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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaint investigations 97449, 98095, 92003 at the above named residential health care facility conducted on 10-12-16, 10-13-16, 10-17-16 and 10-18-16.	S 000		
S3026 SS=G	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 50 residents. The sample included 3 residents, one focus review resident and one closed record review. Based on record review and interview for 1 (#217) of 3 sampled residents, the operator failed to ensure the cognitively impaired resident was not subjected to neglect when facility staff failed to provide services reasonably necessary to ensure this resident ' s safety and well-being and to avoid harm when resident #217 experienced 3 falls with no additional individualized interventions put in place to address the resident ' s fall risk. Resident #217 fell a 4th time on 9-18-16 and experienced a fracture of his/her left lower extremity and was hospitalized.	S3026		

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

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S3026	Continued From page 1 Findings included: - Record review for resident #217 revealed admission on 8-3-16 with diagnoses Dementia, Hypothyroidism, Anxiety, Edema. The record lacked documentation of a Functional Capacity Screening. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 8-3-16 recorded staff physical assistance with medications, dressing, bathing. Per NSA, resident did not need assistance with toileting. Facility staff to provide escorts to/from dining room and community activities due to " heightened risk for falls " and " resident uses a walker as a mobility aid. " " Resident needs help to participate in community activities because of memory loss ...is not always oriented to place, time " and " has difficulty communicating needs and preferences. " Resident Logs stated the following: 8-3-16 at 8:45 pm: "Staff called this nurse to unit. Upon arriving to unit, resident was lying prone on the floor in the hallway. Resident stated he/she was unsure what happened....resident noted with small laceration to left eye approximately 0.5 cm (centimeters) in length...cut came from glasses. Resident's walker was not with him/her..." Signed by licensed staff R. 8-30-16 at 10:17 am: "CNA (certified nurse aide) called and reported that resident was observed on the floor. On assessment, open area noted under chin and left forearm. Complained of pain to jaw area...Fall was unwitnessed. He/She complained of dizziness. also complained of pain to his/her jaw...sent to emergency room for further evaluation..." Signed by licensed staff S.	S3026		

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S3026	Continued From page 2 9-14-16 at 2:45 pm: "Resident observed lying on the floor supine under another resident's wheelchair..." Signed by licensed staff S. 9-18-16 at 6:30 pm: "Notified by (Medication Aide) at approximately 5:55 pm, resident was on the floor. Upon entry to unit resident lying on left side by dining room doors. Range of motion performed, resident verbalized pain to left lower extremity...sent to hospital for evaluation..." Signed by licensed staff T. Note: resident admitted to hospital with left femur fracture and had surgery to repair the fracture (Open Reduction Internal Fixation). Resident returned to facility on 10-13-16 in the afternoon. Observation: Resident returned to facility on 10-13-16 around 4:00 p.m. Was observed sitting in a wheelchair on unit C. Alert and awake but unable to answer any questions regarding his/her care. Resident was unable to state which leg had been injured or whether he/she could stand. Interview on 10-13-16 at 3:30 p.m. with administrative staff A and administrative staff N confirmed the falls on 8-3-16, 8-30-16, 9-14-16 were all unwitnessed and not reported to the department. Confirmed the falls were not investigated for root cause. Review of facility policy for "Falls Management" stated: "Policy Overview: All residents have the potential to fall. A fall is defined as any drop, collapse or tumble. Any witness or reported unwitnessed fall with or without injury is reported ...Residents who sustain a fall should have a post fall investigation completed with interventions identified to reduce the potential for future falls and injury. "	S3026		

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S3026	Continued From page 3 " Policy Detail: 4. A post fall investigation is completed after a resident fall and individualized interventions are included in his/her service plan ....5. If a fall occurs: ...h. additional interventions should be noted on the resident service plan if recurrent falls occur. " The facility failed to provide documentation of investigation and root cause analysis to determine cause of resident ' s falls and determination of personalized interventions to address the possible causes. The facility failed to implement additional individualized interventions to address the resident ' s fall risk. For resident #217, the operator failed to ensure the cognitively impaired resident was not subjected to neglect when facility staff failed to provide services reasonably necessary to ensure this resident ' s safety and well-being and to avoid harm when resident #217 experienced 3 falls with no additional individualized interventions put in place to address the resident ' s fall risk. Resident #217 fell a 4th time on 9-18-16 and experienced a fracture of his/her left lower extremity and was hospitalized.	S3026		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the	S3028		

