STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495393	A. BUILDING _____ B. WING _____	C 09/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SITTER AND BARFOOT VETERANS CARE CENTER	1601 BROADROCK BLVD RICHMOND, VA 23224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 09/11/2018 through 09/12/2018. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 09/11/18 through 09/12/18. One complaint was investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 200 certified bed facility was 193 at the time of the survey. The survey sample consisted of 58 residents.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		10/24/18

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

Electronically Signed | 09/26/2018

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility failed to ensure, that one resident (#69) was treated with respect and dignity while providing personal care. The findings include: Resident #69 was originally admitted 10/1/2008, and readmitted 10/29/2010. His diagnoses include but are not limited to: dementia with behavioral disturbance, adult failure to thrive, chronic pain syndrome, and disc degeneration.	F 550	1. Address how corrective action will be accomplished for the residents found to have been affected by the deficient practice. a. Resident #69 was assessed to see if he was upset with the door to his room being open. Resident was not aware the door was open. No s/s of adverse affect on this resident. 2. Address how the facility will identify other residents having the potential to be	

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F 550	Continued From page 2 His most recent MDS(Minimum Data Set) is a quarterly assessment dated 7/10/2018. This MDS shows that Resident #69 requires assistance with dressing and bathing. The MDS shows that the resident is moderately cognitively impaired. On 9/12/2018 at 1:30 pm, the surveyor was passing Resident #69's room on the way to visit another resident. The surveyor observed that the resident's door was open, and the resident was receiving assistance with perineal hygiene and dressing. The surveyor was able to see the resident's abdomen and hip, and if the resident rolled to the side the resident's genitalia would have been visible from the corridor. The surveyor walked immediately to the office of RN A, the unit manager. RN A and the surveyor returned to the hallway outside the resident's room. When asked what she observed, RN A stated "His door is open. Doors should be closed during personal care. If he turned, you could see his groin." A review of the facility policy titled "Professional and Clinical Ethics" shows the following: "1. Our residents have the right to personal privacy and confidentiality of their personal and clinical records. Personal privacy extends to accommodations, medical treatment, written and telephone communications, personal care, visits and meetings with family or residential groups." An interview with Resident #69 was conducted on 9/12/2018 at 1430. Resident #69 verbalized that he had not noticed his door was open during care, and he had no issues with the care he was provided. No further information was provided prior to exit.	F 550	affected by the same deficient practice. a. All residents have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice does not recur. a. Nursing staff will be educated on closing resident room doors when providing ADL care. b. Other staff that may work on the unit will be educated that resident doors should be closed when ADL care is provided and to correct immediately if needed. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. a. Room rounds will randomly be conducted during the day to ensure resident room doors are closed and dignity is maintained during ADL care. Any discrepancies will be corrected immediately and education provided as needed.	

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F 554	Continued From page 3	F 554		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed for 1 resident (Resident #64) of 59 residents in the survey sample to assess for the safe self administration of medications. For Resident #64, 11 unopened tablets of Gas-ex tablets were found on the bedside table and the resident had not been assessed to self administer medications. The findings included: Resident #64, an 83 year old, was admitted to the facility on 7/12/17. Diagnoses included atrial fibrillation, hypertension, hyperlipidemia, pulmonary disease, reflux, anemia, and vascular disease. The most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 7/3/18. The resident was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required extensive assistance with activities of daily living. On 9/11/18 at 11:30 a.m. an initial tour of the facility was conducted. Resident #64 was not in the room at this time. A card containing 11	F 554	1. a. The medication tablets for resident #64 were brought in by family. The tablets were removed immediately. b. Resident was assessed for self-administration of medications and the IDT determined he is unable to do so. 2. a. All residents have the potential to be affected. 3. a. Resident #64 is alert and oriented (with periods of confusion) and was educated on not keeping medications at bedside. b. Resident's RP was educated on not bringing in outside medications. c. Staff will be educated to look for medications that may have been brought in by family and to remove the medication and notify the charge nurse if any are noted. 4. Random room rounds will be done weekly to observe for potential medications at bedside. Discrepancies will be corrected immediately and education will be provided if indicated.	10/24/18

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F 554	Continued From page 4 unopened, individually packaged gas-ex pills was observed on the bedside table. These pills did not appear to be supplied by the facility. Resident #64's physician orders were reviewed. The order sheet did not include an order for gas-ex. The following Health Status notes were documented in the clinical record: 9/6/18 "refused medication on this shift, stated that he wanted writer to leave medication on his bedside" 8/23/18 "resident refused all morning meds except Breo inhale Flonase and medpass. He wanted writer to leave the cup of pills stated that he doesn't need to be watched taking mediation and to put the cup of pills on the table. writer explained that it was against policy to leave pills in the room. He said in a adamant manner then take the pills with you. Made several attempts to explain why the pills could not be left." Resident #64's care plan was reviewed. It did not include any information regarding the ability to self administer medications. On 9/12/18 at 3:15 p.m., the Director of Nursing (DON) and Administrator were notified that gas-ex pills were observed on Resident #64's bedside table. When asked if Resident #64 had been assessed to self administer medications, the DON stated no.	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive	F 558		10/24/18

