STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255332	A. BUILDING _____ B. WING _____	04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLMES COUNTY LONG TERM CARE CENTER - DURANT	15481 BOWLING GREEN ROAD DURANT, MS 39063

(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 000	INITIAL COMMENTS A standard recertification survey was conducted by Ascellon on behalf of the MS State Department of Health, from 4/8/19 - 4/11/19. In addition, Complaint Intake (CI) MS #15697 was investigated in conjunction with this standard survey. The complaint was unsubstantiated for the allegation regarding a lack of fall prevention measures and unsubstantiated for neglect related to the development of pressure ulcers. An associated deficiency, F580, was cited based on the complaint investigation. The standard survey revealed that the facility was not in substantial compliance with the requirements of participation in Medicare/Medicaid. The following deficiencies resulted from the facility's noncompliance related to the standard survey: F582, F604, F656, F684, and F812. The facility's census on 4/8/19, was 72 residents and the facility held a license for 80 beds.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 580		5/28/19

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

Electronically Signed | 05/09/2019

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F 580	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, the facility failed to notify the representative of one of a change in condition for one (1) of 18 sampled residents, Resident #48.	F 580	1. Resident #48 was discharged to the hospital from the facility on 4/18/19. The Licensed Practical Nurse(LPN) assigned to Resident #48 that day notified the	

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F 580	Continued From page 2 Resident #48 returned to the facility post hospitalization with a deteriorated carbuncle (a carbuncle is a red, swollen, and painful cluster of boils that are connected to each other under the skin) wound; however, the resident's representative was not notified of the change. Findings include: Review of the facility document titled "Notification of Family/Resident Representative" policy, dated 10/16, documented it was the policy of the facility to notify the family or resident representative of all services provided by the facility. This included changes in a resident's condition or status. The family member or the representative will be notified of this change. Resident #48 was admitted to the facility on 6/15/17, with the following diagnoses Diabetes Mellitus, Hypertension, Non-Alzheimer's Dementia, unspecified Lack of Coordination, and unspecified Abnormalities of Gait and Mobility. Record review revealed the resident was returned to the facility from the hospital, on 12/19/19, with an open carbuncle to the sacral area. Review of the "Nurse's Note" dated 12/19/18 at 1:05 PM, documented the resident returned to the facility with an open carbuncle to the sacrum which measured four (4) centimeters (cm) by three and one-half (3.5) cm, with eschar in the center of the wound bed, and the tissue surrounding the eschar was noted to have slough. The note documented: Phoned representative and informed of new orders. Continued review of a nurse's note revealed the family was notified of new physician's orders, but	F 580	Resident Representative (RR). The LPN assigned to the resident will inform RR of any change in condition and document notification specific to the change in residents electronic health record. 2. All residents have the potential to be affected by this deficient practice. 3. An in-service was conducted by the Director of Nursing to educate licensed staff on notification and specific status change documentation in the resident's electronic health record as per policy on 4/16/19. The Director of Nursing, Medical Records Nurse or Minimum Data Set (MDS). Beginning 5/22/2019 the nurse will monitor for significant change on all hospital returns x three (3) months to ensure proper resident representative notification occurs. 4. The Director of Nursing or Registered Nurse (RN) Supervisor will report findings monthly to the Quality Assurance (QA) Committee x 3 months to ensure continued compliance. The QA Committee will make recommendations or changes as needed. 5. All corrective actions were completed on 5/28/2019.	

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F 580	Continued From page 3 not informed about the open wound on the resident's sacrum. Telephonic interview with Family Member #A on 4/9/19 at 9:00 AM, revealed on 1/24/19, a nurse had informed him she was unsure if the family had been notified of the pressure ulcer on 12/19/18, or not. He stated the family was unaware the resident had returned to the facility with an open wound. Interview with the LPN #1, Wound Care Nurse, on 4/10/19 at 10:00 AM, revealed Resident #16 had developed a carbuncle prior to hospitalization; however, when the resident returned, the carbuncle was completely opened. Telephonic interview on 4/11/19 at 10:58 AM, with Family Member #B, revealed the facility had not notified him of an open pressure ulcer on 12/19/18, when the resident had returned to the facility from the hospital. He stated he had only been informed the resident had returned to the facility. Interview on 4/11/19 3:45 PM, with the Director of Nursing (DON), revealed the next of kin should have been notified not only of the resident's return to the facility, but also about any new pressure ulcers which may have developed. She stated nurses were trained on notification during their orientation period to the facility. Interview with Registered Nurse (RN) #1 on 4/11/19 at 4:12 PM, revealed the nurse should always notify the resident's representative whenever a resident returned from the hospital and should inform them of any new wounds and/or treatments.	F 580		

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F 580	Continued From page 4 Interview on 4/11/19 at 4:04 PM, with Licensed Practical Nurse (LPN) #2, revealed the family representative should always be notified their loved one had returned to the facility and if a change in a wound had occurred upon readmission to the facility.	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is	F 582		5/28/19