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S3028	Continued From page 4 administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(A)(C) The facility reported a census of 50 residents. The sample included 3 residents, one focus review resident and one closed record review. Based on record review and interview for 1 (#217) of 3 sampled residents, the operator failed to ensure each allegation of abuse or neglect shall be reported to the department within 24 hours, an investigation shall be started when the operator receives notification of an alleged violation and each alleged violation shall be thoroughly investigated within five working days of the initial report.	S3028		

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S3028	Continued From page 5 Findings included: - Record review for resident #217 revealed admission on 8-3-16 with diagnoses Dementia, Hypothyroidism, Anxiety, Edema. The record lacked documentation of a Functional Capacity Screening. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 8-3-16 recorded staff assistance with medications, dressing, bathing and escorts to/from dining room and community activities. Resident Logs stated the following: 8-3-16 at 8:45 pm: "Staff called this nurse to unit. Upon arriving to unit, resident was lying prone on the floor in the hallway. Resident stated he/she was unsure what happened....resident noted with small laceration to left eye approximately 0.5 cm (centimeters) in length...cut came from glasses. Resident's walker was not with him/her..." Signed by licensed staff R. 8-30-16 at 10:17 am: "CNA (certified nurse aide) called and reported that resident was observed on the floor. On assessment, open area noted under chin and left forearm. Complained of pain to jaw area...Fall was unwitnessed. He/She complained of dizziness. also complained of pain to his/her jaw...sent to emergency room for further evaluation..." Signed by licensed staff S. 9-10-16 at 3:40 pm: "Resident noted to have skin tears to bilateral upper extremities, proximal to elbow. Above left elbow: 3 sites approximately 1) 1.0 x 1.0 cm; 2) 1.0 x 1.0 cm; 3) 1.6 x 0.1 cm. Below right elbow 1.0 x 0.8 cm. Unknown origin. Discovered by (family member)." 9-14-16 at 2:45 pm: "Resident observed lying on the floor supine under another resident's wheelchair..." Signed by licensed staff S.	S3028		

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S3028	Continued From page 6 (Note: resident out of facility for rehabilitation due to a left femur fracture after a fall on 9-18-16.) Interview on 12-13-16 at 3:30 p.m. with administrative staff A and administrative staff N, stated the injury of unknown origin documented on 9-10-16 was not investigated and not reported; confirmed the falls on 8-3-16, 8-30-16, 9-14-16 were all unwitnessed and not reported to the department. Confirmed the fall on 9-14-16 was not investigated. Stated these falls "should have been reported." For resident #217, a cognitively impaired resident, the operator failed to ensure an injury of unknown origin and three unwitnessed falls were reported to the department within 24 hours and thoroughly investigated.	S3028		
S3080 SS=E	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the need for health care services.	S3080		

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S3080	Continued From page 7 This REQUIREMENT is not met as evidenced by: KAR 26-41-201(a) The facility reported a census of 50 residents. The sample included 3 residents, one focus review resident and one closed record review. Based on record review and interview for 1 (#217) of 3 sampled residents and 1 (#220) of 1 closed record, the operator failed to ensure on or before each individual's admission to a residential health care facility, a licensed nurse, a licensed social worker or operator shall conduct a screening to determine the individual's functional capacity and shall record all findings on a screening form specified by the department. Findings included: - Record review for resident #217 revealed admission on 8-3-16 with diagnoses Dementia, Hypothyroidism, Anxiety, Edema. The record lacked documentation of a Functional Capacity Screening on or before admission. Interview on 10-12-16 at 4:44 p.m. with administrative staff A stated he/she was unable to find a functional capacity screening for the resident. For resident #217, the operator failed to ensure a functional capacity screening was conducted on or before admission to determine the resident's functional capacity. - Record review for resident #220 revealed admission on 2-19-16 with diagnosis of Alzheimer's Disease.	S3080		