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F 558	Continued From page 5 services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, and clinical record review, the facility staff failed to accommodate needs for one resident (Resident # 80) in a sample of 59 residents. The facility staff failed to provide Resident # 80 with a specialized call bell to accommodate Resident's physical limitations. Resident # 80 was admitted to the facility on 02/21/2014. Diagnoses for Resident # 80 included depression, Parkinson's disease, aphasia, unspecified dementia without behavioral disturbances, and chronic pain syndrome. Resident # 80's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/10/2018, was coded as an annual assessment. Resident # 80 was coded with a Brief Interview Mental Status (BIMS) score of "13" out of possible "15" indicative of no cognitive impairment. Resident # 80 Functional Status was coded as total dependence for all daily living activities. On 09/11/2018 at approximately 2:30 PM, Resident # 80 was observed in his room, seated in his high-back wheelchair watching TV. The call bell was hung over chair arm with end of call bell hanging off the chair, unreachable by the Resident.	F 558	1. a. Resident #80 was assessed by nursing staff for the potential need for a different call bell. 2. a. Residents with physical limitations have the potential to be affected. 3. a. Staff will try different call bells for resident #80 to determine the most useful. b. Staff will be educated to notify the nurse manager that if, due to physical limitations, a resident is not able to use the regular call bell, a different type of call bell could potentially be provided. 4. a. Random room rounds will be completed asking residents to demonstrate how to use their call bell. Residents that may require a different call bell will be provided a different type of call bell if indicated.	

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F 558	Continued From page 6	F 558		

On 09/12/2018 at 8:10 AM, Resident # 80 was observed lying in bed with call bell resting on his abdomen. When asked if he could reach his call bell, Resident # 80 stated he would have to 'feel around for it'. When asked to demonstrate call bell function, Resident # 80 was unable to move his arms to locate the call bell and activate it.

On 09/12/2018 at 11:25 AM, Resident # 80 was observed lying in bed and call bell remained on his abdomen, unreachable by the Resident.

On 09/12/2018 at approximately 11:45 AM, an interview with CNA A was conducted. When asked how Resident # 80 calls the staff for help, the CNA stated resident is able to press his call bell.

On 09/12/2018 at approximately 11:50 AM, this Surveyor entered Resident #80's room with CNA B and observed Resident lying in bed with the call bell on his abdomen. When asked if the Resident was able to reach his call bell, CNA B did not answer. When Resident # 80 was asked to demonstrate activating the call bell, he was unable to do so. CNA B stated she thinks Resident # 80 needs "one of those flat" call bells so he can activate it easier.

Resident # 80's Care Plan was reviewed. One Focus area dated 07/13/2018 identified risk for injury related to his "use of antidepressant medications, Parkinson's disease, inability to self-position, contractures of all extremities, and dementia." Interventions associated with this focus area included "reinforce need to call for assistance during rounds and prn" and "call light available and answer promptly"

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F 558	Continued From page 7 On 09/12/2018 at 3:30 PM, the Administrator and DON were notified of the concern and they provided no further information.	F 558		
F 573 SS=D	Right to Access/Purchase Copies of Records CFR(s): 483.10(g)(2)(i)(ii)(3) §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and (C)Postage, when the individual has requested the copy be mailed.	F 573		10/24/18

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F 573	Continued From page 8 §483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law. This REQUIREMENT is not met as evidenced by: Based on resident interview and staff interview, the facility staff failed to give access to one resident's medical record. (Resident #186) The findings include: During a resident council meeting held on 09/12/2018 at approximately 9:46 am, Resident #186 stated that she asked to see her Medication Administration Record (MAR) because she wanted to see the last time she had taken a mediation but was denied access to it. On 9/12/2018 at approximately 2:25 pm, an interview was conducted with the Administrator. During the interview the administrator was asked about Resident #186 statement concerning viewing her MAR. The administrator stated that she was not aware of the concern but would look into it. On 9/12/2018 at approximately 6:35 pm, the administrator stated that Resident #186 had asked to see her MAR but the nurse was busy passing medication. The administrator stated that the nurse did not go back and let Resident #186 view her MAR.	F 573	1. a. Resident #186 is unable to state or give any specific information (such as date, nurse, time) she asked to see her MAR. b. Resident #186 was given a copy of her MAR 9/12/2018 when administration was notified resident had requested to see her MAR. 2. a. All residents that request to see their medical record has the potential to be affected. 3. a. Licensed Nurses will be educated that when a resident requests to see his/her medical record, they are allowed to see it upon request. Requests for copies are to go to Medical Records. 4. a. Residents will be asked in resident council, and at random, if they have asked to see their medical record and the response of nursing staff. b. Education will be provided to staff as needed.	

