STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495260	A. BUILDING _____ B. WING _____	C 02/14/2019

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 2/12/19 through 2/14/19. 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 02/12/19 through 02/14/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Five complaints were investigated during the survey. The census in this 120 certified bed facility was 110 at the time of the survey. The survey sample consisted of 38 resident reviews.	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		3/25/19

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

Electronically Signed | 03/05/2019

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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 observation, staff interview and clinical record review, the facility staff failed to ensure a dignified experience for one resident (Resident # 308) in a survey sample of 38 residents. For Resident # 308, the facility staff was observed standing while feeding breakfast. Findings included: Resident #308, a 71 year old, was admitted to the facility on 2/2/19 for skilled nursing services.	F 550	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be	

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F 550	Continued From page 2 Diagnoses included but were not limited to: Epilepsy, dysphasia, hypertension, benign prostatic hyperplasia, Type 2 Diabetes. There was no Minimum Data Set assessment because it was too soon. In the admission assessment, Resident # 308 was assessed as having cognitive impairment and required assistance with activities of daily living to include eating. Resident # 308's physician orders signed 5/30/18 were reviewed. Included was an order dated 1/18/18 "1:1 assist with meals." On 2/13/19 at 8:41 a.m., Resident #308 was observed in his room during the breakfast meal. The breakfast meal tray was on the over bed table positioned over Resident #308's wheelchair. There was a Certified Nursing Assistant (CNA C) standing beside the bed and feeding Resident # 308. On 2/13/19 at 8:51 a.m., observed CNA C removing the tray from Resident # 308's room. On 2/13/19 at 8:59 a.m., an interview was conducted with CNA C who stated she was familiar with Resident # 308 and that he required assistance with eating his meals. CNA C stated she did remember standing while feeding Resident # 308. CNA C stated had been a CNA for 10 years but did not realize that she should not stand while feeding residents. On 2/13/2019 at 9:06 a.m., an interview was conducted with Unit Manager, Licensed Practical Nurse (LPN) A who stated Certified Nursing Assistants and any staff should be seated when feeding residents. LPN A stated Resident # 308 required assistance with his meals. LPN A stated	F 550	completed by the dates indicated. F 550 RESIDENT RIGHTS /EXERCISE OF RIGHTS 1. Resident # 308 is now being fed with dignity. Employee responsible is no longer employed at center . 2. All residents requiring assistance with feeding are at risk for deficient practice 3. SDC or Designee will educate all CNA staff on appropriate methods of feeding while maintaining dignity including being seated when feeding patients. 4. 100% review of patients requiring assistance with feeding completed , 30% of patients will be reviewed weekly times 2 , then monthly times 2 then reviewed quarterly in QAPI committee	

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F 550	Continued From page 3 she would educate the CNA C about the need to be seated while feeding residents. At the end of day meeting on 2/14/19, the Administrator and Corporate Nurse were notified of the feeding assistance issue. The Administrator and Corporate Nurse stated staff members should be seated when feeding residents. No further information was provided.	F 550		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on facility staff interview, clinical record review, and facility documentation review, the facility staff failed for Resident #406 in a survey	F 552	F 552 Right to be informed / Make treatment decisions 1. Resident # 406 is no longer a patient	3/25/19

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F 552	Continued From page 4 sample of 38 residents, to ensure the right to be informed of transportation arrangements. Resident #406's transportation to a medical office was not clarified to allow the responsible party (RP) to go with the resident. The findings included: Resident #406 was a resident of the facility but had no MDS (minimum data set-an assessment protocol) on the record. Review of the nurse's notes dated 11-15-17 revealed the resident had returned from the medical appointment on 11-15-17. There was no note as to the transfer time, date or how transferred in the medical record. On 2-13-19 at 3:45 PM, an interview was conducted with the discharge planner as the DON (director of nursing) or the unit manager named in the complaint no longer worked in the facility. The discharge planner remembered the event as she had talked with the unit manager when it happened. She stated that there was confusion as to whether the daughter was going to transport the resident; when the family arrived that morning, the resident had already been transported to the medical visit. On 2-14-19 at approximately 4:00 PM, the Administrator and Regional nurse consultant were informed of above findings.	F 552	in center . MD has been made aware of transfer issues 2. All Patients who are not their own responsible party requiring appointments outside of center are at risk for deficient practice 3. SDC or designee will educate licensed staff and scheduler on need to clarify and document transport arrangements with responsible parties when required . 4. 30% of resident requiring transport to appointments will be monitored weekly times 2 weeks , monthly times 2 months them quarterly in QAPI committee	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		3/25/19

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F 578	Continued From page 5 §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the	F 578		

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F 578	Continued From page 6 appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to ensure her wishes for advance directives were recorded accurately for one resident (Resident #156) in a survey sample of 38 residents. Resident #156's advanced directives were not located on the electronic record or in the nurse's code book at the nurse's station. The findings included: Resident #156 was a resident of the facility. On 2-13-19 at 11:07 AM a review of the electronic clinical record revealed no orders for advanced directives. The NP (nurse practitioner) notes documented a no code status. Review of the care plan dated 2-5-19 documented "Hospice orders for end of life care." On 2-14-19 at approximately 3:00 PM, the Corporate Nurse Consultant stated the nurse's use a book at the nurse's station to determine the resident's code status. On 2-14-19 at 3:31 PM An interview was conducted with LPN (licensed practical nurse- C), LPN C was asked how they determine someone's code status. LPN C stated, "We look in the code book." However, the resident's code status was not listed in the book. On 2-14-19 at approximately 4:00 PM, the Administrator and Regional nurse consultant	F 578	F 578 Right to request /refuse/discontinue Advance directives 1. Resident #156 . DNR order has since been corrected. MD and responsible party have been made aware . 2. All patients with Advance directives are at risk for deficient practice 3. SDC or Designee will educate all licensed staff on the need to review medical records for advance directives including reviewing with patient /family when needed. An appropriate order will be entered into computer with hard copy of DDNR made available at nurses station. 4. 100% audit of all patients has been completed to ensure accuracy of advance directive, with order and hard copy available . 30% pt will completed weekly times 2 weeks , monthly times 2 monthly and reviewed and followed quarterly in QAPI committee	

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F 578	Continued From page 7 were informed of above findings.	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced	F 583		3/25/19

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F 583	Continued From page 8 by: Based on observation and resident and staff interview, the facility failed to ensure visual privacy for one resident, Resident #155, in a survey sample of 38 residents. Resident #155 was exposed during her bed bath. The findings included: Resident #155 was admitted to the facility on 1-25-19. An MDS (minimum data set-an assessment protocol) had not been completed due to recent admission. The resident was alert and oriented to all spheres, she was noted to have contractures of all extremities, had a flat call alarm. The resident stated she had to have total care for her bath. During the initial interview, the resident voiced concerns her "nether regions" were not being cleaned sufficiently, especially around the catheter. On 2-13-19 at 9:25 AM, Resident #155's bathing was observed. The resident gown was removed, placed at the far end of the bed and during the entire bath, the resident was uncovered completely. There were four individuals in the room including two CNA's (certified nursing assistant), a Registered Nurse and this surveyor. On 2-13-19 at approximately 10:00 AM, the resident was questioned about her bath. She stated, "I was completely uncovered, and it made me uncomfortable. There were a lot of people in the room." On 2-13-19 at 10:35 AM: An interview with the CNA (certified nursing assistant- C) was conducted. The CNA stated, "Should have used	F 583	F583 Personal privacy /Confidentiality of records 1. Patient #155 Has been made aware of her right to privacy during ADL bathing and care . MD and Responsible party have been made aware of deficient practice 2. All resident requiring assistance in bathing are at risk for deficient practice. 3. SDC or Designee Will educate all staff in resident dignity and privacy related to bathing 4. 30% of patients will be reviewed for dignity and privacy weekly times 2 weeks , monthly times 2 months and followed quarterly in QAPI committee	

