STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255318	A. BUILDING _____ B. WING _____	01/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
J G ALEXANDER NURSING CENTER	25112 HIGHWAY 15 UNION, MS 39365

(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 The State Agency (SA) conducted an annual re-certification survey at the facility from 1/02/19 to 1/04/19. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid regulations for participation and cited the regulatory deficiencies at F561, F565, F657, F804, and F812. The census at the time of the survey was 57, and the facility held a license for 60 beds.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to	F 561		2/2/19

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

Electronically Signed | 02/01/2019

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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F 561	Continued From page 1 participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, record review, and facility policy review, the facility failed to honor resident choices related to food preferences for two (2) of six (6) residents in the Resident Council Meeting; Resident #5 and Resident #7. Findings Include: Review of the facility's policy titled, "Resident Rights Policy", dated November 2016, revealed: The resident has the right to and the facility will promote and facilitate self-determination through support of resident's choice. The resident has the right to make choices about aspects of their life in the facility that is significant to the resident. Resident #5 On 01/03/19 at 9:31 AM, an interview with Resident #5 during the Resident Council Meeting, revealed she stated that she has requested well done eggs for breakfast, but they continue to send her medium fried eggs and she does not like them. Resident #5 stated, there was no need to tell dietary you don't like something, because they are going to send you what they want you to have. Resident #5 confirmed, they are not honoring choices related to food preferences. Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #5 was cognitively intact.	F 561	1. The Director of Nurses interviewed Resident #5 and Resident #7 on 1/4/2019 in order to obtain data related-to the resident's food choice preference(s), and on 1/72019, the Director of Nurses submitted data that was obtained to the Dietary Manager, and on 1/7/2019, the Dietary Manager updated these resident's tray cards in order to ensure that these resident's food preference(s) and choice(s) are honored. 2. All residents have the potential to be affected by the same deficient practice. 3. (A.)The Director of Nurses conducted an in-service for the Dietary Manager on 1/7/2019 related-to honoring of resident food choices and food preferences for all residents in order to ensure that all resident's food preferences are honored. (B.) Beginning 1/7/2019, the Dietary Manager will conduct Resident Satisfaction Surveys/Audits twice monthly for at least three months in order to ensure that resident's food preferences are honored. (C.) Beginning 1/4/2019 the Director of Nurses, for at least eight weeks, will obtain data related-to resident food choices for all residents via audit-interviews to be conducted weekly with the Resident council President	

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F 561	Continued From page 2 Resident #7 On 01/03/19 at 09:31 AM, during the Resident Council Meeting, revealed Resident #7 stated, she had problems with acid reflux, and had asked to not have spicy foods on her tray. Resident #7 stated, she has had spicy foods served since her request on November 8, 2018. Resident #7 stated, she can't eat chocolate, and that dietary continues to send it. Resident #7 stated, they continue to send me foods that I have specifically requested to not receive, and I can't eat them. Resident #7 had a BIMS score of 15, which indicated Resident #7 was cognitively intact. On 01/03/19 at 11:00 AM, an interview with the Dietary Consultant (DC) revealed, she stated the facility informs her of food concerns and she notifies the Dietary Manager (DM). The DC stated, the food concerns would be entered into the computer, and becomes a part of likes and dislikes. The DC stated, she was aware that Resident #7 had asked for no spicy foods, and had discussed this with the DM. The DC stated, she was aware that Resident #5 had requested well done eggs, and this had been discussed with the DM. The DC further stated, she visits with the residents to determine their likes and dislikes, and informs the DM so their request can be honored. On 01/03/19 at 11:15 AM, an interview with the Diet Clerk Supervisor (DCS), revealed she stated the residents food likes and dislikes are entered into the computer, and the tray card is printed with each meal. The DCS stated, at the time of	F 561	together with all residents who participate in the Resident Council Subcommittee for Quality Assurance an Provider Improvement of facility dietary service, in order to obtain data related-to resident's food preferences and ensure that resident's food preferences are honored. (D.) The Quality Assurance Nurse will collect and compile results of all audit(s), in-services(s), and data obtained monthly, and submit the same to the Quality Assurance Committee on a monthly basis in order to ensure that resident food preferences are honored. 4. The Quality Assurance Committee will review the results of all scheduled data collection, audit(s), and in-service(s), presented by the Dietary Manager and Quality Assurance Nurse to determine pertinent corrective action(s) as well as the continued frequency of all scheduled data collection, audit(s), and in-service(s) based-upon results achieved.	

