MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26CL	A. BUILDING: _____ B. WING _____	04/11/2019

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

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M 000	Initial Comments During the recertification survey of 4/8/19-4/11/19, conducted by Ascellon, acting on behalf of the MS State Department of Health, the survey determine that the facility was not in compliance with federal requirements at F604, F684 and F812. It was also determined, that the facility is not in compliance with the Minimum Standards of Operation for the Institutions for the Aged or Infirm, state licensure requirements at M500, M610 and M865. The census at the time of survey was 72 and the facility held a license for 80 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his	M 500		5/28/19

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M 500	Continued From page 1 medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;	M 500		

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M 500	Continued From page 2 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other	M 500		

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M 500	Continued From page 3 residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, record review, review of	M 500	I. The facility now ensures that restraints shall only be used for the safety and well-being of the residents after all	

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M 500	Continued From page 4 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: 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	M 500	alternatives have been unsuccessfully attempted. 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. 2. All Resident with seat belts are at risk for 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 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 by the DON and staff development nurse to review the Kardex in Point Click Care before each shift for assigned Resident group to ensure 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.	

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M 500	Continued From page 5 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 #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	M 500	Residents who have lap trays or seat belts will be monitored by the Director of Nursing or Registered Nurse (RN) Supervisor weekly x three (3) 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 ensured 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 corrective actions completed on 5/28/19.	

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M 500	Continued From page 6 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 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.	M 500		

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M 500	Continued From page 7 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 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	M 500		

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M 500	Continued From page 8 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 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.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to:	M 610		5/28/19

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M 610	Continued From page 9 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, record review and interview, the facility failed to ensure one (1) of 18 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	M 610	1. Resident #71 is having proper body alignment while sitting in geri-chair and 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.	

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M 610	Continued From page 10 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 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	M 610	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.	

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M 610	Continued From page 11 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 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	M 610		

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M 610	Continued From page 12 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 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.	M 610		

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	26CL	A. BUILDING: _____ B. WING _____	04/11/2019

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M 610	Continued From page 13 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 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	M 610		

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M 610	Continued From page 14 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 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.	M 610		
M 865	45.30.9 Serving of Meals Serving of Meals. 1. Table should be of a type to seat not more than four (4) or six (6) residents. Residents who are not able to go to the dining room shall be provided sturdy tables (not TV trays) of proper heights. For those who are bedfast or infirm tray service shall be provided in their rooms with the tray resting on a firm support.	M 865		5/28/19

MSDH - Health Facilities Licensure and Certification

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M 865	Continued From page 15 2. Personnel eating meals or snacks on the premises shall be provided facilities separate from and outside of food preparation, tray service, and dishwashing areas. 3. Foods shall be attractively and neatly served. All foods shall be served at proper temperature. Effective equipment shall be provided and procedures established to maintain food at proper temperature during serving. 4. All trays, tables, utensils and supplies such as china, glassware, flatware, linens and paper placemats, or tray covers used for meal service shall be appropriate, sufficient in quantity and in compliance with the applicable sanitation standard. 5. Food Service personnel. A competent person shall be designated by the administrator to be responsible for the total food service of the home. Sufficient staff shall be employed to meet the established standards of food service. Provisions should be made for adequate supervision and training of the employees. This Statute is not met as evidenced by: Level II 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:	M 865	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	

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M 865	Continued From page 16 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 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.	M 865	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 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	

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M 865	Continued From page 17 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 temperature that was too low was: - Vegetable - 130 degrees F	M 865	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 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	