STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255339	A. BUILDING _____ B. WING _____	11/21/2019

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey from 11/18/19 to 11/21/19. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation and cited deficient practice at F757 and F812. The census at the time of the survey was 102 with a bed capacity of 120.	F 000		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and	F 757	483.45	12/12/19

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F 757	Continued From page 1 facility policy review, the facility failed to assess a resident receiving psychotropic medication for possible dosage reduction, Resident #66; one (1) of four (4) Residents reviewed for psychotropic drug dosage reduction. Findings Include: Review of the facility's policy, "Medication Management", dated 9/10, revealed: (on page 9) b. Tapering of a medication dose/gradual dose reduction (GDR): During the first year in which a resident is admitted on a psychopharmacological medication (other than an antipsychotic or a sedative/hypnotic), or after the nursing care center has initiated such medication, the nursing center should attempt to taper the medication during at least two (2) separate quarters (with at least one (1) month between the attempts), unless clinically contraindicated. After the first year, a tapering should be attempted annually, unless contraindicated. Review of Resident #66's medical record revealed the facility admitted Resident #66 on 11/8/17, with diagnoses, which included Alzheimer's Disease and Anxiety disorder. Further review of Resident #66's record revealed she was started on the psychotropic medication Klonopin 0.5 milligrams (mg), one (1) by mouth at hours sleep (hs) for anxiety, on 4/4/18. Record review revealed no documentation a dosage reduction was attempted for the Klonopin since ordered. On 11/20/19 at 8:56 AM, interview with the Pharmacy Consultant revealed a dosage reduction recommendation should have been	F 757	* On 11/20/19, an immediate audit of Resident #66 chart was completed by the Director of Nurses. The Pharmacy Consultant was contacted on 11/20/19 by the Director of Nurses and an immediate dosage recommendation was given for Klonopin 0.5mg at hour of sleep. * An audit of all residents on psychotropic and sedatives/hypnotic with last DGR and next was completed on 12/1/19 by the Consulting Pharmacist. The audit found no other resident was found to have this deficient practice. * The Pharmacy Consultant developed a psychotropic and sedatives/hypnotic utilization by resident tool he began using on 12/1/2019. The results of the audit will be sent to the Administrator and Director of Nursing monthly by the Consulting Pharmacist. * The Administrator and Director of Nursing will review the monthly audit when received from the Pharmacy Consultant for any missed recommendations. The results of the audit will be reported to the Quality Assurance Performance Improvement Committee quarterly by the Administrator and/or Director of Nursing to determine compliance or if any changes in monitoring should be changed.	

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F 757	Continued From page 2 initiated around October 2018, and further reduction attempts thereafter for the Klonopin. The Pharmacy Consultant stated the failure to recommend a dosage reduction was an oversight on his part. On 11/20/19 at 8:58 AM, interview with the Director of Nursing (DON) revealed Resident #66 was admitted to the facility in 2017, and Klonopin was ordered as needed upon admission and changed to routine dosing on 4/4/18, due to anxiety. The DON stated the facility failed to assess the resident for a possible dosage reduction.	F 757		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		12/12/19