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F 583	Continued From page 9 a bath blanket to cover her." On 2-14-19 at approximately 4:00 PM, the Administrator and Regional nurse consultant were informed of above findings.	F 583		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		3/25/19

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F 656	Continued From page 10 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to develop and implement a comprehensive person centered care plan for two Residents (Residents #93, and Resident #94, in a survey sample of 38 residents. 1. Resident #93 did not have a comprehensive care plan for activities and assistance with eating. 2. For Resident #94, the facility staff failed to develop an accurate, resident-centered care plan by including a leg brace intervention that was not ordered by the physician or recommended by occupational therapy. The findings included: 1. Resident #93 did not have a comprehensive care plan for activities and assistance with eating. Resident #93 was admitted to the facility on 10-30-17. Diagnoses include dementia, chronic back pain requiring opioids, congestive heart failure and COPD (chronic obstructive pulmonary disease).	F 656	F 656 Development / Implement of comprehensive care plan 1. a. Patient # 93, Care plan has been revised to indicate assistance with activities and eating assistance. MDS activity coding has been reviewed and revised and activity assessment including goals revised by Activity director. 1.b. Patient # 94 leg brace has since been discontinued by Medical director. Responsible party has been made aware. Wedge pillow has been applied per directions from MD. Responsible party made aware. 2. All patients requiring specialized equipment/positioning devices care related to ADLs including activities and eating are at risk for deficient practice. 3. SDC or designee will educate: a. All Licensed staff on review of care plan related to ADL care/Assistance b. Activity Director will be educated related to updating care plan to ensure optimal level of stimulation based on resident preference. c. Licensed staff will be educated in review of care plans to	

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F 656	Continued From page 11 Resident # 93's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 1-25-19. Resident #93 did not have a Brief Interview of Mental Status (BIMS) score recorded but cognitive skills for daily decision-making were coded as moderately impaired. Resident #93 required extensive to total assistance of all ADL's (activities of daily living such as bed mobility) except for eating, in which she required supervision of one staff member. Activity preferences were not coded. On 2-12-19 at approximately 10:00 AM, Resident #93 was observed asleep in bed in supine position with the resident's TV off. There were no passive activities such as books on tape or music. On 2-12-19 at 4:00 PM, the resident remained in bed with no TV or other stimulation. On 2-13-19 at approximately 10:00 AM, Resident #93 was observed in bed. No activities were observed. On 2-14-19 at approximately 3:00 PM, the resident was observed in bed with no in room activities observed. The care plan dated 1-28-19 was reviewed. For activities, the care plan included: "Support self directed, independent leisure pursuits and activities." The goal was stated as, "Attain or maintain the highest practical well being actively engaged in 1:1 room activities once per week."	F 656	ensure appropriate equipment is utilized on patients as ordered by MD to include active MD order. d. All CNA staff will be educated in use of care plans to ensure appropriate equipment is in use for patient and recorded appropriately in ADL documentation system. 4. 100% audit of resident requiring assistance to eat completed and all residents have had an Activity Assessment and appropriate interventions completed.30% of patients that will require assistance with feeding and activity assessments completed ,then will be audited for accuracy weekly times 2, monthly times 2 then followed quarterly in QAPI committee.	

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F 656	Continued From page 12	F 656		

Interventions were: "Honor patient's preferences of leisure activities and support patient's preference to spend time alone and introspectively."

There had been no changes in activity goals or interventions since 5-18-18.

Review of the resident's activities preferences dated 1-18-18 revealed: "Resident engages in independent leisure 4-5 times per week.. prefers room setting. Resident enjoys watching TV, reading magazines/newspapers, and receiving family visits."

On 2-14-19 at 3:22 PM: The Activities Director was interviewed about Resident #93's activities. She stated, "There is no documentation of my 1:1 visits. She has been kind of hard to do."

On 2-14-19 at 4:00 PM, the Administrator and Corporate Nurse Consultant was notified of above findings.

2. For Resident #94, the facility staff failed to develop an accurate, resident-centered care plan by including a leg brace intervention that was not ordered by the physician or recommended by occupational therapy.

Resident #94, a 96-year old female, was initially admitted to the facility on 06/23/2016. Diagnoses include but not limited to dementia, debility, depression, and anxiety.

Resident #94's most recent Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 12/27/2018 and was coded as an annual assessment. Resident #94 was not coded

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for a Brief Interview of Mental Status (BIMS) but cognitive skills for daily decision-making were coded as severely impaired. Functional status for dressing and personal hygiene was coded as requiring extensive assistance from staff. Functional limitation in range of motion in lower extremities was coded as impaired on both sides.

The care plan was reviewed. A focus created on 06/23/2017 documented, "The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) dementia." An intervention revised on 10/24/18 documented, "WHEELCHAIR - to promote independence and locomotion/mobility throughout the facility
DYCEM-non Slip and non skid device for w/c, to assist with proper body alignment
Reacher to assist in reaching items in room.
Foot Stop Drop-positioning of foot
Leg Brace- contracture of leg
Abduction Wedge-to aid in prevention of contracture of leg"

On 02/14/19, the active physician's orders were reviewed. There was not an order for a leg brace.

On 02/12/19 at 01:24 PM, Resident #94 was observed in her room, seated on a chair saddle in her wheelchair. Resident #94 was fully dressed and had socks on both feet. Right knee was flexed and right foot was resting on soft stop that was attached to the legs of the wheelchair. There was not a wedge pillow between Resident #94's ankles.

On 02/13/19 at 08:44 AM, Resident #94 was observed in her room, seated on a chair saddle in her wheelchair. Resident #94 was fully dressed and had socks on both feet. Right knee was

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flexed and right foot was resting on soft stop that was attached to the legs of the wheelchair. There was not a wedge pillow between Resident #94's ankles.

On 02/13/19 at 11:24 AM, Resident #94's daughter was visiting with her. When asked if she had any concerns about the care her mother was receiving, she showed a picture that was hanging on her mother's closet door. It was a photograph of Resident #94 seated in her wheelchair with a stop drop on the wheelchair leg rests and a wedge pillow between Resident #94's ankles. The daughter stated this was how her mother should be positioned with the wedge pillow in the wheelchair and stated that "one aide said it's supposed to be done daily but some don't do it." At that time LPN E entered Resident #94's room. When asked about wheelchair positioning for Resident #94, she stated she wasn't sure and added, "the aides usually do it."

On 02/13/19 at 1:32 PM, certified nursing assistant (CNA) E was interviewed. When asked about how she knows how to position Resident #94 in the wheelchair, she stated she looks at the kardex (care plan). When asked about the picture in Resident #94's closet, she stated did not know about it.

On 02/13/19 at 01:55 PM, Resident #94 was observed in her room, seated on a chair saddle in her wheelchair. Resident #94 had a brace on her right leg from mid-thigh to ankle. There was not a wedge pillow between Resident #94's ankles.