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F 573	Continued From page 9 The facility staff was made aware of the concern during a briefing on 9/12/2018.	F 573		
F 577 SS=B	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and resident interview, the facility failed to post survey signage and survey results in a readily accessible manner for residents that use wheelchairs. The findings include:	F 577	1. a. Upon notification, the facility, within the hour, moved the survey results binder from the receptionist desk to the table across from the reception desk, along with lowering the sign telling residents where the results are located.	10/24/18

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F 577	Continued From page 10 During a resident council meeting held on 09/12/2018 at approximately 9:46 am, the group was asked if they knew where the survey report from last year was kept. No one in the group knew where the survey report was kept. On 09/12/18 at approximately 10:19 AM, the survey results were observed on counter at the receptionist's desk. The counter of the receptionist's desk was about 4 feet high. However, the survey results were located in between a column and podium leaving about a two foot gap which would be difficult for a resident in a wheelchair to reach. The posting for the survey results was also observed. The posting was at the top of a bulletin board about 5 feet off the ground. However, a resident in a wheelchair would have a difficult time reading the posting. On 09/12/18 at 02:25 PM, an interview was conducted with the Administrator. The administrator stated that she was not aware that the reading the posting and reaching the survey results would be difficult for a resident in a wheelchair. The facility staff was made aware of the concern during a briefing on 9/12/2018.	F 577	2. a. Residents in wheelchairs have the potential to be affected. 3. a. Activity Staff will educate residents in resident council on the new location of the survey results binder. b. Staff will be educated on the location of the survey results binder in order to direct residents to the location if needed. 4. a. Facility staff will randomly ask residents about the location / accessibility of the survey results binder to ensure it is easily accessible.	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for	F 582		10/24/18

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Medicaid of-
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

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SITTER AND BARFOOT VETERANS CARE CENTER	1601 BROADROCK BLVD RICHMOND, VA 23224

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F 582	Continued From page 12 (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to issue a Skilled Nursing Facility Advance Beneficiary Notice (form CMS 10055) for one resident (Resident #44). On 09/12/2018 a review of Skilled Nursing Facility Beneficiary Protection Notification was conducted. The review showed Resident #44 did not receive an Skilled Nursing Facility Advance Beneficiary Notice (form CMS 10055). On 09/12/18 at 10:35 AM, an interview was conducted with Employee B. Employee B stated that a form CMS 10055 was not issued but a form CMS 10123-NOMNC was issued to the resident. Employee B stated that she did not know that a form CMS 10055 needed to be issued. The facility staff was made aware of the concern during a briefing on 9/12/2018.	F 582	1. a. Resident #44 was issued a CMS 10123-NOMNC, which was the form known to the facility to utilize for Advanced Beneficiary Notices (ABN). b. Facility staff, upon notification of CMS form 10055, reviewed the document, instructions for the document, and implemented the use of the document. 2. a. Any resident that requires an ABN has the potential to be affected. 3. a. Social service and Admissions staff will be educated on the use of CMS form 10055 for ABNs. b. CMS form 10055 will be utilized per form instructions. 4. a. An audit of four resident charts a month that required an Advanced Beneficiary Notice will be reviewed for three months to ensure form 10055 was utilized. b. Results of the audit will be brought to the QAA committee for three months to determine if further action is needed.	
F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3)	F 645		10/24/18

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F 645	Continued From page 13 §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after	F 645		

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F 645	Continued From page 14 being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on Resident Interview, Staff Interview, Clinical Record Review, facility failed to ensure level 1 screening tools were completed prior to admission for residents 5 residents, 171, 136, 133, 124, 155. 1. Resident #171 did not have a Level I PASARR completed prior to or upon admission to the facility.	F 645	1. a. Resident #171, #136, #133, #124, #155 have a history and physical in the medical record but do not have the specific PASARR form. b. If resident #171, #136, #133, #124, #155 are admitted to the hospital, a PASARR will be requested from the hospital before re-admission. 2. a. Any new admission has the	