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F 582	Continued From page 5 reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review, interview and facility policy review, the facility failed to notify two (2) of three (3) residents/resident's responsible parties (Resident #52 and Resident #71) of the termination of skilled Medicare therapy prior to the end date of the therapy. This created the potential residents' therapy would not continue if they chose to appeal the decision to terminate Medicare coverage. Findings include: Facility Policy and Notice: Review of the facility's undated "SNF (Skilled Nursing Facility) Medicare Process" policy, revealed, "With a well organized	F 582	1. Resident #52 and Resident # 71 now have a current copy of the Medicare Non-Coverage Notice. Resident #52 has a BIMS score of 14 is cognitively intact. On 5/12/2019 the Social Service Director verbally explained to Resident #52 the policy for Medicare Non-Coverage, had the resident sign the Medicare Non-Coverage Form, and gave a copy to the resident. Resident #71 has a BIMS score of 7 and has severe cognitive impairment. On 5/12/2019 the Social Service Director verbally explained to Resident #71's Resident Representative the policy for Medicare Non-Coverage,	

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F 582	Continued From page 6 Medicare program, there should be no surprises. Unexpected discharges should never occur outside of a sudden death." The policy indicated the discharge potential and goals for each resident would be discussed by the Utilization Review (UR) team. Under instructions, the policy revealed the Discharge Communication form would be completed and distributed. Next Social Services should receive a one-week notice prior to discharging a resident from Medicare. The Social Service Director was required to deliver a Medicare Denial letter (to the resident/responsible party) mandated by Center for Medicare/Medicaid Services (CMS). The policy revealed therapy should notify nursing well in advance of discharge in order to determine whether or not skilled nursing was required. Review of the "Notice of Medicare Non-Coverage" notice (form used by the facility to notify residents of the termination of coverage) dated 10/31/13, revealed the resident would be notified of the date Medicare services would end. The notice read, "Your Medicare health plan and/or provider have determined that Medicare probably will not pay for your current skilled services after the effective date indicated above." The notice indicated the resident had a right to appeal the decision; services would continue during the appeal. In an interview on 4/11/19 at 9:50 AM, the Social Service Director stated the process regarding notification of Medicare non-coverage for termination of skilled therapy was as follows: 1) Therapy staff notified her via a "Seven (7) Day Discharge Notice" of the resident's discharge date from therapy and whether it pertained to Part A or Part B Medicare Coverage. The Social	F 582	had the Resident Representative to sign the Medicare Non-Coverage Form, and gave a copy to the Resident Representative. All residents, or Resident Representatives, who receive Medicare in the facility now receive verbal explanation from the Social Service Director of the Medicare Non-Coverage Policy and Form prior to being discontinued from Medicare services. They also now sign and receive a copy of the Medicare Non-Coverage Form prior to being discontinued from Medicare services. 2. All residents in this facility who receive Medicare have the potential to be affected by this deficient practice. 3. An in-service on 5/8/2019 was performed with the Social Service Director, Director of Nursing, Speech Language Pathologist, Physical Therapist, and Occupational Therapist Assistant by the Administrator. The in-service addressed the policy and procedures for the Notice of Medicare Non-Coverage and all steps in this process. On 5/9/2019, all residents who are currently receiving Medicare Part A and Part B Services were audited by the Quality Assurance Committee for upcoming discharge dates from Medicare services. No residents were identified as needing a Medicare Non-Coverage policy and form explained and signed due to discharge. All Medicare Part A discharges are now given a seven (7) day notice and all Part B discharges are given a three (3) day notice by the Social Service Director when discharge is	

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F 582	Continued From page 7 Service Director stated therapy staff gave her the "Seven (7) Day Discharge Notice" at least seven (7) days prior to the resident's last day of Medicare coverage. 2) The Social Service Director was responsible for providing/mailing the "Notice of Medicare Non-Coverage" notice to the resident or responsible party which included the therapy end date, their right to appeal the decision, and how to ask for an appeal. The "Notice of Medicare Non-Coverage" form included a patient/representative signature line and place to document the date indicating when the notice was received. 3) The Social Service Director stated she documented in a progress note when a resident's therapy ended and when the "Notice of Medicare Non-Coverage" notice was provided or mailed to the resident/responsible party. The Social Service Director stated at least a three (3)-day notice was required to be given to the resident or responsible party; some instances required a three (3)-day notice (discharge from Medicare Part B) and other instances a seven (7)-day notice (discharge from Medicare Part A). In an interview on 4/11/19 at 2:06 PM, the Speech Language Pathologist (SLP) stated the therapy staff filled out the "Seven (7) Day Discharge Notice" form and provided it to the Social Service Director either three (3) or seven (7) days prior to the discharge date. The SLP stated they gave a three (3)-day discharge notice for Medicare Part B and a seven (7)-day notice for Medicare Part A. The SLP stated the Social Service Director then notified the resident or responsible party. The SLP stated there might be documentation in therapy notes of conversations with residents regarding therapy discharge dates due to Medicare non-coverage.	F 582	impending from these Medicare services. 4. Beginning 5/12/2019 the Social Services Director and Administrator will monitor all residents who are currently receiving Medicare skilled services weekly x3 months for impending discharge dates to assure that the proper Medicare Non-coverage form and policy is provided to the resident or Resident Representative prior to the discharge. All information and findings from these audits will be provided to the Quality Assurance Committee weekly by the Social Service Director and Administrator for 3 months or until compliance is achieved. The Quality Assurance Committee will review and make recommendations as needed to sustain compliance. 5. All corrective actions were completed on 5/28/19.	

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Resident #52
Review of the "Seven (7) Day Discharge Notice", dated 12/11/18, revealed therapy staff notified the Social Service Director that Resident #52 would be discharged from therapy on 12/18/18, due to the resident reaching her maximum potential and due to her return to her previous level of functioning.