On 02/13/19 at 3:05 PM, an interview with occupational therapist, Employee M, was conducted. When asked if a leg brace was

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F 656	Continued From page 15 recommended for Resident #94, she stated, "No, we trialed it but she (Resident #94) couldn't tolerate it." On 02/14/19 at 8:45 AM, an interview with licensed practical nurse (LPN) D was conducted. When asked about the importance of a wedge pillow for Resident #94, she stated it prevents further contractures and also prevents skin breakdown. On 02/14/19 at 12:10 PM, the Regional DON stated it is not expected that nursing would initiate a leg brace. The Administrator added that the expectation is that it would be recommended by occupational therapy after evaluation. The occupational therapy (OT) discharge (DC) notes were reviewed. OT discharge recommendations dated 10/15/18 at 5:36 PM documented, "DC OT services. Pt issued following w/c (wheelchair) devices for 6hour+ tolerance 18X16 inch w/c Wedge cushion with pummel Neoprene stop drop on standard leg rests Adductor (sic) wedge pillow between ankles." On 02/14/19 at approximately 4:00 PM, the Administrator and DON were notified of findings and offered no further information or documentation.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		3/25/19

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F 677	Continued From page 16 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, facility staff failed to provide Activity of Daily Living (ADL) assistance for 1 resident (Resident # 304) in a survey sample of 38 residents. For Resident #304, facility staff failed to provide morning care to include oral care prior to serving breakfast. The finding included: Review of the clinical record was conducted on 2/12/2019. Resident # 304, an 85 year old, was admitted to the facility on 2/5/19 for skilled services related to a right femur fracture. Diagnoses included Atrial Fibrillation, Hypertension, Coronary Artery Disease, History of Crohn's Disease, Irritable Bowel Syndrome and debility/weakness. There was no Minimum Data Set assessment done as it was not due at the time of survey. Review of the Admission Nursing Assessment revealed Resident #304 was coded as having no cognitive impairment and required extensive assistance of one person assistance with activities of daily living to include eating. On 2/12/19 at 8:10 AM during the initial tour, Resident # 304 was observed lying in bed. When asked if he had eaten breakfast, Resident # 304 stated the nursing staff do not get him prepared for his day. Resident # 304 said, the staff do not wash his hands, get his dentures and	F 677	F 677 ADL Care provided for dependent residents 1. Resident #304 has been receiving morning care prior to receiving breakfast to include ensuring dentures are in place face and hands washed. He has been attending breakfast in the dining room per his request. Resident #64 has been discharged from the center. 2. All residents unable to get out of bed to go to Dining Room for meals , nor independent with dentures and care prior to meals are at risk for deficient practice. 3. SDC or designee will educate all Licensed and CNA staff on requirement to assist residents who are limited in providing self ADL care related to meals and getting to dining areas, in timely to prevent food being cold. Education will be completed with Licensed, CNA and dietary staff by Dietary manager or designee related to food temperatures and alternate menu service per patient choice, including food to be offered to patients at same time if in semi private rooms. 4.a. 100% of patients have been audited requiring ADL care including help with dentures and desires to eat in dining area prior to meal times. 30% of patients will be reviewed weekly times 2 weeks, monthly times 2 months then followed in QAPI program. 4 b. 30% of meals will be audited for appropriate temperature for palatability weekly times 2 weeks, monthly times 2 months and followed quarterly in QAPI	

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F 677	Continued From page 17 get him ready to eat breakfast. Resident # 304 stated he liked to eat early and would rather eat in the dining room since the food was hot there but the staff was always short so he could not get up in time to go to the dining room. Resident # 304 stated he could wash his own dentures and wash his face and hands but he was unable to get out of bed without assistance of staff members due to a fractured femur. On 2/12/19 at 8:46 AM, the surveyor observed the staff serve a breakfast tray to the roommate of Resident # 304 (Resident # 64). The roommate (Resident # 64) began eating immediately and stated his food was okay but it was cold. He also stated "If you want a hot breakfast, you have to go to the dining room." On 02/12/19 at 08:54 AM an interview was conducted with Resident # 304 who stated the staff do not serve meals on time sometimes. Resident # 304 stated the facility often was short of help. Resident # 304 stated that one day, he "did not get dinner until 6:30 PM. The breaded shrimp was cold and had been sitting out for a couple of hours." Resident # 304 stated he "did not want to eat it (the shrimp) because it is not safe to eat food that's been sitting out for a couple of hours." On 2/12/19 at 8:55 AM this surveyor observed a breakfast tray delivered by nurse, LPN (Licensed Practical Nurse) B, after administering medications to Resident # 304. Resident # 304 told LPN B he could not eat yet because he did not have his dentures in yet. Resident # 304's dentures were observed to be in a pink case sitting on the top of the closet located across from the foot of Resident # 304's bed. Resident # 304	F 677	committee.	

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instructed the LPN B to rinse the dentures and return the cup with a small amount of water in the bottom of the cup. Resident # 304 asked LPN B to get his denture liner out of the top drawer of the closet after she returned with the dentures in the cup with small amount of water in cup.

On 2/12/19 at 8:57 AM, the dentures were given to resident by LPN B. Resident # 304 said "See that's what I mean, they gave me a tray but how am I supposed to eat it without my dentures? And they haven't even helped me wash my face and hands." Resident # 304 stated he was thankful that the nurse (LPN B) gave him a tray but the nurse was busy passing medications. Resident # 304 stated "they must be working short again." Resident # 304 stated he could do everything for himself once the staff gave him his supplies. Resident # 304 stated this was a constant problem. "How do they think I can eat without my dentures?" He also asked "Don't they know I should have my hands and face washed too?"

On 2/13/19 at 8:27 AM, the surveyor observed that Resident # 304's breakfast tray was placed on the overbed table by the Dietary Manager. Resident # 304 was sitting up in his bed. The surveyor asked if he was ready for breakfast. Resident # 304 stated he had not had morning care to wash his hands and did not have his dentures in yet. Resident # 304 stated he would have to wait until the staff got to him. "They must be working short again. This is always a problem."

On 2/13/9 at 8:34 AM, observed the nurse (LPN B) enter Resident # 304's room to pass his medications. At 8:35 AM, LPN B was observed cleaning Resident # 304's dentures and retrieving

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the denture liners from the top drawer in the closet across from the foot of the bed. At 8:42 AM, this surveyor observed Resident # 304 putting the denture liner in and inserting his dentures. At 8:50 AM, Resident # 304 was observed eating his breakfast of pancakes and strawberries. Resident # 304 stated the food was cold but he "had to eat something." Also stated he was given oatmeal and milk but he did "not like oatmeal or milk." Resident # 304 stated he hated to ask for more food but he would have enjoyed the pancakes better if they had been hot.

2/13/19 at 9:05 AM, an interview was conducted with the Unit Manager (LPN A) who stated residents should have hot meals. LPN A walked with the surveyor to Resident # 304's room. Resident # 304 had consumed about half of the pancakes and strawberries. Resident # 304 told LPN A to feel his plate because it was cold to touch. LPN A felt the plate and stated it did feel cool. Resident # 304 told LPN A that he would be okay without more pancakes since he did have something in his stomach and he would be satisfied with a hot cup of coffee. LPN A offered again to get a hot breakfast for him. Resident # 304 declined the meal but again stated he would like a cup of hot coffee.

LPN A stated the facility staff should assist residents with their morning care routines to include washing their faces and hands and mouth care and inserting dentures.