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F 812	Continued From page 3 Based on observation, staff interview, and facility policy review, the facility failed to ensure a safe and sanitary kitchen environment as evidenced by; rust on the stove, excessive grease build up, and pans of water used during cooking with floating particles in the water; for two (2) of two (2) dietary tours. Findings include: Review of the facility's "Cleaning Instructions, Range and Griddle Ovens" policy, revealed it is the policy of the facility that equipment shall be maintained in a clean and sanitary condition. The procedure revealed ranges should be cleaned daily or as needed and the griddles should be cleaned after each use. An observation on 11/18/19 at 10:00 AM, during the initial tour, revealed the outside surface of the left side door on the gas stove was totally covered with reddish brown material and the right oven door two-thirds (2/3) covered with reddish brown material. Observation of the inside of the oven revealed two (2) pans sitting under the racks with water inside the pans. There was a thick cream-colored film on the bottom of both pans and tan and brownish particles floating in the water. The left side of the stove was coated with brownish sticky substance. The grill top area had liquid oil over the top. The rear left burner had grayish colored ash-like material under the grate. An interview on 11/18/19 at 10:40 AM, with the Dietary Manager (DM), revealed the stove was rusted and this had been on the stove since it was brought in from another venue in 1989. She confirmed the side of the stove was covered with old grease and there was oil on the grill section.	F 812	* The range was immediately cleaned on 11/18/19 by the dietary manager. The pan of water was removed and immediately disposed of on 11/18/19 by the Dietary Manager. * All residents that receive food prepared on the range and in the oven had the potential to be affected by this alleged deficiency practice. * A new range was ordered on 11/20/19 and was installed on 12/5/19. The old range was kept clean prior to the new range being installed. The old range was removed from the building and will be disposed of by the maintenance department. Dietary manager and staff were in serviced on policy for cleaning and maintaining sanitary conditions of all equipment on 11/25/19 by Staff Development Director. * A monitoring system has been put into place to ensure proper cleaning of the range. The infection control nurse will check the cleaning schedule for weekly compliance. It will be monitored weekly x four, every other week x four, then monthly beginning 12/11/19. The results of the monitoring will be reported to Quality Assurance Performance Improvement Committee quarterly by Infection Control nurse to determine compliance or if any changes in monitoring should be changed.	

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F 812	Continued From page 4 She stated this could be a fire risk. The DM stated the pans of water are in the oven because they use the oven to proof their rolls. She stated she thought the water had a lime buildup in it. She stated the pans are washed three (3) times a week. The DM confirmed the water was dirty and should not be in the oven. She stated this could be a serious issue due to germs, fungus, or listeria. The DM stated the gray material on the burner was probably paper ashes from the staff lighting the burner because the pilot light goes out. She stated this could increase the risk of a fire. The DM revealed the stove was used on a daily basis. An interview on 11/19/19 at 11:03 AM, with the Administrator (ADM), revealed she had seen the stove and her plan is to work on getting a new stove. The ADM confirmed the stove was "caked up with crud". She stated it was dirty and dangerous.	F 812		

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the facility failed to properly insure the operability of the sprinkler system as required by NFPA 25 table 2-1 and NFPA 25 section 2-2.6. This deficiency practice affected all residents in the facility at the time of survey.	K 353	* Quarterly inspections have been arranged with an outside company to monitor the operability of the sprinkler system. * If the sprinkler system failed to operate all residents in the facility would be	12/12/19

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K 353	Continued From page 1 Findings includes: On 11/18/19 at 10:10 AM, observation and document review revealed the facility could not provide documentation for the quarterly inspection of the sprinkler system during the 4th quarter of 2018, the 1st quarter of 2019, and 2nd quarter of 2019.	K 353	effected by this alleged deficient practice. * A quarterly inspection schedule has been developed with an outside company. Maintenance director will develop a log to ensure compliance with inspections being completed timely. The log will also be added to the safety committee meetings quarterly. * The maintenance director will bring the log to quarterly QAPI meetings for review by committee to determine compliance or if any changes to monitoring should be changed. Maintenance director will report to the Administrator any issues with quarterly inspections immediately.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to properly perform fire drills as per NFPA 101 section 19.7.1.2. This deficiency affected all residents in the facility on the day of	K 712	* A fire drill was conducted on the 7-3 shift to monitor the effectiveness of our procedure.	12/12/19

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K 712	Continued From page 2 survey. Findings include: During document review on November 22, 2019 at 11:20 AM, the facility could not provide adequate and complete documentation of a fire drills conducted on any work shifts during the last calendar year of 2019.	K 712	* The facility acknowledges that all residents of the facility could be affected by this alleged deficient practice; however the bed confined and un-ambulatory residents would be the most affected. * The Maintenance director was in serviced by the Staff Development Coordinator on 11/23/19 on the proper procedure for conducting fire drills. He was also in serviced by Staff Development Coordinator on proper maintenance of all documents. A log was developed for the maintenance director to have a record of fire drills to be conducted timely. Fire drills are to be conducted 1 per shift per quarter. * The safety officer will be monitoring for correct and timely fire drills monthly. The safety officer will report results of monitoring quarterly to QAPI to determine compliance or if any changes to monitoring should be changed to monitoring should be changed. Safety officer will report to the administrator any issues or concerns with fire drills.	

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E 000	Initial Comments ********** Survey conducted on 11/22/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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