food and debris on it. The Administrator stated it was his</p>	F 812			

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F 812	Continued From page 61 expectation for the inside of the microwave to be clean. c. An observation behind the ice machine in the A and B side pantry revealed sleeves of white foam cups and other debris on the floor. The Administrator stated it was his expectation for the areas behind the ice machines to be clean. d. An observation of the two coffee makers in the pantry revealed dried coffee grounds in the filter compartment with a white cotton like matter in both coffee makers. The Administrator stated it was his expectation for the coffee makers to be cleaned after each use.  During an interview conducted on 2/14/19 at 4:38 PM the Administrator stated it was his expectation for food to be produced, stored, prepared in a sanitary manner, equipment to be clean, and chemicals to be labeled.	F 812			
F 814 SS=C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4)  §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep maintain clean garbage cans in the kitchen, failed to maintain the dumpster area free of debris, and failed to ensure proper disposal of food wrappers in one of two dining rooms.  Findings included:  1. An observation conducted of the kitchen on 2/11/19 at 9:22 AM revealed five of five trash cans to have had dirt, grease, food, debris, and	F 814	F814 1- The trash cans, and the trash compactor, and surrounding areas were cleaned on 2/14/19 by Environmental Director (ED).  The bus trays and food wrappers were removed from the tray cart and the tray cart in B side dining was cleaned on 2/13/19 by Center Executive Director (CED).	3/14/19	

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F 814	<p>Continued From page 62</p> <p>buildup on the outside of the trash cans observed in the kitchen and dish room.</p> <p>2. An observation of the garbage compactor area was conducted on 2/11/19 at approximately 10:40 AM. The observation revealed black matter and food debris under and around the base of the cement pad the compactor sat on. In addition, there was a trash can which was full of aluminum cans, a large wheeled bin with leaves, water, and other black matter in it, a housekeeping cart, a wooden pallet, a trash can, and 3 trash can covers. All the observed items were on the ground in the immediate vicinity around the trash compactor.</p> <p>An interview with the Administrator was conducted in conjunction with an observation of the garbage compactor area on 2/13/19 at 11:30 AM. The observation revealed black matter and food debris under and around the base of the cement pad the compactor sat on. In addition, there was a trash can which was full of aluminum cans, a large wheeled bin with leaves, water, and other black matter in it, a housekeeping cart, a wooden pallet, a trash can, and 3 trash can covers. All the observed items were on the ground in the immediate vicinity around the trash compactor. The Administrator stated the area had been used for storage of housekeeping items, but he said the items had not been used in a long time and could be disposed of.</p> <p>3. An observation of the B side dining room was conducted on 2/13/19 at 4:49 PM. There was a two doored, vinyl/plastic/metal, green tray cart in the dining room. An observation of the compartment behind the left side door revealed a bus pan slid sideways in the tray storage area</p>	F 814	<p>2- All dietary staff were educated on the proper procedure for handling garbage and refuse on 3/7/19 by District Dietary Manager (DDM). All new employees will be educated on the proper procedure for handling garbage and refuse by the Dietary Manager (DM).</p> <p>3- The Garbage and Refuse Monitoring Tool will be completed by DM 5x weekly x 3 months to ensure garbage receptacles in kitchen and at dumpster area are clean, as well as to ensure that the dumpster area is clean and there is no debris on the ground around the compactor.</p> <p>The Center Executive Director (CED) will audit the Dumpster Area and garbage receptacles using the Sanitation check List, 1x weekly x 3 months.</p> <p>4- DM and CED will bring the Garbage and Refuse Monitoring Tool to the monthly Quality Assurance (QA) meeting for review. DM is responsible for POC.</p>		