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F 645	Continued From page 15 2. Resident #136 did not have a Level I PASARR completed prior to or upon admission to the facility. 3. For Resident # 133 the facility failed to ensure Resident #133 had PASARR Level I screening prior to or on admission to facility. 4. Resident #124 did not have a Level I PASARR completed prior to admission to the facility. 5. Resident # 155 did not have a Level I PASARR screening completed prior to admission. The findings included: 1. Resident #171 did not have a Level I PASARR completed prior to or upon admission to the facility Resident #171 was admitted to the facility on 01/09/15. His most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 08/28/18. Resident #171's diagnoses included hypertension, dementia, major depression, unspecified psychosis, and anxiety. Resident #171 required supervision of one person for bed mobility, transfers, ambulation, and eating; required limited assistance of one person for dressing, toileting, and hygiene; and required extensive assistance of one person for bathing. On 9/11/2018, Resident #171's record was reviewed. His diagnoses of mental illness was noted, and the survey team requested that his Pre-Admission Screening and Resident Review (PASARR) be provided. On 09/12/18 at 1:00 PM, Employee A, from the Business Office, informed	F 645	potential to be affected. 3. a. The Admissions department will request a PASARR form be completed on all new admissions. b. The PASARR form will be scanned into the residents medical record. 4. a. An audit of four new admission charts a month will be reviewed for three months for PASARR forms. b. Results of the audit will be brought to the QA committee for three months to determine if further action is needed.	

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F 645	Continued From page 16	F 645		

the survey team that the requested PASARRs could not be located.

The findings were presented to the Administrator and Director of Nursing at the end of day meeting on 9/12/2018. No further information was provided.

2. Resident #136 did not have a Level I PASARR completed prior to or upon admission to the facility.

Resident #136 was admitted to the facility on 09/01/2015. His most recent Minimum Data Set (MDS) Assessment was an Annual Assessment with an Assessment Reference Date (ARD) of 07/31/18. Resident #136's diagnoses included hypertension, hyperlipidemia, dementia, anxiety, and schizophrenia. Resident #136 required extensive assistance of two people for bed mobility and transfers; required extensive assistance of one person for dressing, eating, and toileting; and total assistance of one person for bathing and hygiene.

On 9/11/2018, Resident #136's record was reviewed. His diagnoses of mental illness was noted, and the survey team requested that his Pre-Admission Screening and Resident Review (PASARR) be provided. On 09/12/18 at 1:00 PM, Employee A, from the Business Office, informed the survey team that the requested PASARRs could not be located.

The findings were presented to the Administrator and Director of Nursing at the end of day meeting on 9/12/2018. No further information was provided.

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3. For Resident # 133 the facility failed to ensure Resident #133 had PASARR Level I screening prior to or on admission to facility.

Resident #133 a 75 year old male was admitted to the facility on 9/3/2015 with diagnoses of but not limited to Paranoid Schizophrenia, Major Depressive Disorder, Unspecified Psychosis, other symptoms and signs involving cognitive function. and BPH (Benign Prostatic Hypertrophy).

On 9/11/2018, a clinical record review was conducted and the PASARR Level I Screening was not found in the clinical record.

On 9/12/2018 at 11:00 AM, an interview was conducted with Employee A who stated that she did not have a PASARR Level 1 or II for Resident #133 because he was admitted prior to 2017 and is private pay. She further elaborated that she had been told by the Administrator that the facility didn't require a PASARR on all admissions until last year and up until last year private pay residents were not expected to have a PASARR screening done.

The administration was made aware of issue at end of day meeting on 9/12/2018 and no further information was provided.

4. Resident #124 did not have a Level I PASARR completed prior to admission to the facility.

Resident #124 was admitted to the facility on 6-7-17. Diagnoses for Resident #124 included

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but not limited to, Dementia, high blood pressure, anxiety and PTSD (post traumatic stress disorder). Resident #124's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 7-31-18 coded Resident #124 with a BIMS (brief interview of mental status) of "14" out of a possible 15, or no cognitive impairment. In addition, the Minimum Data Set coded Resident #124 as requiring standby to limited assistance with ADL's (activities of daily living such as eating and mobility). Resident #124 was also coded as receiving 7 days of antidepressant and antianxiety medications.

Review of the clinical record revealed the resident did not have a Level I PASARR on the clinical record.

On 09-12-18 at 12:07 PM, the Social Worker (SW) was asked for a copy of the resident's PASARR. The SW stated, "He does not have one, at the time we didn't have to do these." She went on to state that the VA (veteran's administration) did not do Level I PASARR.

On 9-12-18 at approximately 6:00 PM, the Administrator was notified of the above findings.

5. Resident # 155 did not have a Level I PASARR screening completed prior to admission.

Resident # 155 was admitted to the facility on 10/09/2015 and current diagnoses include unspecified dementia with behavioral disturbances, single episode of major depressive disorder, unspecified mood disorder, bipolar disorder, and unspecified insomnia.