Review of the "Notice of Medicare Non-Coverage" (no date on the form when it was given to the resident) indicated Resident #52's last day of Medicare coverage for Medicare Part A was 12/18/18. The "Notice of Medicare Non-Coverage" form indicated a request for an appeal must be made to the Quality Improvement Organization (QIO) and had to be made by no later than noon of the day before the effective end date of services noted in the form, which would have been on 12/17/18. The "Notice of Medicare Non-Coverage" also indicated if the deadline for an immediate appeal was missed, the resident/responsible party could contact their Medicare health plan. The form included a line to document the plan contact information. The plan contact information of the form was blank/not filled out. The resident's signature was documented on the form on 12/18/18, which was her last day of Medicare coverage.

Review of a 12/14/18 "Skilled Medicare Part A Note - Social Service" note documented in full, "Resident is a full code. Resident is alert to self. She is doing well. Will be discharged from Part A Services on 12/18/18. Social Service will provide support and assistance as needed."

In an interview with the Social Service Director on

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F 582	Continued From page 9 4/11/19 at 9:50 AM, she verified the progress note did not document the date when the resident was notified of Medicare non-coverage. The Social Service Director verified there was no documentation showing Resident #52 was notified prior to 12/18/18, the end date of therapy, of the Medicare non-coverage. In an interview on 4/11/19 at 2:06 PM, with the SLP, she stated she remembered discussing Resident #52's discharge with her; however, upon review of therapy notes, stated she could not find any documentation of this discussion. Resident #71 Review of the resident's "Seven (7) Day Discharge Notice", dated 12/21/18, revealed therapy staff notified the Social Service Director that Resident #71 would be discharged from Medicare Part A on 12/24/18, due to the resident reaching his maximum potential. Review of the "Notice of Medicare Non-Coverage" (no date on the form when it was given to the resident's responsible party), indicated Resident #71's last day of Medicare coverage for skilled therapy was 12/18/18, six (6) days prior to the date documented on the "Seven (7) Day Discharge Notice of 12/24/18)." The resident's representative signature was documented on the form on 12/27/18, which was three (3) days after her last day of Medicare coverage of 12/24/18, per the "Seven (7) Day Discharge Notice." Review of a 12/21/18 "Skilled Medicare Part A Note - Social Service" note documented in full, "Resident is a full code. He is alert to self and place. He is doing well. No other concerns at	F 582		

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F 582	Continued From page 10 this time. Resident will be discharged from Part A Services on December 24, 2018, due to decline to participate. Social service will continue to provide support and assistance as needed." In an interview with the Social Service Director on 4/11/19 at 9:50 AM, she verified the progress note did not document the date when the resident's responsible party was notified of Medicare non-coverage. The Social Service Director verified there was no documentation showing Resident #71's responsible party was notified prior to 12/27/18, of the Medicare non-coverage, which was after the end date of therapy. The Social Service Director stated she thought she sent the "Notice of Medicare Non-Coverage" to the resident's representative on 12/21/18; however, she verified there was no documentation of this. The Social Service Director verified the resident's representative signed the form after the resident was discharged from therapy. In an interview on 4/11/19 at 2:06 PM, with the SLP, she stated Resident #71 did not always cooperate with therapy. The SLP stated the resident's responsible party would have been contacted by Social Services for notification of the end of Medicare coverage for therapy.	F 582		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for	F 604		5/28/19

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F 604	Continued From page 11 purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and interview, the facility failed to ensure two (2) of 18 sampled residents (Resident #16 and Resident #39) were free from physical restraints imposed for purpose of discipline or convenience and that were not required to treat the residents' medical symptoms. The facility failed to use the least restrictive alternative for the least amount time and document ongoing re-evaluation of the need for restraints. Findings include:	F 604	1. Resident #39 was assessed by Director of Nursing (DON) on 4/10/2019 and was found unable to consistently remove seat belt on demand and order has been changed to restraint.Resident #16 was assessed by DON on 4/10/2019 and was unable to +remove seat belt on demand. Seat belt was discontinued. The facility now ensures that restraints shall only be used for the safety and wellbeing of the residents after all alternatives have been unsuccessfully attempted.	

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F 604	Continued From page 12 Review of the facility's "Physical Restraint" policy, dated 10/2016, revealed "Restraints shall only be used for the safety and well-being of the residents and only after other alternatives have been tried unsuccessfully ...Restraints will only be used after other alternatives have been tried unsuccessfully, and only with the informed consent from the resident, physician and/or resident representative ...The Restraint Decision Form will be completed prior to the application of restraints. This form will be reviewed quarterly during the MDS (Minimum Data Set) observation period and as indicated." Observation on 4/8/19 at 2:51 PM, revealed Resident #16 was sitting in a wheelchair in the hallway and wearing a seat belt. Observation of the resident on 4/8/19 at 3:47 PM, during activities, revealed Resident #16 was sitting in a wheelchair with the seat belt fastened. The resident was unable to remove the seat belt upon request made by the Activity Staff #1. Observation of Resident #16 on 4/9/19 at 12:31 PM, revealed the resident in the dining hall, sitting in a wheelchair with the seatbelt fastened. Upon request from the Director of Nursing (DON) to remove the seatbelt, the resident was able to remove it. Record review revealed Resident #16 had the following diagnoses: Senile Degeneration of the Brain, Abnormalities of Gait and Mobility, Muscle Weakness, Lack of Coordination, Primary Osteoarthritis, and a History of Falling. Review of the resident's Significant Change in Status Minimum Data Set (MDS), signed and dated by the facility on 2/7/19, revealed Resident	F 604	2. All Resident with seat belts are at risk for this deficient practice. All residents who have seat belts have been reassessed by DON and Registered Nurse (RN) Supervisor on 5/22/2019. Care plan and orders were updated as well to reflect as a restraint as warranted. 3. All Licensed staff was in serviced on April 16. 2019 by the Director of Nursing (DON) and Staff Development Nurse regarding restraint decision form being completed before application of a restraint with the exception of an emergency situation that threatens the safety and well being of the Resident or others. The decision form will be completed prior to application of restraints. Certified Nursing Assistants were in serviced on 5/14/21019 by the DON and staff development nurse to review the Kardex in Point Click Care before each shift for assigned Resident group to assure type of restraint utilized for the Resident.The Restraint Committee, which consists of Physical Therapy, Director of Nursing, Unit Manager and Restorative Certified Nursing Assistant, will meet prior to restraint application to ascertain all alternatives have been attempted. Beginning on 5/22/2019, residents who have lap trays or seat belts will be monitored by the Director of Nursing or RN Supervisor weekly x three months to determine if the resident is able to release the device. 4. Findings will be brought to the Quality Assurance(QA) Committee weekly to	