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F 814	Continued From page 63 which contained at least 10 empty honey bun wrappers and empty potato chip bags. In addition to the wrappers/bags being inside the bus pan, there were also wrappers on the bottom of the tray area inside the cart.  An interview with the Administrator was conducted in conjunction with an observation of the B side dining room on 2/13/19 at 5:38 PM. There was a two doored, vinyl/plastic/metal, green tray cart in the dining room. An observation of the compartment behind the left side door revealed a bus pan slid sideways in the tray storage area which contained at least 10 empty honey bun wrappers and empty potato chip bags. In addition to the wrappers/bags being inside the bus pan, there were also wrappers on the bottom of the tray area inside the cart. The Administrator stated it was his expectation for garbage such as wrappers to be properly disposed of.  During an interview conducted with the Administrator on 2/14/19 at 4:38 PM he stated it was his expectation for the garbage area to be kept clean, for garbage to be properly disposed of, and for garbage receptacles such as the garbage cans in the kitchen to be cleaned as necessary.	F 814			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		3/14/19	

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F 880	Continued From page 64 diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880			

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F 880	<p>Continued From page 65</p> <p>must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility staff failed to clean a glucometer per the manufacturer's instructions after use in 1 of 2 observations of staff obtaining blood glucose reading (Resident #76).</p> <p>Findings included:</p> <p>Review of the manufacturer's instructions for Use of the towelettes the facility used to disinfect their glucometers revealed the towelettes should be used in a two-step disinfecting process:</p> <p>"One wipe is required to preclean then a second wipe is required to disinfect. Repeated use of the product may be required to ensure the surface remains visibly wet for 3 minutes at room temperature Trichophyton metagrophytes</p>	F 880	<p>F880</p> <p>Element 1: The process of ensuring glucometers cleaned per manufacturers <input type="checkbox"/> instructions before February 11, 2019. The facility failed to ensure glucometer was cleaned appropriately per manufacturers <input type="checkbox"/> instructions after use. Glucometer was properly cleaned on 2-13-19 prior to use.</p> <p>Element 2: The nurse management team will complete 100% audit of 8 glucometers to ensure they were properly cleaned and appropriate wipes/towelettes are readily available to all licensed nurses by 2-18-19.</p>		

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F 880	<p>Continued From page 66 and Salmonella enterica. The towelettes effectively kills Human Immunodeficiency Virus Type 1 (HIV-1), Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV) on precleaned environmental surfaces/objects previously soiled with blood/body fluids in healthcare settings or other settings in which there is expected likelihood of soiling of surfaces/objects previously soiled with blood/body fluids in healthcare settings."</p> <p>During an observation of Nurse #3 on 2/13/19 at 5:20 pm, she completed a finger stick blood glucose check for Resident #76 using a glucometer used for multiple residents on the 200 Hall. Nurse #3 completed the finger stick blood glucose check and used one towelette to clean the glucometer and placed it back into the storage container. She did not wrap the glucometer in another towelette or put it in a bag. The storage container also contained loose lancets and alcohol pads.</p> <p>An interview with Nurse #3 on 2/13/19 at 5:45 pm revealed she was not aware the glucometer should be cleaned with one wipe and then another wipe should be used to ensure the surface of the glucometer should be visibly wet for 3 minutes per the manufacturer's recommendations for disinfecting the surface of the glucometer.</p> <p>On 2/13/19 at 6:05 pm the Director of Nursing stated she would ensure the glucometer was cleaned properly and would educate Nurse #3 and all the other nurses on the proper cleaning of the glucometer.</p> <p>A second interview with the Director of Nursing on 2/14/19 at 11:11 am revealed she expected the</p>	F 880	<p>Element 3: The Director of Nursing/Nurse Practice Educator re-educated licensed nursing staff by 3-14-19. Education includes that licensed nurse is to they are disinfecting/cleaning glucometers using the two-step process. One wipe is required to preclean and the second wipe is required to disinfect. Repeated use of the towelette may be necessary to ensure that glucometer surface remains visibly wet for 3 minutes at room temperature.</p> <p>Element 4 Unit manager/nurse management designee will audit 3 random fingersticks and disinfecting of glucometer on each unit 3 X weekly X 4 weeks, 1 X weekly X 4 weeks, 1 X every two weeks X 4 weeks, monthly X 3 months. Director of nursing will submit results of audits to the monthly QAPI meeting for review. Director of Nursing is responsible for implementing the acceptable plan of correction. Date of compliance will be 3-14-2019. Director of Nursing will bring to QAPI on a monthly basis X 6 months.</p>		