At the end of day meeting on 2/14/19, the Administrator and Corporate Nurse were notified of the failure of the staff to assist Resident # 304 with his ADL's prior to breakfast. They were also informed that Resident # 304 and his roommate

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F 677	Continued From page 20 (Resident # 64) were served their trays at different times during both days of observation. Both stated residents should receive ADL care to include mouth care prior to breakfast being served so the residents can eat. No further information was provided.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record reviews, and facility documentation, the facility failed to assess and provide on-going resident-centered activities for one Resident (Resident #93) out of a sample of 38 residents. Resident #93 was observed to be in his room for 3 days without getting out of bed and with no meaningful activities provided. The findings included: Resident #93 was admitted to the facility on 10-30-17. Diagnoses include dementia, chronic	F 679	F 679 Activity Meet Interest /Needs each resident 1.Resident #93, Activity care plan, assessment, participation, intervention and implementation have since been updated and revised to provide highest level of wellbeing. 2. All residents confined to bed per preference or necessity are at risk for deficient practice. 3. SDC or designee will educate: Activity staff need to provide accurate/current activity assessment, participation, interventions and implementation that are the matching care plan in order to provide	3/25/19

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F 679	Continued From page 21 back pain requiring opioids, congestive heart failure and COPD (chronic obstructive pulmonary disease). Resident # 93's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 1-25-19. Resident #93 did not have a Brief Interview of Mental Status (BIMS) score recorded but cognitive skills for daily decision-making were coded as moderately impaired. Resident #93 required extensive to total assistance of all ADL's (activities of daily living such as bed mobility) except for eating, in which she required supervision of one staff member. Activity preferences were not coded. On 2-12-19 at approximately 10:00 AM, Resident #93 was observed asleep in bed in supine position with the resident's TV off. There were no passive activities such as books on tape or music. On 2-12-19 at 4:00 PM, the resident remained in bed with no TV or other stimulation. On 2-13-19 at approximately 10:00 AM, Resident #93 was observed in bed. No activities were observed. On 2-14-19 at approximately 3:00 PM, the resident was observed in bed with no in room activities observed. The care plan dated 1-28-19 was reviewed. For activities, the care plan included: "Support self directed, independent leisure pursuits and activities. The goal was stated as, "Attain or maintain the highest practical well being actively engaged in 1:1 room activities once per week."	F 679	the highest level of wellbeing. 4 .100% audit of all residents bedridden by choice or necessity to ensure they have current activity assessments, participation, interventions and implementations are matching care plan goals completed, then 30% of residents weekly times 2, monthly times 2, then followed quarterly in QAPI committee.	

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F 679	Continued From page 22 Interventions were: "Honor patient's preferences of leisure activities and support patient's preference to spend time alone and introspectively." There had been no changes in activity goals or interventions since 5-18-18. Review of the resident's activities preferences dated 1-18-18 revealed: "Resident engages in independent leisure 4-5 times per week.. prefers room setting. Resident enjoys watching TV, reading magazines/newspapers, and receiving family visits." On 2-14-19 at 3:22 PM: The Activities Director was interviewed about Resident #93's activities. She stated, "There is no documentation of my 1:1 visits. She has been kind of hard to do." On 2-14-19 at 4:00 PM, the Administrator and Corporate Nurse Consultant was notified of above findings.	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		3/25/19

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F 686	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, facility documentation and clinical record reviews, the facility staff failed to, for one Resident, Resident #93 of 38 residents in the survey sample, ensure interventions to prevent pressure ulcers were in place. Resident #93's orange service light was on through multiple observations and her heels were not elevated off the mattress. The findings included: Resident #93 was admitted to the facility on 10-30-17. Diagnoses include dementia, chronic back pain requiring opioids, congestive heart failure and COPD (chronic obstructive pulmonary disease). Resident # 93's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 1-25-19. Resident #93 did not have a Brief Interview of Mental Status (BIMS) score recorded but cognitive skills for daily decision-making were coded as moderately impaired. Resident #93 required extensive to total assistance of all ADL's (activities of daily living such as bed mobility) except for eating, in which she required supervision of one staff member. The resident had no pressure ulcers, but was coded as a risk for pressure ulcers. On 2-12-19 at approximately 10:00 AM, Resident #93 was observed asleep in bed in supine (face upward) position. A heelz up heel elevator device was in use, but the resident's heels were resting	F 686	F 686 Treatment and services to prevent/heal Pressure ulcer 1. Resident #93 heels up device is now in place as ordered MD and RP aware of potential deficient practice. Specialty mattress has been replaced related to warning light being on. 2. All residents with Heels up device or specialty mattress are at risk for deficient practice. 3. SDC or designee will educate all Nursing staff in Heels up device and need for heels to be off loaded while in use. All Staff will be made aware that any warning light on specialty mattress is to be brought to attention of Unit manager/central supply director or maintenance director during daily rounds. 4. All residents with Heels up device will be monitored for offloading compliance weekly x2 weeks monthly times 2 months, then reviewed in QA/A meeting. Residents with specialty air mattresses will be reviewed for appropriate operation daily times 2 weeks, weekly times 2 weeks months times 2 months then followed quarterly in QAPI committee.	

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F 686	Continued From page 24 flat on the mattress. In addition, the resident's specialty mattress in place had the orange service light on. On 2-12-19 at 4:00 PM, the resident remained in bed with no TV or other stimulation. Her heels remained on mattress and the orange service light remained on. LPN (licensed practical nurse C) was notified and stated she had no idea what the orange light meant. LPN (C) contacted the person responsible to monitor the beds. On 2-13-19, the regional nurse consultant presented documentation that the company was notified to switch out the mattress. The mattress was checked and the orange service light was off. On 2-14-19 at 4:00 PM, the Administrator and Corporate Nurse Consultant was notified of above findings.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and	F 688		3/25/19

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F 688	Continued From page 25 assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, family interview, staff interview, clinical record review, and facility documentation, the facility staff failed to provide intervention (wedge pillow) to prevent further decrease in range of motion for one Resident (Resident # 94) in a sample size of 38 residents. The findings include: Resident #94, a 96-year old female, was initially admitted to the facility on 06/23/2016. Diagnoses include but not limited to dementia, debility, depression, and anxiety. Resident #94's most recent Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 12/27/2018 and was coded as an annual assessment. Resident #94 was not coded for a Brief Interview of Mental Status (BIMS) but cognitive skills for daily decision-making were coded as severely impaired. Functional status for dressing and personal hygiene was coded as requiring extensive assistance from staff. Functional limitation in range of motion in lower extremities was coded as impaired on both sides. On 02/12/19 at 01:24 PM, Resident #94 was observed in her room, seated on a chair saddle in her wheelchair. Resident #94 was fully dressed and had socks on both feet. Right knee was flexed and right foot was resting on soft stop that was attached to the legs of the wheelchair. There was not a wedge pillow between Resident #94's	F 688	F 688 Increase /prevention in ROM /Mobility 1. Resident # 94 Wedge pillow has been applied per directions from MD. Responsible party made aware. 2. All patients requiring specialized equipment/care related to prevention in ROM/Mobility may be at risk for deficient practice. 3. SDC or designee will educate: a. All Licensed staff on review of care plan related to ADL care / Assistance c. Licensed staff will be educated in review of care plans to ensure appropriate equipment is utilized on patients as ordered by MD to include active MD order. d. All CNA staff will be educated in use of care plans to ensure appropriate equipment is in use for patient and recorded appropriately in ADL documentation system 4. 100% audit of resident requiring specialized equipment related to mobility has been completed. And will be audited weekly times 2, monthly times 2, then followed quarterly in QAPI committee.	