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F 604	Continued From page 13 #16's cognitive skills to be severely impaired. Resident #16 was assessed to be independent with bed mobility and locomotion on and off the unit. Resident #16 required extensive assistance of one (1) staff with transfers and dressing and was dependent on one (1) person for personal hygiene and bathing. Resident #16 was assessed to have no falls and assessed not have any physical restraints. Review of the "Nurses' Notes", dated 7/21/18, revealed the resident had gotten up frequently without assistance from the wheelchair. Nursing staff notified the Medical Doctor and received a new order for a self-releasing seat belt. Resident #16 was instructed and able to return demonstration on self-releasing the seat belt. Continued review of the medical record revealed no initial or quarterly assessments to confirm the resident could release the seat belt upon command. Interview with Licensed Practical Nurse #1 on 4/10/19 at 5:17 PM, revealed if a resident could self-release a seat belt it was not considered a restraint. She stated Resident #16 was able, at times, to release her seat belt but there were times she could not. She stated she had observed a decline in the Resident #16's ability to release the seatbelt on her own. Interview on 4/10/19 at 5:13 PM with the Director of Nursing (DON), revealed a resident should be able to release a seat belt upon command or it would otherwise be considered a restraint. She stated the resident should have been re-assessed quarterly to assure the seatbelt could be self-released upon command. She	F 604	ensure continued compliance by the Director of Nursing or RN Supervisor weekly to ensure continued compliance. The QA Committee will make recommendations or changes as necessary. 5. All corrections were completed by 5/28/2019	

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F 604	Continued From page 14 stated the resident must have fallen between the cracks as no quarterly restraint assessments had been performed. Interview with Registered Nurse #1 on 4/11/19 at 4:12 PM, revealed a self-releasing seat belt was considered a restraint if the resident could not release the belt upon command. Resident #39 Observation on 4/8/19 at 11:30 AM, during initial tour, revealed Resident #39 sitting in dining room waiting for lunch. Resident #39 was observed with a seatbelt across her lap. Resident #39 was observed with a chair alarm on her wheelchair and clipped to the back of her shirt. Observation on 4/8/19 at 3:00 PM, revealed Resident #39 sitting in common area with a seatbelt across her lap and a chair alarm on her wheelchair clipped to the back of her shirt. Observation on 4/9/19 at 12:15 PM, revealed Resident #39 self-propelling through the common area towards her room. Resident #39 was observed with a seatbelt across her lap and a chair alarm on her wheelchair clipped to the back of her shirt. Observation on 4/11/19 at 8:36 AM, revealed Resident #39 sitting up in her wheelchair being pushed in the hallway by staff. The resident's seat belt and chair alarm noted intact. Observation on 4/11/19 at 9:50 AM, revealed Resident #39, sitting near the nurse's station, and was able to release the seat belt on command. A review of the Face Sheet revealed the facility admitted Resident #39 on 7/2/15, with diagnoses	F 604		

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F 604	Continued From page 15 which included Schizophrenia, Generalized Muscle Weakness, Delusional Disorder, Anxiety Disorder, and Dementia. Review of Resident #39's Quarterly Minimum Data Set with a ARD of 2/22/19 revealed the resident was assessed with a Brief Interview for Mental Status Score of 7, indicating severe impairment in cognitive skills for daily decision-making. Resident #39 was assessed as having one (1) fall with no injury. Resident #39 was assessed as using a bed and chair alarm daily. Review of Resident #39's Care Area Assessment (CAA) Summary, dated 6/11/18, revealed triggered for care plan areas included cognitive loss/dementia, visual function, communication, ADL (activities of daily living) functional/rehabilitation potential, urinary incontinence and indwelling catheter, psychosocial well-being, activities, falls, nutritional status, dental care, pressure ulcer, psychotropic drug use and pain. Further review revealed physical restraints was not triggered. Review of Resident #39's "Nurse's Note", dated 8/8/18, revealed "Resident is up in W/C (wheelchair) in rotunda. Has refused to stay in bed. Self-releasing lap belt in use." Additional review of Resident #39's hard chart and electronic medical records revealed no assessments, documentation, evaluations consent or order for use of the self-releasing seat belt. Review of Resident #39's comprehensive care plans revised on 3/26/19, revealed there was no	F 604		