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F 561	Continued From page 3 meal set up, one person is at the front of the line calling out food preferences, while another person is placing food on the tray. The Surveyor reviewed the tray card for Resident #5 and Resident #7 with the DCS. The DCS confirmed Resident #5 had requested well done fried egg on her preferences list, and Resident #7 tray card included dislikes of no spicy foods and no chocolate. The DCS stated, it was obvious the staff was not reading the tray cards, or they were not paying attention, or they would have known not to send the dislikes. The DCS confirmed, the residents' food preferences were not being honored.	F 561		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their	F 565		2/2/19

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F 565	Continued From page 4 response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, record review, and facility policy review, the facility failed to resolve grievances related to food concerns in a timely manner for three (3) of six (6) residents attending Resident Council Meeting; Resident #5, Resident #7 and Resident #16. Findings Include: Review of the facility's policy titled, "Grievance Policy", dated November 2016, revealed: The resident has the right to and this facility will make prompt efforts to resolve grievances the resident may have. This facility grievance policy ensures the prompt resolution of all grievances regarding the residents' rights. Resident #5 On 01/03/19 at 09:31 AM, during the Resident Council Meeting, Resident #5 stated, she had requested well done eggs and they continue to send medium fried eggs, and she can't eat them. Resident #5 stated, there was no need to tell	F 565	1. On 1/10/2019, the Dietary Manager interviewed Resident #5, Resident #7, and Resident #16, obtained data related-to applicable grievance(s) concerning food preference(s) voiced by the residents in Resident Council, and made applicable changes to the resident's tray cards in order to ensure prompt resolution of resident grievance(s) and that these resident's food preference(s) and choice(s) are honored. 2. All residents have the potential to be affected by the same deficient practice. 3. (A.)The Director of Nurses conducted an in-service for the Dietary Manager on 1/7/2019 related-to proper methods for resolution of resident grievances in order to ensure that all resident's food preference(s) and related grievance(s) are promptly resolved. (B.) On 1/4/2019, the Director of Nurses conducted one-on-one counseling	

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F 565	Continued From page 5 dietary you don't like something, because they are going to send you what they want you to have. Resident #7 On 01/03/19 at 09:31 AM, during the Resident Council Meeting, Resident #7 stated, she has had problems with acid reflux, and had asked to not have spicy foods on her tray. Resident #7 stated, she has continued to receive spicy foods after the November 8, 2018 request. Resident #7 stated, she can't eat chocolate, and had requested that it not be sent, but they continue to send chocolate. Review of the Resident Council Meeting minutes, dated 11/8/2018, reflected Resident #7 had stated, she couldn't eat anything spicy. A review of the facility's follow-up notes of the Resident Council meeting reflected, Dietary aware of issues. Resident #16 On 01/03/19 at 09:31 AM, during the Resident Council Meeting, Resident #16 stated, he had asked to not have juice and fruit on his tray, and they continue to send it. Resident #16 stated, he had issues with Gout, and he can't eat fruit and fruit juices. Resident #16 stated, dietary staff had come to his room on two (2) occasions and he had talked with them once, during the Resident Council meeting. Resident #16 stated, he had asked to have his ham ground up without the trimming, and they continue to include the trim on the ham which causes him to choke. Review of the Resident Council Meeting minutes, dated 8/9/2018, revealed Resident #16's	F 565	for the benefit of the Resident Council President in order to ensure that s/he is aware of the facility policy related-to prompt resolution of grievances for the benefit of all facility residents, with emphasis concerning resolution of grievance(s) pertaining-to resident food preferences. (C.) Beginning 1/31/2019 the Director of Nurses will audit the minutes of the Resident Council on a monthly basis for at least six months in order to ensure the prompt resolution of all resident grievances related-to resident rights. (D.) Beginning 1/4/2019 the Director of Nurses and the Activity Director will meet with the Resident Council Subcommittee for Quality Assurance and Provider Improvement for facility dietary service grievance resolution on a monthly basis for at least six months in order to ensure that resident grievances related-to food preferences are being promptly resolved, and the Director of Nurses and Activity Director will compile the data obtained from their meeting(s) with the residents for the purpose of initiating requisite facility action and Quality Assurance review. (E.) The Quality Assurance Nurse will compile the result(s) of all data obtained, audit(s), and in-service(s) on a monthly basis, and submit the same to the Quality Assurance Committee on a monthly basis in order to ensure prompt resolution of resident grievances. 4. The Quality Assurance Committee will review the results of all scheduled data collection, audit(s), and in-service(s),	