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F 688	Continued From page 26	F 688		

ankles.

On 02/13/19 at 08:44 AM, Resident #94 was observed in her room, seated on a chair saddle in her wheelchair. Resident #94 was fully dressed and had socks on both feet. Right knee was flexed and right foot was resting on soft stop that was attached to the legs of the wheelchair. There was not a wedge pillow between Resident #94's ankles.

On 02/13/19 at 11:24 AM, Resident #94's daughter was visiting with her. When asked if she had any concerns about the care her mother was receiving, she showed a picture that was hanging on her mother's closet door. It was a photograph of Resident #94 seated in her wheelchair with a stop drop on the wheelchair leg rests and a wedge pillow between Resident #94's ankles. The daughter stated this was how her mother should be positioned with the wedge pillow in the wheelchair and stated that "one aide said it's supposed to be done daily but some don't do it." At that time LPN E entered Resident #94's room. When asked about wheelchair positioning for Resident #94, she stated she wasn't sure and added, "the aides usually do it."

On 02/13/19 at 1:32 PM, certified nursing assistant (CNA) E was interviewed. When asked about how she knows how to position Resident #94 in the wheelchair, she stated she looks at the kardex (care plan). When asked about the picture in Resident #94's closet, she stated did not know about it.

On 02/13/19 at 01:55 PM, Resident #94 was observed in her room, seated on a chair saddle in her wheelchair. Resident #94 had a brace on her

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F 688	Continued From page 27	F 688		

right leg from mid-thigh to ankle. There was not a wedge pillow between Resident #94's ankles.

On 02/14/19 at 8:45 AM, an interview with licensed practical nurse (LPN) D was conducted. When asked about the importance of a wedge pillow for Resident #94, she stated it prevents further contractures and also prevents skin breakdown.

On 02/14/19, the active physician's orders were reviewed. There was not an order for a leg brace.

The occupational therapy (OT) discharge (DC) notes were reviewed. OT discharge recommendations dated 10/15/18 at 5:36 PM documented, "DC OT services. Pt issued following w/c (wheelchair) devices for 6hour+ tolerance
18X16 inch w/c
Wedge cushion with pummel
Neoprene stop drop on standard leg rests
Adductor (sic) wedge pillow between ankles."

The care plan was reviewed. A focus created on 06/23/2017 documented, "The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) dementia." An intervention revised on 10/24/18 documented, "WHEELCHAIR - to promote independence and locomotion/mobility throughout the facility
DYCEM-non Slip and non skid device for w/c, to assist with proper body alignment
Reacher to assist in reaching items in room.
Foot Stop Drop-positioning of foot
Leg Brace- contracture of leg
Abduction Wedge-to aid in prevention of contracture of leg"

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F 688	Continued From page 28 On 02/14/19 at approximately 4:00 PM, the Administrator and DON were notified of findings and offered no further information or documentation.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel	F 690		3/25/19

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F 690	Continued From page 29 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, resident and staff interview and clinical record review, the facility staff failed to, for one resident, Resident #155 in a survey sample of 38 residents, ensure the indwelling catheter was cleaned in a manner to prevent infection. Resident #155's catheter care was not performed appropriately (cleansed form back to front, bringing bacteria toward the catheter). The findings included: Resident #155 was admitted to the facility on 1-25-19. An MDS (minimum data set-an assessment protocol) had not been completed due to recent admission. The resident had an indwelling catheter due to urinary retention. On 2-13-19 at 11:09 AM, an interview was conducted with the resident. Resident #155 was alert and oriented to all spheres, she was noted to have contractures of all extremities, had a flat call alarm. The resident stated she had to have total care for her bath. During the initial interview, the resident voiced concerns her "nether regions" were not being cleaned sufficiently, especially around the catheter. On 2-13-19 at 9:25 AM Observed catheter care. CNA (certified nursing assistant -C) Cleaned front to back and cleaned catheter away from the urethra while on her back. However, when	F 690	F 690 Bowel Bladder Incontinence , Catheter , UTI 1. Resident #155 since been discharged from center. MD and RP have been made aware of deficient practice. 2. All patients with Catheters may be at risk for deficient practice. 3. SDC or designee will inservice all CNA staff in Peri care / Catheter care to prevent negative outcome including but not limited to infection. 4. Audit 100% of all residents with catheters have been completed, 30 % residents with catheters will be audited weekly times 2 weeks, monthly times 2 weeks then review quarterly in QAPI committee.	

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F 690	Continued From page 30 resident was turned to the side, CNA-C cleaned from the rectum toward the urethra several times, potentially infecting the resident with disease causing bacteria. On 2-13-19 at 10:35 AM: An interview with the CNA (certified nursing assistant- C) was conducted. The CNA stated, "I should have cleaned her front to back, it could cause infections." On 2-14-19 at approximately 4:00 PM, the Administrator and Regional nurse consultant were informed of above findings.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 692		3/25/19

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F 692	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to provide a physician ordered nutritional supplement, and failed to implement interventions for further weight loss for one resident (Resident #93) of 38 residents in the survey sample. Resident #93 did not receive her supplements or whole milk, did not receive her substitute meal cut into bite sized pieces and did not receive supervision for her meals. The findings included: Resident #93 was admitted to the facility on 10-30-17. Diagnoses include dementia, chronic back pain requiring opioids, congestive heart failure and COPD (chronic obstructive pulmonary disease). Resident # 93's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 1-25-19. Resident #93 did not have a Brief Interview of Mental Status (BIMS) score recorded but cognitive skills for daily decision-making were coded as moderately impaired. Resident #93 required extensive to total assistance of all ADL's (activities of daily living such as bed mobility) except for eating, in which she required supervision of one staff member. The resident's weight coded on this MDS was "unknown." She was listed as requiring a mechanically altered diet. On 2-12-19 at 3:07 PM, a review of the clinical	F 692	F692 1. Resident #93. Corporate Dietitian or designee reviewed supplement, diet, and supervision needs for resident #93 with all dining services staff and nursing staff. Corporate Dietitian completed nutrition assessment for resident #93 confirming supplement and diet needs. PCC EMR and Mealtracker menu system updated on 3/2/19. 2. All residents requiring supplements, modified texture diets, and supervision are at risk. Corporate Dietitian completed an audit of all patients requiring supplements and all diets to ensure that all supplements ordered and all diet orders were indicated correctly on menu tickets. Corporate Dietitian completed an audit of all active patient care plans and menu tickets to ensure that supervision needs were correctly indicated, any discrepancies were corrected. The Corporate Dietitian or designee in-serviced all dining services and nursing staff on the importance of serving meals as indicated on menu tickets, the standards for modified texture diets, and process for providing supervision with meals. 3. The Corporate Dietitian will complete a 30% tray accuracy audit once per week x 4 weeks, then monthly x 2 months, and then quarterly x 1 quarter, to ensure residents receive accurate meals based on diet and supplement orders, and supervision needs. 4. The results of the tray accuracy audits	