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S3080	Continued From page 8 The record lacked documentation of a Functional Capacity Screening. Interview on 10-13-16 at 4:30 p.m. with administrative staff A confirmed the record lacked documentation of a functional capacity screening. For resident #220, the operator failed to ensure a functional capacity screening was conducted on or before admission to determine the resident's functional capacity.	S3080		
S3082 SS=D	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The facility reported a census of 50 residents. The sample included 2 residents, one focus review resident and one closed record review. Based on record review and interview for 1 (#216) of 3 sampled residents, the operator failed to ensure designated facility staff ensured that the resident's functional capacity at the time of screening is accurately reflected on that resident's screening form. Findings included: - Record review for resident #216 revealed	S3082		

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S3082	Continued From page 9	S3082		

admission on 10-6-16 with diagnoses Dementia, Chronic Kidney Disease, Abdominal Aortic Aneurysm, Hypertension, Depression, Aortic Stenosis, Chronic Constipation and Insomnia.

The Functional Capacity Screen (FCS) dated 10-4-16 recorded resident required physical assistance with bathing, dressing, toileting; supervision with eating; independent with transfers and walking/mobility; and unable to perform management of medication and treatments. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems included impaired decision-making.

The FCS lacked identification of falls/unsteadiness as a current problem. Per Resident FCS Manual, falls, unsteadiness to be identified if "resident has fallen within the last 180 days and/or exhibits unsteadiness when attempting to rise from a chair or when walking.

Physician Progress Note dated 9-16-16 from previous facility documented a wound (ear laceration) and stated "Falls, recent with ear laceration. discontinue sutures in 10 days after repair."

Occupational Therapy evaluation conducted on 10-10-16 stated: "...Unsafe with roller walker. Watch him/her closely. He/she does not line up well and is at risk for falls."

Interview on 10-13-16 at 2:53 p.m. with administrative nurse D confirmed falls/unsteadiness should have been identified as a problem for resident.

For resident #216, the operator failed to ensure

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S3082	Continued From page 10 designated facility staff accurately identified the resident's functional capacity by identifying his/her risk for falls on the screening form.	S3082		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1)(2)(3) The facility reported a census of 50 residents. The sample included 3 residents, one focus review resident and one closed record review. Based on record review and interview for 2 (#216, #217) of 3 sampled residents, the operator failed to ensure the negotiated service agreements shall provide a description of the services the resident will receive, identification of the provider	S3085		

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S3085	Continued From page 11 of each service and identification of each party responsible for payment if outside resources provide a service. Findings included: - Record review for resident #216 revealed admission on 10-6-16 with diagnoses Dementia, Chronic Kidney Disease, Abdominal Aortic Aneurysm, Hypertension, Depression, Aortic Stenosis, Chronic Constipation and Insomnia. The Functional Capacity Screen (FCS) dated 10-4-16 recorded resident required physical assistance with bathing, dressing, toileting; supervision with eating; independent with transfers and walking/mobility; and unable to perform management of medication and treatments. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems included impaired decision-making. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 10-4-16 recorded services for staff assistance with medications, bathing, bathroom assistance, escorts to/from dining room. The NSA/HCSP lacked identification of the home health agency for physical therapy. occupational therapy and speech therapy, pharmacy choice and diet order. Physician's order dated 9-30-16 for Regular Diet. Physician's order dated 10-6-16 for PT/OT/ST (Physical Therapy/Occupational Therapy/Speech Therapy) to evaluate and treat as indicated. Record revealed occupational therapist from home health agency performed an evaluation of resident on 10-10-16.	S3085		