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F 880	Continued From page 67 nursing staff to clean the glucometers properly and per the manufacturer's recommendations for the towelettes the facility uses.  On 2/14/19 at 5:39 pm an interview with the Administrator revealed his expectation was the glucometers would be cleaned properly and the nursing staff would be re-educated on proper cleaning of the glucometers.	F 880			
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4)  §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to maintain an effective pest control program for one of two nourishment rooms (B side nourishment room), three of fourteen fluorescent ceiling lights in the kitchen, one of two dining areas (A side dining room), and one of four resident halls (500 Hall).  Findings included:  Pest control summary of services from the pest control service were reviewed for the following dates of 7/2/18, 7/12/18, 7/30/18, 8/9/18, 8/23/18, 8/31/18, 10/2/18, 10/24/18, 11/8/18, 11/12/18, and 2/6/19. No concerns with the B side nourishment, and A and B side dining room. Recommendations were observed on the summary of services were dated for original recommendation date. The following recommendations were documented on the summary of services: 4/17/18: Cookline-An	F 925	F925  1. Side B nourishment room cabinet under sink was cleaned out and doors secured on 2/14/19 by Maintenance Director (MD) Kitchen fluorescent ceiling lights were cleaned on 2/13/19 by MD All steam table pans and window seals behind the steam table were cleaned on 2/14/19 by Housekeeper. Rooms/Bathrooms for Rooms 511, 513, 515, 505, 501 and 509 were retreated by Pest Control Company on 3/13/19.  2. MD completed an audit on 3/4/19 of all nourishment rooms, Dining rooms, kitchen fluorescent ceiling lights, dining rooms and all residents <input type="checkbox"/> rooms/bathrooms to ensure there are no signs of pests. . Any areas found to have signs of pests where treated by pest	3/14/19	

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F 925	<p>Continued From page 68</p> <p>accumulation of food product noted. Please remove food product to prevent attraction by pests. 5/15/18: Patient Rooms-Please remove food product to prevent attraction by pests. 6/4/18: Kitchen-An accumulation of food product waste noted throughout kitchen and dish area. Please remove food product to prevent attraction by pests. 8/9/18: Prep Sink (kitchen area)-Cracks or damage to wall allowing pest access. Please repair to prevent pest entry. 8/23/18: Dishwash-Debris collecting under all dishwasher areas. Please remove debris to prevent unsanitary conditions and attraction by pests. The following visits had recommendations regarding trees/vegetation touching the building, trim to prevent pest entry to structure; 7/2/18, 7/12/18, 7/30/18, 8/9/18, 8/23/18, 8/31/18, 10/2/18, 10/24/18, and 2/6/19. The following visits had recommendations regarding patient rooms having had cracks or damage to the floor damage/holes/gaps to the walls of the building allowing pest access, please repair to prevent pest entry; 10/2/18, 10/24/18, 11/12/18, and 2/6/19.</p> <p>A review was completed of the facility work orders from 1/1/19 through 2/12/18. The review revealed the following work orders concerning pest activity;</p> <p>-1/3/19: ants in a resident's room, starting in a resident's bathroom, room 511. Comment by maintenance-No ants observed.</p> <p>-1/7/19: ants in the bathroom sink, bathroom between rooms 513 and 515. Comment by maintenance-No ants observed, pest control to treat the room.</p> <p>-1/8/19: ants in the bathroom; bathroom between rooms 513 and 515. Comment by maintenance-Pest control to treat room.</p>	F 925	<p>control company.</p> <p>Environmental Director (ED) completed an audit on 2/14/19 if all steam tables in dining rooms to ensure there were no signs of pests. Any signs of pest was reported to MD so that the pest control company is contacted and areas can be treated.</p> <p>3. Center Executive Director (CED) re-educated Maintenance Staff and ED on facilities Pest Management Policy on 3/6/19. ED re-educated Housekeeping/Laundry staff on cleaning schedule of all dining room steam wells on 3/8/19.</p> <p>4. MD/Maintenance Designee will complete random inspections of nourishments rooms, resident rooms, kitchen fluorescent ceiling lights 1x weekly x 3 months to ensure no signs of pests are found. MD will submit audits to monthly Quality Assurance (QA) meeting for review. MD will be responsible for this part of the POC. ED/Housekeeping Designee will complete random inspections of steam wells in all dining rooms 1x weekly x 3 months to ensure no signs of pests are found. ED will submit audits to monthly Quality Assurance (QA) meeting for review. ED will be responsible for this part of POC.</p>		