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F 604	Continued From page 16 care plan developed addressing use of the self-releasing seat belt. Interview with the Director of Nursing (DON) on 4/11/19 at 12:55 PM, revealed there was no order for use of seat belt, assessment, consent or care plans addressing the seat belt use for Resident #39. During an interview on 4/11/19 at 4:50 PM, the DON stated the use of restraints and enablers are discussed every morning at their stand-up meeting. She state, "If a resident has had multiple falls, recommendations are given. Once a decision on the intervention is made, the Physician is called, and an order is obtained. The family is notified for consent and a care plan is developed. Re-evaluation is done daily. Return demonstration is also done daily." The DON stated she was not sure why the assessments and documentation was not done for Resident #39.	F 604		
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	F 656		5/28/19

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F 656	Continued From page 17 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. (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 observations, staff interview, record review and facility policy review, the facility failed to develop a comprehensive care plan to include the use of a restraint for two (2) of 18 sampled residents (Resident #36 and Resident #39). Findings include: A review of the facility's "Care Plans-Comprehensive" policy, dated 10/2016,	F 656	1. On 5/22/2019, a care plan was placed in Resident #36's electronic care plan by the MDS Nurse indicating residents need for the use of a lap tray at all times when out of bed. On 5/22/2019, a care plan was placed in resident #39's electronic care plan by the Minimum Data Set (MDS) Nurse indicating residents need for the use of a seat belt restraint at all times when out of bed. All residents are now	

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F 656	Continued From page 18 revealed "The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the Minimum Data Set (MDS)." "Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes." "Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change." Resident #36 Review of Resident #36's comprehensive care plan with focus areas initiated on 3/6/17, 3/8/17, 3/9/17, 6/19/17, 8/7/17, 8/17/17, 9/27/17, 11/20/18, 3/19/19, and 3/22/19, revealed there was not a care plan addressing the use of a lap tray. Observation on 4/10/19 at 11:40 AM, revealed Resident #36 sitting in the dining room. Resident #36's lap tray was attached to the wheelchair. Resident #36 was unable to release the lap tray. Observation on 4/11/19 at 8:30 AM, revealed Resident #36 sitting up in her room. Resident #36's lap tray was attached to the wheelchair. A review of the resident's "Face Sheet" revealed the facility admitted Resident #36 on 3/28/17, with diagnoses which included Mood Disorder, Anxiety Disorder, Major Depressive Disorder, Generalized Muscle Weakness and Adult Failure to Thrive. Review of Resident #36's Annual MDS, with an Assessment Reference Date (ARD) of 2/20/19, revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate impairment in cognitive skills. Resident #36 was	F 656	assessed on admission, quarterly, and as needed to assure care plan is up to date. 2. All residents in this facility who use an enabler or restraint have the potential to be affected by this deficient practice. No other residents were identified as being affected at this time. 3. On 4/14/2019, an in-service was conducted by the Director of Nursing (DON) with all Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nurses Assistants (CNA) to educate on the Care Plan Policy and importance of evaluating, planning, and organizing resident care for each resident. All residents who had an enabler or restraint at that time had their care plan audited by the DON and MDS Nurse on 4/14/2019 to assure that all residents with an enabler or restraint had a care plan and physicians order to reflect so in the electronic medical record. No further issues were discovered with care plans or physicians' orders as a result of this audit. 4. The DON, MDS Nurse, or Medical Records Nurse will conduct an audit one (1) time every week to review the electronic medical record for all residents' who have an enabler and/or restraint in place. The audit will be conducted on these resident's care plans and physicians' orders to assure that all residents who use these devices have a care plan and physicians' order in the electronic medical record. If found during weekly audits that these items are not in	

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F 656	Continued From page 19 assessed as requiring total physical assistance of one (1) person for bed mobility, transfers, locomotion on and off the unit. Resident #36 was assessed as not steady, only able to stabilize with staff assistance for moving from seated to standing position, moving on and off toilet and surface-to-surface transfers. Resident #36 had range of motion (ROM) impairment on both sides in the upper and lower extremities, utilized a wheelchair for mobility. Resident #36 did not have any falls. Physical Restraints or alarms were not assessed on the MDS. Review of Resident #36's "Occupational Therapy Note" dated 4/2/18 revealed "Patient demonstrated increase trunk stabilization skills to promote upright sitting balance in w/c (wheelchair) with lap tray for body alignment and safety awareness." Review of Resident #36's "Occupational Therapy Note" dated 4/3/18, revealed "Therapist placed patient in 16 x 16 w/c with roho cushion and lap tray yesterday with good posture and noted increase in sitting tolerance at four (4) to six (6) hours today." Review of Resident #36's "Order Summary Report" for April 2019, revealed an order dated 4/6/18 "Patient may sit in w/c with roho cushion for pressure relief plus lap try to maintain in upright posture." Resident #39 Review of Resident #39's comprehensive care plan with focus areas initiated on 7/14/15, 7/15/15, 9/30/15, 12/21/15, 3/14/16, 9/9/16,	F 656	the resident's records, they will be corrected in the appropriate manner by the DON, MDS Nurse, or Medical Records Nurse at time of discovery. These audits will remain an ongoing duty to assure that compliance is sustained. Findings of these audits will be discussed and reviewed every week at the weekly Quality Assurance (QA) Committee meeting as an ongoing process with no end date with recommendations or changes made as necessary. 5. All corrective actions were completed on 5/28/2019	