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F 692	Continued From page 32 record revealed a history of significant weight loss and weight interventions such as restorative dining, whole milk on trays and nutritional supplements. On 2-13-19 at 8:40 AM, Resident #93 was observed in bed with her breakfast tray in front of her. She was lying almost flat. On 2-13-19 at 8:50 AM, Resident #93 was observed still lying flat. The resident stated, "it's hard to eat lying down." The tray card read: "Bite sized strawberries." However, the Strawberries were observed whole, soft. On 2-13-19 at 8:53 AM, CNA (certified nursing assistant-A) was asked to come to the room. The CNA was asked to look at resident. She stated, "She is lying flat, because of her back." CNA was asked to read tray card, She stated, "She has 2% milk." However, the order was for whole milk. CNA-A was unable to find other discrepancies, until it was pointed out by the surveyor that the strawberries were whole. CNA-A stated she would cut up the strawberries and report it. The CNA also reported the resident did not want to be raised up due to her back pain. On 2-13-19 at 9:57 AM, a review of the care plan dated 1-28-19 revealed the resident is to have supervision during her meals. The resident was alone for the above observations. On 2-13-19 at 12:35 PM, the resident stated she "did not want to be raised up." There was no milk on her tray. She stated, "I want eggs, I love eggs." On 2-13-19 at 1:15 PM, the resident was raised in	F 692	will be reported to the QAPI committee.	

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F 692	Continued From page 33 the bed. She was served a whole sandwich, not bite sized as ordered. LPN-C was asked about her supplements. She stated, "The daughter gives her supplement." She went on to state that the supplements were ordered twice daily. On 2-14-19 at approximately 4:00 PM, the Administrator and Regional nurse consultant were informed of above findings.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility and clinical record documentation, the facility staff failed to, for one resident, Resident #60, in a survey sample of 38 residents, provide respiratory care and services to maintain the highest practicable wellbeing. Resident #60's filter for the oxygen concentrator was dusty. The findings included: Resident #60 was admitted to the facility on 4-1-16. Diagnoses include dementia, COPD	F 695	F 695 Respiratory tracheostomy care and suctioning 1. Resident #60 oxygen filter has been replaced. MD and Responsible party aware of potential for deficient practice. 2. All residents with use of oxygen concentrators with filters are at risk. 3. SDC or designee will inservice Unit managers and central supply director in weekly change of filters or washing per manufacturers guidelines. 4. All Oxygen concentrators have had filters checked for cleanliness. Audits will continue weekly times 2 weeks monthly times 2 weeks and reviewed quarterly in	3/25/19

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F 695	Continued From page 34 (chronic obstructive pulmonary disease), anemia and coronary artery disease. Resident # 60's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 1-4-19. Resident #60's Brief Interview of Mental Status (BIMS) score was "10" out of a possible 15, or mild cognitive impairment. Resident #60 required set up assistance of all ADL's (activities of daily living such as bed mobility). The resident was coded as using oxygen in the past 7 days. On 2-12-19 at 10:34 AM, during an observation, the resident was observed receiving 2 liters of oxygen by a nasal cannula. The filter in the back of the concentrator was dusty. On 2-14-19 at 11:23 AM, a review of the concentrator revealed the filter remained dusty. The Corporate DON (director of nursing) entered the room and stated, " It is dusty, supposed to be changed every Wednesday." The TAR (treatment record) was reviewed; the documentation revealed the change of oxygen was done 2-13-19. The Corporate DON stated the filter would be washed or replaced weekly with the tubing change. Review of the facility policy and procedure regarding respiratory care read: "Nasal cannulas, simple masks, and Venturi mask must be changed every week, dated and initialed. On 2-14-19 at approximately 4:00 PM, the Administrator and Regional nurse consultant were informed of above findings.	F 695	QAPI committee.	
F 801	Qualified Dietary Staff	F 801		3/25/19

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F 801 SS=F	Continued From page 35 CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of	F 801		

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F 801	Continued From page 36 this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to employ staff with the skill sets to carry out the functions of the food and nutrition service.	F 801	F801 1. The current/unqualified Dining Services Manager was terminated on 3/1/19, and recruitment began for a	

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F 801	Continued From page 37 Facility failed to designate a person to serve as the director of food and nutrition services who is a certified dietary manager after one year of employment. The findings included: On 2/13/19 during a record review it was identified that Employee E was hired on 1/22/18. During interview with Employees D & E on 2/13/19 at 4:40 pm she stated "I have not enrolled in a Certified Dietary Manager Course yet." During a staff interview with Employee D on 2/13/19, she provided the surveyor with a Serv Safe certificate and stated that the employee on the certificate, "last day was yesterday," on 2/12/19. "No other staff are Serv Safe Certified." The Administrator and Corporate Dietitian were notified of findings on 2/14/19.	F 801	qualified Dining Services Manager. As of 3/1/19, the Corporate Dietitian assigned to this center has increased visit frequency to provide additional supervision and oversight, and a qualified interim Dining Services Manager was assigned 3/4/19 until a permanent, full-time Dining Services Manager is hired. 2. All residents are at risk. 3. Human Resource Manager will verify credentials/education of Dining Services Manager upon hire and annually. Corporate Dietitian will provide feedback to Administration on Dining Services Manager performance during facility visits. 4. The Human Resource Manager will verify annually that the Dining services Manager maintains the appropriate credential for performance of their job and the audit results will be reported to Administration.	
F 804 SS=D	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 and staff	F 804	F804	3/25/19

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F 804	Continued From page 38 interview, the facility failed to ensure food was served at a palatable temperature for two Residents (Resident #304, #305) in a sample size of 38 residents. 1. For Resident # 304, the facility staff failed to provide a hot breakfast on 2/12/19 and 2/13/19. 2. For Resident #305, the pizza was cold. The findings included: 1. For Resident # 304, the facility staff failed to provide a hot breakfast on 2/12/19 and 2/13/19. Resident # 304, an 85 year old, was admitted to the facility on 2/5/19 for skilled services related to a right femur fracture. Diagnoses included Atrial Fibrillation, Hypertension, Coronary Artery Disease, History of Crohn's Disease, Irritable Bowel Syndrome and debility/weakness. There was no Minimum Data Set assessment done as it was not due at the time of survey. Review of the Admission Nursing Assessment revealed Resident #304 was coded as cognitively intact, continent of bowel and bladder and required assistance with activities of daily living. He was coded as independent in eating. On 2/12/19 at 8:46 AM, this surveyor observed the staff serve a breakfast tray to the roommate of Resident # 304 (Resident # 64). The roommate (Resident # 64) began eating immediately and stated his food was okay but it was cold. He also stated "If you want a hot breakfast, you have to go to the dining room." 02/12/19 08:54 AM, an interview was conducted	F 804	1. Residents #304, 305 and 62. All concerns regarding palatability were immediately addressed at time of meal service. 2. All residents are at risk. 3. The Corporate Dietitian and Dining Services Manager provided in-service education to all dietary staff on meal service standards, meal times, proper food temperatures during storage and service, how to properly take food temperatures, and how to calibrate a thermometer. The Staff Development Coordinator or designee will provide education to all nursing staff regarding meal service standards. 4. The Corporate Dietitian will complete a 30% tray service evaluation once per week x 4 weeks, then monthly x 2 months, and then quarterly in QAPI committee.	

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with Resident # 304 who stated the staff do not serve meals on times sometimes. Resident # 304 stated the facility often was short of help. Resident # 304 stated that one day, he "did not get dinner until 6:30 PM. The breaded shrimp was cold and had been sitting out for a couple of hours." Resident # 304 stated he "did not want to eat it (the shrimp) because it is not safe to eat food that's been sitting out for a couple of hours."