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F 565	Continued From page 6 documented concern related to ham being grounded up, but they don't take the rim off, and he can't chew it. On 01/03/19 at 10:25 AM, an interview with the Director of Nursing (DON), revealed she stated, the Dietary Manager (DM) was out of town until this weekend and not available for contact. The DON stated, when a resident voices a food concern to her, she contacts the DM, and she talks to the resident about the concern. The DON stated, the DM should follow up with the resident in a week or so, to see if their concern has been resolved. On 01/03/19 at 10:39 AM, an interview with the Social Worker (SW), revealed she stated, food concerns have been brought to her attention, and any concerns are referred to the DM for investigation and resolution. On 01/03/19 at 11:00 AM, an interview with the Dietary Consultant (DC) revealed she stated, that she communicates all food concerns to the DM. The DC stated, the facility informs her of food concerns and she notifies the DM. The DC stated, the food concerns would be entered into the computer, and become a part of likes and dislikes. The DC stated, she was aware that Resident #7 had asked for no spicy foods, and had discussed this with the DM. The DC stated, she was aware that Resident #5 had requested well done eggs and this had been discussed with the DM. The DC further stated, she was aware that Resident #16 had requested no fruit or fruit juices, but couldn't remember if she had discussed this with the DM. The DC stated, she visits with the residents to determine their likes and dislikes, and informs the DM so their request	F 565	presented by the Quality Assurance Nurse and Director of Nurses to determine pertinent corrective action(s) as well as the continued frequency of all scheduled data collection, audit(s), and in-service(s) based-upon results achieved.	

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F 565	Continued From page 7 can be honored. On 01/03/19 at 11:15 AM, an interview with the Diet Clerk Supervisor, confirmed the residents concerns related to food preferences had not been resolved, since the residents continued to receive foods they specifically requested not to receive.	F 565		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		2/2/19

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F 657	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, observation, and facility policy review, the facility failed to revise the comprehensive care plan related to nutrition for one (1) of 27 resident care plans reviewed; Resident #19. Findings include: Review of the facility policy titled, "Comprehensive Resident Centered Care Plans", undated, revealed the facility will develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights and that includes measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. An observation, on 01/02/19 at 12:35 PM, revealed Resident # 19 sitting in the dining room at a table and feeding self a Pureed diet with thickened liquids. Record review of Resident #19's January 2019 Physician Orders, revealed an order, dated 7/31/18 for a Pureed diet with Nectar thick liquids. Record review of the Dietary Departmental Notes, dated 8/2/18, revealed an entry documented, "Order to have a Pureed diet with Nectar thick liquids."	F 657	1. The Minimum Data Set Registered Nurse revised the Plan of Care for Resident #19 on 1/3/2019 in order to ensure accuracy related-to dietary orders. 2. All residents have the potential to be affected by the same deficient practice. 3. (A.) On 1/4/2019, the Director of Nurses conducted and in-service for all Minimum Data Set nursing staff related-to proper updates for Plans of Care concerning dietary orders in order to ensure that Plans of Care are appropriately revised when new dietary orders are written. (B.) Beginning 1/10/2019, the Dietary Consultant will audit all dietary orders on a monthly basis for at least four months in order to ensure that Plans of Care are appropriately revised when new dietary orders are written. (C.) The Quality Assurance Nurse will collect the results of all audit(s) and in-service(s) on a monthly basis for submission to the Quality Assurance Committee in order to ensure that dietary Plans of Care are appropriately revised when new dietary orders are written. 4. The Quality Assurance Committee will review the results of all scheduled data collection, audit(s), and in-service(s), presented by the Quality Assurance Nurse and Director of Nurses to determine pertinent corrective action(s) as well as the continued frequency of all scheduled	

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F 657	Continued From page 9 Record review of Resident # 19's printed comprehensive care plan on the chart and the computerized comprehensive care plan, revealed the problem to address Alteration in Nutrition, with an onset date of 10/06/15 and goal and target date of 1/25/19. The approaches revealed, "Resident to receive a mechanical soft diet with gravy and ground meats with thin liquids." On 01/03/19 at 10:34 AM, an interview with the Minimum Data Set Registered Nurse (MDS RN), confirmed Resident 19's care plan on the chart and in the computer, had mechanical soft diet with thin liquids and chopped meat listed as an approach on the problem addressing Alteration in Nutrition. The MDS RN confirmed, the comprehensive care plan for Resident # 19 was not updated with the order from 7/18 for a pureed diet and nectar thick liquids, when the care plan was updated on 10/25/18. The MDS RN revealed, the staff just missed it and that she did not understand what happened. The MDS RN further revealed, they pull the residents' current Physician's orders at care plan conference, and check off all current orders against the care plan, to make sure it is accurate.	F 657	data collection, audit(s), and in-service(s) based-upon results achieved.	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.	F 804		2/2/19