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F 656	Continued From page 20 6/11/18, 9/19/18, 3/26/19, revealed there was not a care plan addressing the use of the seat belt developed in the comprehensive care plan. Observation on 4/8/19 at 11:30 AM, during initial tour, Resident #39 was observed sitting in dining room waiting for lunch. Resident #39 had a seatbelt across her lap. Resident #39 had a chair alarm on her wheelchair; clipped to the back of her shirt. Observation on 4/9/19 at 12:15 PM, revealed Resident #39 self-propelling through the common area with a self-release seatbelt across her lap and a chair alarm on her wheelchair. Observation on 4/11/19 at 9:50 AM, revealed Resident #39 able to release her self-release seat belt on command. A review of the resident's "Face Sheet" revealed Resident #39 on 7/2/15, was admitted with diagnoses which included Schizophrenia, Generalized Muscle Weakness, Delusional Disorder, Anxiety Disorder, and Dementia. Review of Resident #39's Quarterly MDS, with an Assessment Reference Date (ARD) of 2/22/19, revealed a BIMS score of 7, which indicated severe impairment in cognitive. Resident #39 was as assessed as independent with no setup or physical help from staff for bed mobility. Resident #39 was assessed as requiring total physical assistance of one (1) person for transfers. Resident #39 was assessed as not steady, but able to stabilize without staff assistance with moving from seated to standing position. Resident #39 was assessed as having limited range of motion (ROM) impairment on one (1)	F 656		

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F 656	Continued From page 21 side in the upper extremity and on both sides in the lower extremities. Resident #39 used a wheelchair for mobility. Resident #39 was assessed as having one (1) fall with no injury. Resident #36 was assessed as using bed and chair alarms daily. Review of Resident #39's "Order Summary Report" for April 2019, revealed no order for the use of the self-releasing seat belt. During an interview on 4/11/19 at 4:50 PM, the Director of Nursing (DON) stated, "No, there is not a care plan addressing the use of Resident #36's lap tray or Resident #39's self-releasing seat belt." The DON stated, "Once the decision is made to use a device, the MDS nurse is notified immediately the same day to care plan." The DON stated the facility discussed these types of issues daily. The DON stated, "Our facility is too small for a department not to be notified of changes on the same day the change occurs."	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure one (1) of 18	F 684	1. Resident #71 is having proper body alignment while sitting in geri-chair and	5/28/19

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F 684	Continued From page 22 residents, Resident #71, received care in accordance with professional standards and the comprehensive care plan. Resident #71, who was unable to maintain his position in the chair without staff assistance, was not repositioned to maintain adequate posture for optimal breathing and comfort. Findings include: Review of the Resident #71's undated "Admission Record" revealed the resident had diagnoses including Dementia, Attention and Concentration Deficit, Chronic Obstructive Pulmonary Disease (COPD), Shortness of Breath (SOB), Osteoarthritis, Lack of Coordination, and Contracture. Resident #71 was also documented with a history of falling. The resident had a gastrostomy feeding tube and utilized oxygen. View of the "Order Summary Report" for the month of April 2019, revealed there was a physician's order that read, "May use reclined Geri-chair when OOB (out of bed) as an enabler for positioning" initiated on 2/15/18. The resident was prescribed oxygen at three (3) liters continuously for shortness of breath, initiated on 8/29/17. Review of the 1/4/19 Annual Minimum Data Set (MDS), under the Cognitive Patterns section, revealed Resident #71 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated he was severely impaired in cognition. The Functional Status section revealed Resident #71 required extensive assistance or was totally dependent on staff with activities of daily living (ADLs). Resident #71 required extensive assistance of two (2) or more staff for bed	F 684	being repositioned every two hours by Nursing staff. 2. All residents who using a geri-chair or wheelchair and cannot reposition themselves, have the potential to be affected by this deficient practice. Residents who sit in geri-chair and wheelchair were assessed by Director of Nursing for proper body alignment on 4/12/19 and repositioning every 2 hrs. No negative findings noted. 3. An in-service was conducted on 5/14/2019 by the Director of Nursing and Staff Development with all Nursing Staff regarding maintaining a correct anatomical and changing position every two hours and whenever necessary for all residents requiring the use of a geri-chair or wheelchair. Beginning on 5/22/2019, residents who use geri-chairs and wheelchairs will be monitored daily by the Director or Nursing or RN Supervisor x two (2) weeks, then weekly x three (3) months to ensure that all resident are being repositioned every two hours and sitting with proper body alignment. 4. Findings will be brought to the Quality Assurance (QA)Committee weekly by the Director of Nursing or RN Supervisor to ensure continued compliance. The QA committee will make recommendations or changes as needed. 5. All corrective actions completed on 5/28/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255332	A. BUILDING _____ B. WING _____	04/11/2019