On 2/12/19 at 9:06 AM, Resident # 304 began eating his breakfast. Resident # 304 stated it was" cold but at least it was something to eat."

On 2/13/19 at 8:50 AM Resident # 304 was observed eating his breakfast of pancakes and strawberries. Resident # 304 stated the food was cold but he "had to eat something." Also stated he was given oatmeal and milk but he did "not like oatmeal or milk." Resident # 304 stated he hated to ask for more food but he would have enjoyed the pancakes better if they had been hot.

2/13/19 at 9:05 AM, an interview was conducted with the Unit Manager (LPN A) who stated residents should have hot meals. LPN A walked with the surveyor to Resident # 304's room. Resident # 304 had consumed about half of the pancakes and strawberries. Resident # 304 told LPN A to feel his plate because it was cold to touch. LPN A felt the plate and stated it did feel cool. Resident # 304 told LPN A that he would be okay without more pancakes since he did have something in his stomach and he would be satisfied with a hot cup of coffee. LPN A offered again to get a hot breakfast for him. Resident # 304 declined the meal but again stated he would like a cup of hot coffee.

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LPN A stated residents should have hot meals or meals at the desired temperatures. Hot foods should be hot and cold foods should be cold."

At the end of day meeting on 2/14/19, the Administrator and Corporate Nurse were notified of the failure of the staff to ensure Resident # 304's food was served at an appetizing temperature. Both stated it was not acceptable for residents to receive food that was not at the appropriate temperature.

No further information was provided.

2. For Resident #305, the pizza was cold.

On 2/13/19 at 11:45am, Resident #305 complained that his pizza was cold. A replacement piece was served to resident and upon interview he indicated it was much better.

On 02/13/19 at 12:08PM, during meal service observation in the West Wing Dining room Employee F was observed to be at a table documenting. An interview with Employee F revealed she was documenting "food temperatures,"

Employee F stated that Employee G had written the temperatures in the first column of the form and she was coping the temperatures to the second and third column".

When observing the document with Employee F and E, Employee E stated "they all have the same handwriting, it's the same person". Column 1 is where regular texture food temperatures are recorded, column two is for the mechanical soft textures and column 3 is used for pureed texture.

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Observation revealed that regular texture foods were being held on the steam table and pureed foods were being held in an enclosed/heated food cart which was a separate unit with a temperature reading of 129.2 degrees on the digital thermometer reading. This means copying temperatures from column one to column two and three would not be accurate. Employees E and F were asked if the food temperatures were taken she said "I did not check temperatures."

Meal service began in the west wing dining room at 11:30am for residents eating in the dining room. Temperatures were not taken. The preparation of plates for residents eating in their rooms began at 12:08pm. During observation the tray cart reached the floor/hall, the Certified Nursing Assistant (CNA)'s were pouring beverages, adding condiments to the tray and obtaining the dessert for each tray before taking tray to the resident in their room. A tossed garden salad was in a large service bowl, covered on the bottom rack of the dessert tray and was not in any device/system to ensure it remained at a safe and appetizing temperature. One resident requested milk and the CNA went to obtain it but there was none in the pantry fridge and she had to go to the kitchen to obtain it, therefore further delaying the delivery of meal tray to the resident.

The last tray was served to the resident at 1:20pm. Temperatures were then taken by employee D on a sample/test tray. The results were:
pureed green beans temperature was at 110 degrees,
Mashed potatoes 122.3 degrees
Meat temperature was at 112.1

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F 804	Continued From page 42 Lemon pie dessert 56.8 Tossed garden salad at 48.9. From the time meal service began until the last tray was served was 1 hour and 50 minutes.	F 804		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, clinical record review, the facility staff failed to provide a therapeutic diet for 2 residents (Residents #93, and #91), in a survey sample of 38 residents. 1. Resident #93 did not receive her diet as ordered to include whole milk and minced foods. 2. Resident #91 did not receive minced green beans. Resident was observed to be coughing during her meal. The findings included: 1. Resident #93 did not receive her diet as ordered to include whole milk and minced foods.	F 808	F808 1. Residents #93 and 91. Mechanically altered diet guidelines were reviewed with dietary staff on 2/14/19. 2. All residents on a mechanically altered diet are at risk. The Corporate Dietitian or designee will conduct education with all dining services staff and all nursing staff on mechanically altered diet guidelines and the importance of serving meals as indicated on the menu ticket. 3. The Corporate Dietitian will complete a 30% tray accuracy audit once per week x 4 weeks, then monthly x 2 months, and then quarterly x 1 quarter, to ensure residents receive accurate meals based on diet orders. 4. The results of the tray accuracy audits	3/25/19

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F 808	Continued From page 43 Resident #93 was admitted to the facility on 10-30-17. Diagnoses include dementia, chronic back pain requiring opioids, congestive heart failure and COPD (chronic obstructive pulmonary disease). Resident # 93's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 1-25-19. Resident #93 did not have a Brief Interview of Mental Status (BIMS) score recorded but cognitive skills for daily decision-making were coded as moderately impaired. Resident #93 required extensive to total assistance of all ADL's (activities of daily living such as bed mobility) except for eating, in which she required supervision of one staff member. The resident's weight coded on this MDS was "unknown." She was listed as requiring a mechanically altered diet. On 2-12-19 at 3:07 PM, a review of the clinical record revealed a history of significant weight loss and weight interventions such as restorative dining, whole milk on trays and nutritional supplements. On 2-13-19 at 8:40 AM, Resident #93 was observed in bed with her breakfast tray in front of her. She was lying almost flat. On 2-13-19 at 8:50 AM, Resident #93 was observed still lying flat. The resident stated, "it's hard to eat lying down." The tray card read: "Bite sized strawberries." Strawberries were whole, soft. On 2-13-19 at 8:53 AM CNA (certified nursing assistant-A) was asked to come to the room. The CNA was asked to look at resident. She	F 808	will be reported to the QAPI committee.	

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stated, "She is lying flat, because of her back." CNA was asked to read tray card, She stated, "She has 2% milk." However, the order was for whole milk. CAN-A was unable to find other discrepancies on the tray, until pointed out by the surveyor that the strawberries were whole. CNA-A stated she would cut up the strawberries and report it. The CNA also reported the resident did not want to be raised up due to her back pain.

On 2-13-19 at 1:15 PM, the resident was raised in the bed. She was served a whole sandwich, not bite sized as ordered.

On 2-14-19 at approximately 4:00 PM, the Administrator and Regional nurse consultant were informed of above findings.

2. Resident #91 did not receive minced green beans. Resident was observed to be coughing during her meal.

Resident #91 was admitted to the facility on 3-8-14 with diagnoses including high blood pressure and diabetes.

Resident # 91's most recent quarterly Minimum Data Set (MDS) had an Assessment Reference Date (ARD) of 1-17-19. Resident #91 had a Brief Interview of Mental Status (BIMS) score of "14" out of a possible 15, or no cognitive impairment. Resident #91 required extensive to total assistance of all ADL's (activities of daily living such as bed mobility) except for eating, in which she required supervision of one staff member. The MDS coded the resident as having swallowing issues and coughing and choking at meals.