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F 645	Continued From page 19 Resident # 155's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/14/2018 was coded as a quarterly review. Resident # 155 was coded with a Brief Interview of Mental Status score of "13" out of possible "15" indicative of no cognitive impairment. The MDS quarterly review also indicated Resident # 155 had received antipsychotic and antidepressant medications and there was no recent psychological therapy by a licensed mental health professional. Review of clinical record revealed there was no PASARR I or II screening documentation on the chart. The resident was being treated for bipolar disorder and depression. On 09/12/2018, the Administrator and DON were notified and they offered no further documentation.	F 645		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, and clinical record review the facility staff failed, for 1 resident (Resident #56) of the survey sample of	F 689	1. a. Resident #56 was immediately assessed at the time of the event. 2. a. All residents that receive hot liquids	10/24/18

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F 689	Continued From page 20 59 residents, to mitigate accident hazards to prevent burns. This resulted in harm. Resident #56 spilled hot coffee prepared by staff causing a second degree burn (harm). The facility failed to monitor hot liquid temperatures or assess the resident for hot liquid safety before and after the burn. The findings included: Resident #56 was admitted to the facility on 12-7-15. Diagnoses for Resident #56 included but not limited to, congestive heart failure and high blood pressure. Resident #56's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 7-3-18 coded Resident #56 with a BIMS (brief interview of mental status) of "15" out of a possible 15, or no cognitive impairment. In addition, the Minimum Data Set coded Resident #56 requiring standby to limited assistance with ADL's (activities of daily living such as eating and mobility). Resident #56 was also coded as having a second or third degree burn requiring ointment and dressings. There were no ROM (range of motion) issues documented on the MDS. On 9/11/18, the facility presented an "Investigation of Abnormal Skin Findings dated 7-3-18 occurring at 12:00 PM, documenting a burn to the left hip from spilling hot coffee. There was no investigation, follow up or interventions on this form documenting preventative measures for the resident. On 9/12/18 at 8:47 AM, Resident #56 was observed up to the dining room. The resident had eaten all of his breakfast. He was observed	F 689	have the potential to be affected. 3. a. Staff will be educated that liquids cannot be heated in a microwave. b. Staff will be educated that hot water for coffee, etc. is to come from the dispenser on the coffee machine or from the dietary department. c. Manufacturers instructions will be reviewed on recommended temperatures for the coffee and hot water from the machines. d. Coffee cups with lids will be ordered and available to residents for use. e. Dietary will follow regulation required temperatures for dispensing hot liquids (such as soups). f. Residents will be offered adaptive equipment as needed for hot liquids. 4. a. Temperatures will be taken weekly for three months, then monthly for the coffee and hot water that comes from the coffee dispenser in the craft room and on the Richmond Neighborhood. b. The facility will follow manufacturers instructions on temperatures. c. Discrepancies will be corrected immediately.	

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to be sleeping at the table and his oxygen was in place.

On 9/12/18 at 9:30 am, an interview with Resident #56 was conducted regarding burns received in July from spilling hot coffee. The resident stated that "A lady fixed hot water" for his instant coffee (stated all the residents at his table got the same type of coffee) that was "heated in the microwave." He went on to state that he took a sip by touching the coffee "with my lip and I started." He said that it was after that he had spilled the coffee on his left side, receiving a burn.

The nurse's notes for this date (7-3-18) revealed the resident had received 2 blisters from the burn. The resident stated "they are healed now." Treatment records showed the resident was treated with an antibiotic ointment and dressings.

On 9-12-18, Resident #56's care plan dated 7-3-18 under the category of alteration in skin integrity revealed the following: "Blisters left hip with treatment...receiving treatment to blister areas left hip secondary to coffee spill. No pain or other concerns." The care plan also addressed the resident is independent for eating with set up of tray.

On 9/12/18 at 12:49 PM, staff served coffee to resident in the dining room where Resident #56 resides; the temperature of the coffee was checked by dietary staff with the temperature being 139 degrees.

09/12/18 at 3:40 PM, an interview with the kitchen manager regarding hot liquids was conducted. The manager reported one resident had been

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burned by hot coffee. She stated on the unit where Resident #56 resides, residents can get their own coffee. She further stated the resident was changed to an adaptive cup, which he refuses to use. She added that the facility does not assess for safety with hot liquids.

Clinical record review revealed there were no assessments for safety with hot liquids. Review of the temperature logs revealed there are no temperatures for hot water/coffee.

On 9/12/18 at 3:55 PM, an observation in the craft room (area contained vending machines), showed there was a Bunn coffee/hot water dispenser that was located on the counter that could be accessed by residents. Cups were available at the dispenser. The temperature was checked by the kitchen manager of the coffee and hot water. The coffee was 165.5 degrees Fahrenheit, the hot water was 161.4 degrees.

On 9/12/18 at 4:00 PM, an observation in the BC (resident dining area) area, showed there was a hot water/coffee dispenser of the same type. The hot water temperature was 156.9 degrees and the coffee was 165.2 degrees. This dispenser could also be accessed by residents.