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F 684	Continued From page 23 mobility, transfers, hygiene and dressing. Resident #71 was totally dependent on one (1) staff for locomotion on and off the unit, and toilet use. The resident was impaired in range of motion (ROM) on one (1) side for both the upper and lower extremities. Review of the "ADL Functional/Rehabilitation Potential CAA (Care Area Assessment) Worksheet", (part of the 1/4/19 Annual MDS), revealed the resident triggered for further assessment in this area. Issues identified in the CAA included mood decline, recent hospitalization, and communication problems. Resident #71 was identified as being at risk for functional decline due to depression and complications of immobility including contractures and incontinence. The Care Plan Consideration section indicated a care plan would be developed with a goal of avoiding complications, maintaining current level of functioning, and minimizing risk. Review of the care plan dated 10/22/18, revealed Resident #71 had shortness of breath and remained on oxygen therapy. The goal was for Resident #71 to maintain a normal breathing pattern. One (1)of the interventions was to position Resident #71, with proper body alignment, for optimal breathing pattern. Review of the care plan dated 10/22/18, revealed Resident #71 required assistance with activities of daily living related to cognitive deficits and refusal to do many things he could do. The goal was for the resident's needs to be met with assistance of staff. Interventions included extensive assistance as needed for bed mobility, transfers with mechanical lift and use of a medium sling, extensive to total assist with	F 684		

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F 684	Continued From page 24 personal hygiene, dressing, and toileting. Total care was required for propelling the Geri-chair and bathing. The care plan indicated resident #71 required two (2)-person assistance at times. Review of the care plan dated 10/22/18, revealed Resident #71 required use of a reclined Geri-chair when out of bed for positioning. The goal was to sustain no injury. Interventions included use of the reclined Geri-chair when out of bed as an enabler for positioning and repositioning the resident every two (2) hours and as needed. Review of the care plan dated 12/31/18, revealed Resident #71 had frequent pain related to the diagnosis of Osteoarthritis. The goal was for break through pain episodes to be resolved within an hour of intervention. Interventions included positioning the resident for comfort. Observations revealed the resident had suboptimal positioning in the Geri-chair as follows: - On 4/8/19 from 11:50 AM - 12:15 PM, Resident #71 sat in his Geri-chair in the main dining room at a table eating lunch. The Geri-chair was in a semi-reclined position. Resident #71 leaned to the left side, was slumped down in the chair and his lower legs and feet were hanging unsupported off the end of leg support. Staff did not reposition Resident #71 during the meal. There were numerous staff in the dining room during the lunch meal. - On 4/09/19 at 9:35 AM, Resident #71 was seated in the Geri-chair in a semi-reclined position in the central circular gathering area. Resident #71 was leaning to the left and slumped	F 684		

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F 684	Continued From page 25 down in the chair; his feet were hanging unsupported off the end of the leg support. There were nursing staff members walking through this area at the time. A nurse and Certified Nurse Aide (CNA) attended to the resident's oxygen cannula which was not in his nose; however, they did not reposition him in the chair. - On 4/9/19 at 11:50 AM, Resident #71 was seated in the Geri-chair in a semi-reclined position in the dining room eating lunch. He was slumped down in the chair with his feet hanging unsupported off the edge of the chair. One (1) of his slippers had fallen off and was on the floor below the chair. - On 4/10/19 at 11:15 AM, Resident #71 was seated in the Geri-chair in a semi-reclined position along wall near the central circular gathering area. The resident was slouched down in the chair with his feet hanging off edge of leg support of the chair. - On 4/10/19 at 1:47 PM, and again at 2:12 PM, Resident #71 was seated in the Geri-chair in a semi-reclined position in the main dining room sleeping. The resident was slouched down in the chair with his feet hanging off edge of leg support of the chair. In an interview on 4/10/19 at 2:40 PM, Certified Nursing Assistant (CNA) #3 stated Resident #71 required extensive assistance or was totally dependent with ADLS. CNA #3 stated Resident #71 required extensive assistance for bed mobility and transfers. CNA #3 stated Resident #71 required a mechanical lift for transfers. CNA #3 stated Resident #71 had a contracture and could barely open one of his hands. CNA #3	F 684		

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F 684	Continued From page 26 stated Resident #71 was incontinent of bowel and bladder and was dependent on staff to change his incontinent brief. CNA #3 stated Resident #71 sat in a Geri-chair in a semi-reclined position when he was up and out of bed. CNA #3 stated Resident #71 could not maintain his posture if he sat upright, verifying the need for the chair to be in a semi-reclined position. CNA #3 stated Resident #71 could not reposition himself in the Geri-chair and indicated he required staff assistance to reposition. CNA #3 stated, "He seems to lean to the left even in the bed. We have to reposition him." In an interview on 4/11/19 10:16 AM, the Physical Therapist (PT) stated one (1) of Resident #71's hip joints had dissolved. The PT stated Resident #71 liked to be out of his room and was most comfortable in a Geri-chair. The PT stated, "He must be reclined to disperse his body weight. He does lean to the left." The PT stated they tried different pillows to maintain his position. The PT stated she would reassess the resident's current position in the Geri- chair as he had not been on her case load recently. In a follow up telephone interview on 4/11/19 at 2:05 PM, the PT stated she assessed Resident #71's position in the Geri-chair and stated he did not need any positioning devices or a different chair. The PT stated the resident was slumped in the chair when she assessed him and when staff repositioned him, his position was aligned and was okay. She stated she instructed nursing staff to follow up to ensure he was positioned appropriately. In an interview on 4/11/19 at 2:58 PM, Registered Nurse (RN) #2 stated Resident #71 could move	F 684		

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F 684	Continued From page 27 his upper body but not his lower body and stated he typically leaned over to the side. RN #2 stated staff should pull him up in the chair if he slid down. In an interview on 4/11/19 at 4:50 PM, the Director of Nursing (DON) stated residents should be repositioned every two (2) hours routinely; however, if a resident was not correctly positioned or aligned, the resident should be repositioned at that time. The DON stated Resident #71 could reposition himself when he was in bed, but most of the time he would not. The DON stated the nurses should be monitoring the resident's positioning in the Geri-chair, indicating he should be aligned and not slumped down.	F 684		
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	F 812		5/28/19