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F 808	Continued From page 45 On 2-13-19 at 12:07 PM, Resident # 91 was observed to be choking and two staff were there. Her meal ticket was observed to say minced seasoned green beans; However, she was served green beans that were not minced. The Dietary Manager was interviewed and acknowledged "some pieces are a little big, pieces are not minced". The Dietary Manager removed the green beans and didn't replace them. On 2-13-19, the Food service manager presented a modified texture diet which included: Minced/moist food size of 4 CM (centimeters). On 2-14-19 at approximately 4:00 PM, the Administrator and Regional nurse consultant were informed of above findings.	F 808		
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.	F 812		3/25/19

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F 812	Continued From page 46 §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, staff interview and facility documentation review the facility staff failed to store and serve food in accordance with professional standards for food service safety. Facility staff failed to accurately monitor food temperatures, hold food at appropriate temperature, and reheat food to appropriate temperature. The findings included: On 2/12/19 at 8:35 AM, during observation of the walk-in freezer there were opened, uncovered, undated tortilla shells in freezer and hot dogs in freezer without an open date. During an interview the cook (employee H) stated if they were opened and undated, the items should be thrown away. During the observation of the walk-in cooler, grapes were noted in a zip lock bag (not in original packaging) without a date. The cook stated the date should have been written in the white writable area of the bag. Review of facility documentation of Freezer temperature logs revealed an employee had recorded freezer temperatures on 2/12/19 to be at 20 degrees Fahrenheit. The cook stated she recorded the temperature this morning and when asked, she said it was 20 degrees Fahrenheit this morning. When asked if this was within range, she stated yes; and therefore no corrective	F 812	F812 1. Corporate Dietitian completed sanitation rounds 2/14/19 and items with no use by date, expired, not sealed, were discarded. Dirty equipment and service ware was cleaned/sanitized immediately. Department cleaning schedule was revised and implemented on 3/5/19. Pest Control Operator was contacted and department was treated for pests on 3/5/19. 2. All residents are at risk. The Corporate Dietitian or designee will conduct education to all Dining Services staff regarding proper food temperatures and documentation requirements, proper food storage practices, cleaning standards, and cleaning schedule. All dietary staff was assigned the Relias Food Safety training module. 3. The Dining Services Manager or designee will complete a Supervisor Checklist daily. The Administrator or designee will review the Supervisor Checklist for accuracy weekly x 2 weeks, monthly x 2 months, and then quarterly x 1 quarter. The Corporate Dietitian will complete a sanitation inspection monthly. 4. The results of the supervisor checklist audits and sanitation inspections will be reported to the QAPI committee.	

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action was taken. Record review indicated freezer temperatures for the freezer was 10 degrees Fahrenheit or less.

Upon observation of the kitchen, multiple gnats were noted throughout the kitchen. There were two gnats observed on the green cutting board over the 3 compartment sink as well as on the inside cover of a clean dish rack. During an interview with the kitchen staff, the assistant stated that the pest control representative comes regularly and due to the gnat problem he put out cups of vinegar which were observed in multiple locations throughout the kitchen.

Observation of the sugar bin revealed a black substance. The dietary manager (employee E) used a scoop to remove the item and it was observed to be an insect. Observation of the can opener revealed residue noted on the blade of the can opener. Dust noted on the entrance door of the kitchen and fan located above the entrance door of the kitchen.

Observation of the dishwasher temperature log revealed numerous occasions where the rinse temp failed to obtain 180 degrees. On 3 occasions (2/2, 2/10, 2/11) the dishmachine temperature didn't reach the correct temperature. There was no evidence that staff had recognized and done anything to correct this issue. Staff interview with the staff member who was actively using the dish machine during observation stated she didn't know what the temperature was supposed to be; she just writes it down and if they are close to what has been written before it is ok.

During an interview with the dietary manager about the temps on 2/2, 2/10 & 2/11

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revealed the following: she stated the temps were recorded during peak meal time and she was in a hurry and didn't write what was done to correct the issue. There were no rinse temps recorded on 2/2/19 and 2/3/19 for the lunch meal. She also mentioned that they are out of the temp recording stickers put on dishes to ensure the temperature does in-fact reach 180 degrees in the event that the digital temp reading is inaccurate.

On 2/14/19 at 9:00 AM, an observation of the kitchen the can opener revealed it still had grime present and the cook indicated she had just used it. Dust still present on the fan and door and wall at the entrance of the kitchen. Dishes were noted in the 3 compartment sink. Interview with the Corporate RD (registered dietician) revealed the statement that the staff does not use this sink regularly.

On 2/14/19 at 10:22 AM, an interview was conducted with the Corporate RD revealed the following statement, "We do not have dishwasher rinse temps for lunch on 2/2/19 and 2/3/19.

On 2/14/19 at 9:00 AM, further observation of the kitchen revealed gnats were observed on two cutting boards over the three compartment sink and on the serving utensils hanging over the 3 compartment sink. Multiple gnats were noted to be flying through the entire kitchen area and a bowl of food being prepared was on the food prep table uncovered.

On 2/14/19 at 11:47 PM, observation of lunch in the East Wing Dining Room revealed two CNA's (certified nursing assistants) present serving beverages, plating tossed salads and soup and serving these items to residents without any hair

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495260	A. BUILDING _____ B. WING _____	C 02/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAUFONT HEALTH AND REHABILITATION CENTER	200 HIOAKS ROAD RICHMOND, VA 23225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 49 nets on. On 2-14-19 at approximately 4:00 PM, the Administrator and Regional nurse consultant were informed of above findings.	F 812		
F 925 SS=E	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 observation, facility records and staff interview the facility failed to maintain an effective pest control program. The facility had gnats flying throughout the kitchen and on clean dishes. The findings included: On 2/12/19 8:35am during the initial tour of the kitchen gnats were noted to be on cutting boards, gnats inside the open cover of clean food service cart with dishes and flying throughout the kitchen area. It was also observed to be multiple cups of vinegar sitting through the kitchen in hand washing areas, food prep areas and dish washing areas. An Interview with staff member E stated that "the pest control representative comes regularly and due to the gnat problem he put out cups of vinegar". On 02/14/19 at 09:00 AM, observation of the kitchen gnats were observed on two cutting boards over the three compartment sink and on the serving utensils hanging over the 3	F 925	F925 1. Corporate Dietitian completed sanitation rounds 2/14/19 and potentially contaminated food/supplies were discarded and potentially contaminated equipment and service ware was cleaned/sanitized immediately. The Maintenance Director cleaned all drains The Pest Control Operator completed treatment visit on 2/19/19. 2. All residents are at risk. 3. Current PCO reports reviewed and PCO company contacted to increase visit frequency and change treatment regimen as needed for increased effectiveness. Dining Services Manager will observe department for pests daily as part of Supervisor Checklist completion and will report presence of pests to Maintenance Director based on occurrence. Dining Services Manager will communicate weekly with Administrator and Maintenance Director regarding effectiveness of PCO treatment and visit frequency needs.	3/25/19

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F 925	Continued From page 50 compartment sink. Multiple gnats were noted to be flying through the entire kitchen area and a bowl of food being prepared was on the food prep table uncovered. Review of facility records revealed that the pest control company had been treating for flies/flying insets in the kitchen since November 2018 and a recent as February 6, 2019. The Administrator was notified of findings on 2/13/19.	F 925	4. A check for evidence of pests will be conducted as part of the sanitation inspection completed monthly by the Corporate Dietitian. Results of sanitation inspection will be included on the Corporate Dietitian visit report to Administration. Administrator or designee will monitor for pests weekly times two weeks, monthly times two months and quarterly in QAPI committee.	