The Burn Foundation gives the following information on burns: "Coffee, tea, soup and hot tap water can be hot enough to cause serious burn injury:

Hot Water Causes Third Degree Burns ...
...in 1 second at 156º
...in 2 seconds at 149º
...in 5 seconds at 140º
...in 15 seconds at 133º. "

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F 689	Continued From page 23 Merriam-Webster describes a second degree as: "a burn marked by pain, blistering, and superficial destruction of dermis with edema and hyperemia of the tissues beneath the burn." On 9/12/18 at 4:05 PM, an interview with the facility Administrator was conducted. She stated all she knew was that the resident had spilled coffee on himself, and that she had not here during this time, being out on sick leave. She stated the only interventions put in place after the burn was the adaptive cup, but that he refused it. The Administrator showed a QA (quality assurance) document on the computer that she "could not print out " which did not address cause or etiology of the burn except he had spilled hot coffee. There was no follow up with monitoring hot liquid temperatures or education of the staff to prevent further burns. On 9-12-18 at 6:25 PM, the Administrator was notified of harm level deficiency.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		10/24/18

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F 690	Continued From page 24 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review the facility failed to maintain a catheter in a manner to prevent the spread of infection for 1 resident (Resident #107) of 59 residents in the survey sample. Resident #107's catheter bag was observed on the floor on two occasions. The findings included: Resident #107, an 86 year old, was admitted to the facility on 1/24/18. Diagnoses included benign prostatic hyperplasia, hyperlipidemia,	F 690	1. a. The privacy bag was re-adjusted for resident #107. 2. a. All residents with catheter bags have the potential to be affected. 3. a. Nursing staff will be educated that catheter bags are to be in a privacy bag off the floor. If the bag reaches the floor, adjustments to the placement of the privacy bag need to be made. c. Random rounds will be made by nursing administration on residents with catheters to observe for use of privacy bags and infection control practices with	

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F 690	Continued From page 25 atrial fibrillation, and hernia. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 7/24/18. The resident was coded with a Brief Interview of Mental Status score of 11 indicating moderate cognitive impairment and required extensive assistance with activities of daily living. Resident #107 had a physician order dated 4/26/18 for a Foley catheter. On 9/11/18 at 11:35 a.m., Resident #107 was seated in a wheelchair in his room. The catheter bag was hanging from the bottom of the seat. The catheter bag was in a privacy bag. The bottom 1/4 of the bag was laying on floor. On 9/12/18 at 11:17 a.m., Resident #107 was seated in a wheelchair in his room. The catheter bag was hanging from the bottom of the seat. The catheter bag was in a privacy bag. The bottom 1/4 of the bag was laying on floor. On 9/12/18 at 3:33 p.m. the Director Of Nursing (DON) and Administrator were notified that the catheter bag was observed on the floor on two occasions. The DON was asked how the catheter bag should be maintained. She stated the catheter bag should be in a privacy bag off of the floor. The facility policy titled "Foley Catheter Use" was reviewed. Step 4 of the procedure read, "4. Care will be provided to prevent infections to the extent possible." Potter and Perry. (2005). Fundamentals of	F 690	the catheter. Discrepancies will be corrected immediately and education provided as needed. 4. a. Eight residents a month will be observed by the QA nurse / designee for three months for the use of privacy bags being off the floor. Discrepancies will be corrected immediately and education provided as needed.	

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F 690	Continued From page 26 Nursing (pp 1348). 6th edition., provided the following guidance on maintaining a closed drainage system for catheterization, "After inserting an indwelling catheter, the nurse maintains a closed urinary drainage system to minimize the risk of infection. Urinary drainage bags are plastic and can hold about 1000 to 1500 ml (milliliter) of urine. The bag should hang on the bed frame or wheelchair without touching the floor."	F 690		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755		10/24/18

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F 755	Continued From page 27 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed for 1 resident (Resident #64) of 59 residents in the survey sample to ensure safekeeping of hard scripts for controlled medications. For Resident #64, the facility staff failed to send a hard copy script dated 7/12/17 for Tramadol (narcotic pain medication) 50 milligrams 1 tab three times per day to the Pharmacy. The findings included: Resident #64, an 83 year old, was admitted to the facility on 7/12/17. Diagnoses included atrial fibrillation, hypertension, hyperlipidemia, pulmonary disease, reflux, anemia, vascular disease, and pain. The most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 7/3/18. The resident was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required extensive assistance with activities of daily living. Resident #64's paper portion of the clinical record was reviewed. Included in the record was the hard script for Tramadol 50 milligrams 1 tab three times per day. This script did not appear to have	F 755	1. a. The hard scripts for resident #64 were taken to the Pharmacy for destruction. 2. a. All residents have the potential to be affected. 3. a. Nursing staff will be educated on what to do with hard scripts that come with a resident from the hospital or outside appointment (ie: verify order with attending MD for use of the prescribed medication, and then script is to be taken to the pharmacy or placed in the pharmacy bin). b. All resident charts will be reviewed to ensure there are no hard scripts on the medical record. 4. a. Charts will be reviewed by the Unit Manager/designee during monthly order review for hard scripts on the medical record. b. Discrepancies will be corrected immediately.	