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S3085	Continued From page 12 Interview on 10-13-16 at 2:53 p.m. with administrative staff N stated the resident was being seen by a home health agency for therapy and confirmed the NSA/HCSP lacked identification of the home health agency that provides PT/OT/ST; identification of the pharmacy provider and documentation of the type of diet resident would receive. For resident #216, the operator failed to ensure the NSA/HCSP provided a description of the services the resident would receive which included therapy per home health agency, pharmacy provider and type of diet the resident would receive. - Record review for resident #217 revealed admission on 8-3-16 with diagnoses Dementia, Hypothyroidism, Anxiety, Edema. The record lacked documentation of a Functional Capacity Screening. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 8-3-16 recorded staff assistance with medications, dressing, bathing and escorts to/from dining room and community activities. NSA stated "Uses a walker but unsteady gait. PT/OT (physical therapy/occupational therapy) to evaluate and treat. The NSA lacked identification of the home health agency who provided the physical and occupational therapy. Interview on 10-13-16 at 3:43 p.m. with administrative staff N confirmed the NSA lacked identification of the home health agency providing	S3085		

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S3085	Continued From page 13 PT/OT. For resident #217, the operator failed to ensure the NSA/HCSP provided identification of the outside provider for physical and occupational therapy.	S3085		
S3155 SS=D	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 50 residents. The sample included 3 residents, one focus review resident and one closed record. Based on observation, record review and interview for 1 (#218) of 3 sampled residents, the operator failed to ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. Findings included:	S3155		

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(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) COMPLETE DATE
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- Record review for resident #218 revealed admission on 5-28-09 with diagnoses Dementia, Hypertension, Hyperlipidemia, Atrial Fibrillation, Depression, Glaucoma, Alzheimer's Disease, Peripheral Edema, Lymphedema, Coronary Artery Disease, and Cerebral Arthrosclerosis.

The Functional Capacity Screen dated 7-5-16 recorded resident required physical assistance with bathing, dressing, transfers and eating. Unable to perform toileting, walking/mobility and management of medications/treatments. Incontinent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems included falls, impaired vision and impaired decision-making.

The negotiated service agreement/health care service plan (NSA/HCSP) dated 7-5-16 revealed services for total staff assist with bathing, dressing and grooming; two-person transfers with Hoyer lift; staff assistance with medication administration, ordering and storage; and listed an outside agency for hospice services. The NSA/HCSP lacked documentation of interventions to address actual skin impairment and risk for further skin impairment.

Observation of resident on 10-13-16 at 10:12 a.m. revealed resident resting in hospital bed with low air loss mattress. Resident had scabbed area (1 centimeter in diameter) with no drainage noted to left lateral ankle surrounded by pinkish area which measured about 1.5 cm. Sacral area excoriated and bright red measuring approximately 12 cm.

Interview on 10-13-16 at 3:37 p.m. with administrative staff N confirmed the NSA/HCSP

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S3155	Continued From page 15 lacked instructions to certified staff for management of actual skin impairment. For resident #218, the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to address resident's actual skin impairment and risk for further impairment.	S3155		
S3216 SS=E	26-41-205 (i) Disposition of Medication (i) Accountability and disposition of medications. Licensed nurses and medication aides shall maintain records of the receipt and disposition of all medications managed by the facility in sufficient detail for an accurate reconciliation. (1) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued controlled medications and biologicals according to acceptable standards of practice by one of the following combinations: (A) Two licensed nurses; or (B) a licensed nurse and a licensed pharmacist. (2) Records shall be maintained documenting the destruction of any deteriorated, outdated, or discontinued non-controlled medications and biologicals according to acceptable standards of practice by any of the following combinations: (A) Two licensed nurses; (B) a licensed nurse and a medication aide; (C) a licensed nurse and a licensed pharmacist; or (D) a medication aide and a licensed pharmacist. This REQUIREMENT is not met as evidenced by:	S3216		