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F 925	<p>Continued From page 69</p> <p>-1/10/19: ants in the bathroom sink of room 515. Comment by maintenance-No ants observed.</p> <p>-1/21/19: Resident refused to get dressed until someone sprayed for the 1,000 ants in her room. Room 505. Comment by maintenance-Cleaned area where ants were found.</p> <p>-1/24/19: Ants in the window sill and on the table and around room 501. Comment by maintenance-Cleaned area where ants were seen.</p> <p>-1/28/19: Roaches behind coffee pot and refrigerator, side B dining room. Comment by maintenance-Called pest control to come treat area.</p> <p>During a round of the kitchen with the Regional Manager of the dietary services company of the kitchen conducted on 2/13/19 at 10:46 AM visible, nonmoving, distinguishable insects were observed in 3 of the 14 lights. Unidentifiable, dark objects, nonmoving, were observed in 8 of the 14 lights.</p> <p>During an interview with Nurse #8 on 2/13/19 at 11:49 AM the nurse stated he had seen ants in the bathrooms of room 501 and room 509 within the past 1-2 months.</p> <p>An observation of the dining room on the A side of the facility was conducted on 2/13/19 at 4:44 PM. The observation revealed 3 dead bugs in 1 of the 3 steam table pans and multiple dead small flies were observed around the window behind the steam table.</p> <p>An observation of the B-side pantry was conducted on 2/13/19 at 5:04 PM. An observation in the cabinet under the sink revealed exposed particle board wood which had been</p>	F 925			

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F 925	<p>Continued From page 70</p> <p>water damaged, a triggered but empty mouse trap, rodent feces, and insect body parts.</p> <p>A round was conducted with the Administrator on 2/13/19 at 5:38 PM. During the round the following observations were made 3 dead bugs in 1 of the 3 steam table pans and multiple dead small flies were observed around the window behind the steam table in the A side dining room and an observation in the cabinet under the sink revealed exposed particle board wood which had been water damaged, a triggered but empty mouse trap, rodent feces, and insect body parts. The Administrator stated the steam tables had not been used in the dining rooms for service in at least 4-5 months and that it was his expectation for the steam tables and the area under the sinks in the pantries be clean.</p> <p>An interview was conducted on 2/14/19 12:29 PM with the exterminator who provided pest control services at the facility on 2/6/19. The exterminator stated he had discovered small ants, or sugar ants, in the B side dining room during the service on 2/6/19 and the pest control services provided service to the facility twice a month. The exterminator further stated the information documented in the report provided to the facility was very specific and provided information regarding pest control efforts by the facility and the pest control company.</p> <p>An interview was conducted with the facility Maintenance Director (MD) on 2/14/19 at 3:56 PM. The MD stated the exterminator had told him several businesses in the area had been having problems with ants and the exterminator had been putting ant bait out. The MD stated he had seen ants in the facility from time to time and</p>	F 925			

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

PRINTED: 03/27/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345286</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/14/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>SALISBURY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>710 JULIAN ROAD</b> <b>SALISBURY, NC 28147</b>		
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F 925	<p>Continued From page 71</p> <p>had seen ants in the bathroom of room 513 back on 1/7/19. The MD stated they were small black ants, sugar ants. The MD stated the treatment which the pest control services used had killed the ants and the pest control company treated the building around the perimeter on the outside. The MD stated each time there was a complaint about ants he contacted the pest control company to come to the facility to provide treatment.</p> <p>During an interview conducted with the Administrator on 2/14/18 at 4:38 PM he stated it was his expectation for the pest control company to manage pest problems.</p>	F 925			