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F 755	Continued From page 28 been voided. This order was not an order listed on Resident #64's current physician order sheet. On 9/12/18 around 1:30 p.m., the Director of Nursing (DON) was asked if she could tell by looking at the script if it had been filled by the pharmacy. She stated no. The DON was asked to determine if the script had been filled by the pharmacy. On 9/12/18 at 3:15 p.m., during the end of day meeting with the DON and Administrator, the DON stated that the script had been filled by the pharmacy. When asked what the staff were supposed to do with a script after they had sent the order to the pharmacy, the DON stated that the hard script should be voided out either by drawing a line through the script or writing VOID across the script. She stated that the script then needed to be sent to the pharmacy to be shredded. The facility policy titled "Physician Orders" was provided. The policy did not address the procedure for securing hard scripts for controlled medications.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		10/24/18

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F 761	Continued From page 29 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility document review, facility failed to ensure proper labeling of opened insulin vials. The findings include: On 09/11/18 at 02:32 PM, a medication cart on the Bayside unit was inspected. The inspection showed a open vial of Humalog with no open date. At that time an interview was conducted with LPN A. LPN A stated that the Humalog was for a resident that just arrived. LPN A stated that the Humalog was opened but had no open date. On 09/11/18 at 02:55 PM, a medication cart on the Shenandoah unit was inspected. The inspection showed an open vial of Lantus with no open date.	F 761	1. a. The unlabeled insulin vials were discarded. 2. a. Residents that require insulin have the potential to be affected. 3. a. Nursing staff will be educated on labeling insulin vials when opened. b. Pharmacy will do random cart audits monthly for observance of labeling. Discrepancies will be corrected immediately and education provided as needed. 4. a. Four medication carts a month will be checked / audited by Nursing Administration for three months for labeled insulin. Discrepancies will be corrected and education provided as	

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F 761	Continued From page 30 The facility staff was made aware of the concern during a briefing on 9/12/2018.	F 761	needed. b. Results of the audit will be brought to QA for three months to determine if further action is needed.	
F 804 SS=G	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 observation, resident interview, staff interview, facility documentation review, and clinical record review the facility staff failed, for one Resident, (Resident #56) of the survey sample of 59 residents, to ensure that hot liquids were served at a safe temperature, resulting in a second degree burn (harm). Resident #56 spilled hot coffee prepared by staff causing a second degree burn (harm). The facility failed to monitor hot liquid temperatures. The findings included: Resident #56 was admitted to the facility on 12-7-15. Diagnoses for Resident #56 included but not limited to, congestive heart failure and high blood pressure. Resident #56's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 7-3-18 coded	F 804	1. a. Resident #56 was immediately assessed at the time of the event. 2. a. All residents that receive hot liquids have the potential to be affected. 3. a. Staff will be educated that liquids cannot be heated in a microwave. b. Staff will be educated that hot water for coffee, etc. is to come from the dispenser on the coffee machine or from the dietary department. c. Manufacturers instructions will be reviewed on recommended temperatures for the coffee and hot water from the machines. d. Coffee cups with lids will be ordered and available to residents for use. e. Dietary will follow regulation required temperatures for dispensing hot liquids	10/24/18

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F 804	Continued From page 31 Resident #56 with a BIMS (brief interview of mental status) of "15" out of a possible 15, or no cognitive impairment. In addition, the Minimum Data Set coded Resident #56 requiring standby to limited assistance with ADL's (activities of daily living such as eating and mobility). Resident #56 was also coded as having a second or third degree burn requiring ointment and dressings. There were no ROM (range of motion) issues documented on the MDS. On 9/11/18, the facility presented an "Investigation of Abnormal Skin Findings dated 7-3-18 occurring at 12:00 PM, documenting a burn to the left hip from spilling hot coffee. There was no investigation, follow up or interventions on this form documenting preventative measures for the resident. On 9/12/18 at 8:47 AM, Resident #56 was observed up to the dining room. The resident had eaten all of his breakfast. He was observed to be sleeping at the table and his oxygen was in place. On 9/12/18 at 9:30 am, an interview with Resident #56 was conducted regarding burns received in July from spilling hot coffee. The resident stated that "A lady fixed hot water" for his instant coffee (stated all the residents at his table got the same type of coffee) that was "heated in the microwave." He went on to state that he took a sip by touching the coffee "with my lip and I started." He said that it was after that he had spilled the coffee on his left side, receiving a burn. The nurse's notes for this date (7-3-18) revealed the resident had received 2 blisters from the burn.	F 804	(such as soups). f. Residents will be offered adaptive equipment as needed for hot liquids. 4. a. Temperatures will be taken weekly for three months, then monthly for the coffee and hot water that comes from the coffee dispenser in the craft room and on the Richmond Neighborhood. b. The facility will follow manufacturers instructions on temperatures. c. Discrepancies will be corrected immediately.	