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S3216	Continued From page 16 KAR 26-41-205(i) The facility reported a census of 50 residents. The sample included 3 residents, one focus review resident and one closed record review. Based on observation and interview for 8 (#221, #222, #223, #224, #225, #226, #227, #228) non sampled residents, the operator failed to ensure licensed nurses and medication aides shall maintain records of the receipt and disposition of all medication managed by the facility in sufficient detail for an accurate reconciliation. Findings included: - Observation during entrance tour on 10-12-16 at 12:00 p.m. of medication room revealed three small plastic bins sitting on the counter with a variety of medications. The third bin contained the following: For resident #221: Donepezil 5 mg (milligrams) (for Dementia), filled 3-26-16, 64 tabs (tablets); Namenda XR 28 mg (Dementia), filled 3-7-16, 25 caps (capsules); Clonidine 0.1 mg (Hypertension), filled 3-30-16, 40 tabs; Metoprolol ER 25 mg (Hypertension), filled 5-1-16, 15 whole tabs, 18 half-tabs; Hydralazine 50 mg (Hypertension), filled 2-3-16, 56 tabs; Simvastatin 40 mg (High Cholesterol), filled 3-5-16, 35 whole tabs, 24 half-tabs; Simvastatin 20 mg (High Cholesterol), filled 7-26-16, 28 tabs. For resident #222: Donepezil 10 mg (Dementia), filled 3-14-16, 28 tabs; Atorvastatin 10 mg (High Cholesterol), filled 6-1-16, approximately 90 tabs. For resident #223: Latanoprost 0.005% ophthalmic solution (Glaucoma), 1 opened bottle. For resident #224: Clear Lax (over the counter laxative), 3/4 bottle. For resident #225: 3-pack of Epi Pens (for severe allergy reactions)which expired 9-14-16;	S3216		

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Risperdone 0.5 mg (anti-psychotic), filled 6-28-16, 24 tabs.
For resident #226: Triamcinolone Acetonide (topical ointment for rashes) 0.1%, opened tube.
For resident #227: Docusate 100 mg (laxative), filled 9-19-16, 17 caps.
For resident #228: D 3, 1000 IU (International Units), over the counter supplement, approximately 150 tabs; Loperamide 2 mg (over the counter anti-diarrheal), 200 caplets; Probiotic Gummies (over the counter), 120 gummies.

Interview on 10-12-16 at 11:48 a.m. with certified staff P stated the first bin of medication was possibly "overflow" (bottles and topicals); the second bin he/she thought were to be returned to the pharmacy (unit dose cards only). Stated the third bin of medication he/she wasn't sure about, some were to be destroyed (bottles, topicals and unit dose cards).

Interview on 10-12-16 at 12:00 p.m. with licensed staff Q stated he/she had started going through the medications and was "not sure about what's in there." Confirmed he/she did not know what medications were in the bins on the counter and there was no documentation of the medications. Further stated (when asked for medication destruction logs) that narcotics were the only medications logged when destroyed. Confirmed they did not log non-controlled medications and over the counter medications when destroyed.

Facility policy for "Medications and Treatments - Unused Medication Disposal/Return to Resident/Legally Responsible Party or Pharmacy" Policy Overview for "Discontinued and unused Medications": "When a resident is living in the community, unused and discontinued non-controlled medications should be returned to

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S3216	Continued From page 18 the resident/legally responsible party or pharmacy for credit. If resident/legally responsible party or pharmacy will not accept the medications, the non-controlled medications should be disposed of properly at the community within 30 days." The policy contained a requirement to "Complete the applicable information on a Medication Disposal-Return to Pharmacy or Resident/Legally Responsible Party form" or "Complete the applicable information on a Medication Disposal-Individual Resident form." Interview on 10-12-16 at 4:00 p.m. with administrative staff N confirmed the licensed nurses and medication aides failed to follow the facility policy and failed to document the destruction of non-controlled medications on a log for an accurate reconciliation. For 8 non-sampled residents, the operator failed to ensure licensed nurses and medication aides shall maintain records of the receipt and disposition of all medication managed by the facility in sufficient detail for an accurate reconciliation.	S3216		
S3298 SS=E	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to	S3298		

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prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used.
(3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations.