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F 812	Continued From page 28 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure food was stored and served in a manner to minimize the potential spread of food borne illness to all residents (except those who received nutrition via feeding tube only). Specifically, tray line holding temperatures were not within safe ranges. This affected 63 of 72 residents. Findings include: Review of the U.S. Public Health Service, Food and Drug Administration, 2017 "Food Code" Section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding, page 95 revealed, the holding temperature for the safety of hot food shall be maintained at a temperature of 135 degrees Fahrenheit (F) or above. The initial kitchen inspection was conducted with the Dietary Manager on 4/8/19, from 11:28 AM through 11:50 AM. The Dietary Manager took the temperatures of the foods remaining on the tray line right after lunch meal service to the residents in the main dining room. Specific temperatures that were too low included: - Pureed broccoli - 110 degrees Fahrenheit (F) - Pureed chicken - 113 degrees F - Gravy - 110 degrees F The Dietary Manager was interviewed at the time of the observation, and stated the tray line hot food-holding temperatures should be a minimum of 135 degrees F. On 4/11/19 at 4:24 PM, Cook #1 took tray line	F 812	1. All residents who receive a meal tray in this facility now receive their food served at the proper and safe holding temperature. On 4/8/19, 4/10/19 and 4/11/19 all food that did not have proper holding temperature was properly disposed of so not to be served to other residents. The Dietary Manager and Registered Nurse Supervisor immediately performed a visual check and verbal interview of all residents that participated in the meals to ensure that no illness or symptoms had taken place following all episodes of improper holding temperatures. No residents at the time of initial visual checks exhibited signs and symptoms of food borne illness. The Dietary Manager also notified all nursing staff after each episode on 4/8/19, 4/10/19, and 4/11/19 to begin monitoring for any symptoms of food borne illness that is observed over a period of 72 hours. No illness was discovered or reported within 72 hours of food consumption following all three (3) dates. 2. All residents and others who consume food prepared in the dietary department have the potential to be affected by the same deficient practice of improper food holding temperatures. 3. All dietary personnel were in-serviced by the Dietary Manager on the Storage of Cooked Foods policy on 4/8/19. All foods after being cooked to the required minimum internal temperature and being served hot, will be held on hot holding	

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F 812	Continued From page 29 temperatures right before the beginning of tray line meal service for the evening meal. Specific temperatures that were too low included: - Pureed noodles - 120 degrees F - Mashed potatoes - 130 degrees F - Gravy - 90 degrees F On 4/11/19 at 4:30 PM, the Dietary Manager was interviewed and verified hot foods should be at least 135 degrees F in the steam table/on the tray line and if they were not, the food should be removed from the tray line, reheated, and then placed back on the tray line once the foods were hot enough. On 4/11/19 at 4:46 PM, interview with Cook #1, revealed she had reheated the gravy prior to serving it; however, she did not reheat the pureed noodles or mashed potatoes. Cook #1 verified she had already served pureed noodles and mashed to potatoes to some residents. Cook #1 stated she was aware the gravy was not hot enough; that was why she reheated it. She stated she would reheat the pureed noodles and mashed potatoes now, as there were still residents that had not yet been served. The "Food Holding Temperatures" logs were requested for the four (4) days of the survey; the following concerns with temperatures of foods on the tray line were identified. On 4/8/19, for the lunch meal, hot holding temperatures that were too low included: - Meat - 120 degrees F - Starch - 123 degrees F - Vegetable - 127 degrees F On 4/10/19, for the lunch meal, a hot holding	F 812	equipment that will keep the food at a minimum 135 F or higher. In the in-service, the dietary staff were instructed by the Dietary Manager to stir food at regular intervals to distribute heat evenly, check internal food temperatures at least every two (2) hours using a calibrated thermometer, and to discard potentially hazardous foods after four (4) hours if it has not been held at 135 F or above. Beginning on 5/11/2019, the on duty cook now monitors and records temperature of the water inside the steam table at each meal serve time to ensure it has reached and maintains the appropriate and safe temperature. All food placed inside the steam have a temperature taken prior to and during every meal to ensure that the holding temperature is 135 degrees or above and then recorded in a food temperature holding log. If a food item on the serving line does not meet the required temperature, it is now immediately removed and properly disposed of. 4. Beginning on 5/12/2019, the serving line temperature book will be monitored daily x three (3) months by the on-duty cook and the Dietary Manager for proper holding temperatures of at least 135 F. All temperatures will be recorded by the on-duty cook daily x3 months with each meal. The Dietary Manger will do daily temperature checks five (5) days a week x3 months on the food items prior to being served and again once food is served to residents for at least 3 meal trays with each check. The on-duty cook will do daily temperature checks on Saturday and	

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F 812	Continued From page 30 temperature that was too low was: - Vegetable - 130 degrees F	F 812	Sunday x3 months on the food items prior to being served and again once food is served to residents for at least 3 meal trays with each check. The weekly food temperature log results will be brought to the Quality Assurance (QA) Committee meeting and discussed during the weekly meeting x3 months or until compliance is achieved. The QA committed will monitor logs for incorrect temperatures and make recommendations or take action if equipment needs replacing for a period of 3 months or until compliance is achieved. 5. All corrective actions were completed on 5/28/2019	

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 04/30/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 4/11/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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