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F 804	Continued From page 32	F 804		

The resident stated "they are healed now." Treatment records showed the resident was treated with an antibiotic ointment and dressings.

On 9-12-18, Resident #56's care plan dated 7-3-18 under the category of alteration in skin integrity revealed the following: "Blisters left hip with treatment...receiving treatment to blister areas left hip secondary to coffee spill. No pain or other concerns." The care plan also addressed the resident is independent for eating with set up of tray.

On 9/12/18 at 12:49 PM, staff served coffee to resident in the dining room where Resident #56 resides; the temperature of the coffee was checked by dietary staff with the temperature being 139 degrees.

09/12/18 at 3:40 PM, an interview with the kitchen manager regarding hot liquids was conducted. The manager reported one resident had been burned by hot coffee. She stated on the unit where Resident #56 resides, residents can get their own coffee. She further stated the resident was changed to an adaptive cup, which he refuses to use. She added that the facility does not assess for safety with hot liquids.

Clinical record review revealed there were no assessments for safety with hot liquids. Review of the temperature logs revealed there are no temperatures for hot water/coffee.

On 9/12/18 at 3:55 PM, an observation in the craft room (area contained vending machines), showed there was a Bunn coffee/hot water dispenser that was located on the counter that could be accessed by residents. Cups were

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F 804	Continued From page 33	F 804		

available at the dispenser. The temperature was checked by the kitchen manager of the coffee and hot water. The coffee was 165.5 degrees Fahrenheit, the hot water was 161.4 degrees.

On 9/12/18 at 4:00 PM, an observation in the BC (resident dining area) area, showed there was a hot water/coffee dispenser of the same type. The hot water temperature was 156.9 degrees and the coffee was 165.2 degrees. This dispenser could also be accessed by residents.

The Burn Foundation gives the following information on burns: "Coffee, tea, soup and hot tap water can be hot enough to cause serious burn injury:

Hot Water Causes Third Degree Burns ...
...in 1 second at 156º
...in 2 seconds at 149º
...in 5 seconds at 140º
...in 15 seconds at 133º. "

Merriam-Webster describes a second degree as: "a burn marked by pain, blistering, and superficial destruction of dermis with edema and hyperemia of the tissues beneath the burn."

On 9/12/18 at 4:05 PM, an interview with the facility Administrator was conducted. She stated all she knew was that the resident had spilled coffee on himself, and that she had not here during this time, being out on sick leave. She stated the only interventions put in place after the burn was the adaptive cup, but that he refused it. The Administrator showed a QA (quality assurance) document on the computer that she "could not print out " which did not address cause or etiology of the burn except he had spilled hot

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F 804	Continued From page 34 coffee. There was no follow up with monitoring hot liquid temperatures or education of the staff to prevent further burns. On 9-12-18 at 6:25 PM, the Administrator was notified of harm level deficiency.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, the facility staff failed to serve food in accordance with professional standards for food safety. Dietary staff in the main kitchen and Richmond Unit were observed to use hand sanitizer as a substitution for hand washing during meal service.	F 812	1. a. Hand sanitizer dispensers were removed from the main kitchen and the Richmond kitchen areas. 2. a. All residents have the potential to be affected. 3. a. Dietary staff will be educated on	10/24/18

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F 812	Continued From page 35 The findings included: An initial tour of the main kitchen was conducted on 9/11/18 at 10:50 a.m. with the Dietary Manager. During the tour, multiple dispensers of hand sanitizer were observed affixed to the walls of the kitchen. On 9/12/18 at 8:10 a.m., breakfast service was observed on the Richmond Unit. Dietary Aide A was working in the kitchen located on the BC hall. There was a hand sanitizer dispenser affixed to the wall in the kitchen. At 8:20 a.m., Dietary Aide A used the hand sanitizer instead of washing her hands while preparing the breakfast trays. A sink was located outside of the kitchen area. Dietary Aide A was observed to wash her hands at the sink earlier in the observation after using the phone which was also located outside of the kitchen. The sink in the kitchen was unusable as it contained three full pan lids. On 9/12/18 at 11:55 a.m., Dietary Aide B was observed to prepare to serve the lunch meal from the steam table in the main kitchen. She was observed to use hand sanitizer instead of washing her hands before serving the meal. On 9/12/18 at 3:55 p.m., it was reviewed with the Dietary Manager that using hand sanitizer as a replacement for handwashing in the food service setting was not allowable. She was notified that the federal regulation was updated in November 2017.	F 812	hand washing during meal service. b. Dietary staff will be educated that hand sanitizer is not a substitute for hand washing. c. The Dietary manager / designee will randomly make rounds during meal service observing for proper hand washing. 4. a. The Dietitian / designee will randomly observe staff weekly for three months observing for proper hand washing. Discrepancies will be corrected immediately and education provided as needed.	