This REQUIREMENT is not met as evidenced by:
KAR 26-41-206(d)

The facility reported a census of 50 residents. The sample included 3 residents. The operator failed to ensure food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature as evidenced by record review and interview for all residents receiving dietary services.

Findings included:

- Tour of facility on 10-12-16 from 10:50 am to around 1:15 pm revealed a building with three "units". Each unit has a capacity of 19 beds and has a full kitchen for preparation and serving of meals. There is a main kitchen where food is cooked/prepared then taken to each unit kitchen in a hot cart and transferred to a steam table. Certified staff plate and serve the food from the steam tables.

During tour of main kitchen on 10-12-16 at 11:03 am with administrative nurse D, surveyor requested food temperature logs for October 2016 from dietary staff E. Dietary staff E initially provided complete temperature logs for 10-10-16

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S3298	Continued From page 20 and 10-11-16; later provided complete logs for October 2016. Observation of the Unit A kitchen on 10-12-16 at 11:37 a.m. revealed the kitchen lacked documentation of food temperatures. Interview on 10-12-16 at 11:40 a.m. with certified staff F stated " I think they do it when they bring it (food)." Interview on 10-12-16 at 11:40 a.m. with certified staff G confirmed no food temperatures were taken or logged prior to serving food. Observation of the Unit B kitchen on 10-12-16 at 12:30 p.m. revealed the kitchen lacked documentation of food temperatures. Observed two uncovered plates of food (Beef Stroganoff with Noodles, Carrots/Broccoli and a roll) sitting on the counter to be served to residents. Interviews on 10-12-16 at 12:40 a.m. with certified staff H and certified staff J stated dietary staff E "checks it for us before he/she brings it," and confirmed no food temperatures were taken or logged prior to serving on the unit. Staff stated the plates of food were for two residents who were currently in the beauty shop and they could reheat in the microwave prior to serving to the residents. When asked why food was removed from the steam table, staff stated" we thought they were on the way already." Observation of the Unit C kitchen on 10-12-16 at 12:53 p.m. revealed the kitchen lacked documentation of food temperatures. Interview on 10-12-16 at 1:06 p.m. with certified staff K confirmed no food temperatures are taken on the unit prior to serving food.	S3298		

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S3298	Continued From page 21 Observation on 10-13-16 at 11:55 a.m. revealed certified staff M prepping meal and plates for residents. Menu included chicken tenders, potatoes, macaroni and cheese and broccoli/cauliflower mix with food temperatures per certified staff M as follows: Chicken tenders 110 degrees F (Fahrenheit); Potatoes 112 degrees F; Macaroni and Cheese 130 degrees F and broccoli/cauliflower mix 130 degrees F. Certified staff M stated food temperatures should be at least 135 degrees F and reheated the chicken and potatoes prior to serving. Further stated staff used to take food temperatures, just stopped for some reason. Interview on 10-13-16 at 2:45 p.m. with administrative staff A stated "we bought thermometers today" and provided to each unit kitchen, but confirmed they had not officially in-serviced staff yet on using them, stated "they just know to do it." Review of facility policy for "Temperature Standard for Preparation" revealed: "Policy Overview: To ensure the safety of our residents and associates, it is critical that all products are cooked to the appropriate final internal cooking temperature for the appropriate amount of time per standards established by the Food and Drug Administration. " "Policy Detail: 3. All communities should cook foods to the minimal internal cooking temperatures that is maintained for a specific time ...Poultry, Stuffed Meats, Eggs Fish and Meat: 165 degrees F; Ground Meat 155 degrees F; Fruit or Vegetable Hot Held for Service 140 degrees F. Commercially Processed, Ready to Eat Food Hot Held: 140 degrees F;	S3298		

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S3298	Continued From page 22 Reheated Foods 165 degrees F for 15 seconds" The facility failed to follow its policy for monitoring food temperatures and the policy lacked procedure for documentation of food temperature monitoring. For all residents, the operator failed to ensure food was prepared using safe methods that conserved the nutritive value, flavor and appearance and was served at the proper temperatures.	S3298		