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F 804	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, observation, record review and facility policy review the facility failed to serve palatable meals to residents for three (3) of 22 residents interviewed regarding food; Resident #5, Resident #13 and Resident #33. Findings include: Review of the facility policy titled, "Nutritive Value/Appearance, Palatable/Prefer Temp", dated November 2016, revealed: Each resident will receive and the facility will provide -- a. Food prepared by the methods that conserve nutritive value, flavor and appearance. b. Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Resident #5 On 01/02/19 at 02:23 PM, an interview with Resident #5, revealed she stated that she does not like the food. Resident #5 stated, she usually eats her breakfast and that's it. The resident stated, her daughter brings her food from home, and she usually eats that when she gets hungry. On 01/03/19 at 04:00 PM, an interview with Resident #5, revealed she stated the lunch today was fair. The resident stated, she was able to eat a small portion of the food. Resident #5 further stated, it was a lot better today than it had been in the past. The resident revealed, in the past, she had not been able to eat the roast.	F 804	1. Dietary Manager and Director of Nurses interviewed Resident #5, Resident #13, and Resident #33 on 1/7/2019; documented data facts related-to likes and dislikes voiced by these residents concerning food palatability; and on 1/7/2019, the Dietary Manager altered these resident's meal tray preparation cards in order to ensure palatable and attractive meals in accordance with the likes, dislikes, and pertinent data facts voiced by these residents. 2. All residents have the potential to be affected by the same deficient practice. 3. (A.) On 1/7/2019, Dietary Staff was in-serviced by the Registered Dietician and the Dietary Manager related-to proper procedures concerning how to follow menus and recipes in order to ensure that all food served to residents is attractive and palatable. (B.) Beginning on 1/7/2019, the Quality Assurance Nurse will receive and audit a test tray at least five times per week for at least four weeks in order to ensure that residents receive palatable and attractive meals. (C.) Beginning on 1/7/2019, the Dietary Manager will conduct Resident Satisfaction Surveys/Audit(s) at least twice monthly for at least three months in order to ensure that residents receive palatable and attractive meals. (D.) The Quality Assurance Nurse will compile all findings related-to test tray	

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F 804	Continued From page 11 Resident #13 On 01/02/19 at 11:40 AM, an interview with Resident #13, revealed she does not like the food. The resident stated, it is not seasoned properly. On 01/03/19 at 03:09 PM, an interview with Resident #13, revealed she stated, that she really didn't like the food today. Resident #13, stated, her roll was in her green beans and it was soggy, and she couldn't eat it. The resident stated, she is often served food that she feels is undercooked, such as peas and squash. Resident #13 stated, she will ask for buttermilk and cornbread at dinner, because she knows this is something she will eat and can eat. Resident #33 On 01/02/19 at 11:56 AM, an interview with Resident #33, revealed, he stated he couldn't eat the food here. Resident #33 stated, he liked the breakfast fine, but that's the only meal he eats. Resident #33 stated, he snacks the remainder of the day. 01/03/19 at 01:34 PM, Resident #33 stated, that he did not eat the meal today. The resident stated, he looked at it, and it didn't look good, so he didn't eat it. Resident #33 stated, he ate his breakfast this morning. The resident stated, if he gets hungry this afternoon, he had some snacks that he could eat. 01/03/19 at 11:00 AM, an interview with the Dietary Consultant (DC), revealed she stated, the food lacks seasoning, and she has received	F 804	audit(s), satisfaction survey(s)/audit(s), and in-service(s) on a monthly basis, and submit the same to the Quality Assurance Committee on a monthly basis in order to ensure that residents receive palatable and attractive meals. 4. The Quality Assurance Committee will review the results of all scheduled data collection, audit(s), and in-service(s), presented by the Quality Assurance Nurse to determine pertinent corrective action(s) as well as the continued frequency of all scheduled data collection, audit(s), and in-service(s) based-upon results achieved.	

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F 804	Continued From page 12 complaints regarding the food. The DC stated, she understood that it was very important to the residents that they have good food to eat. On 01/03/19 at 12:15 PM, a test tray was obtained by the Surveyor to test for food palatability. The temperature of the food was okay. The roast was mushy and stringy, and did not have the firmness one would expect of meat. The roast had more of a watery, overcooked consistency. The carrots were soggy and had a watery consistency. The rice and broccoli was bland, and had no taste.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record	F 812	1. Dietary Manager and Registered	2/2/19

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F 812	Continued From page 13 review, and facility policy review, the facility failed to provide a clean and sanitary environment for two (2) of three (3) kitchen tour observations. Findings include: A review of the facility's policy titled, "Cleaning Instructions Cleaning Refrigerators", dated 2005, revealed the refrigerators will be washed thoroughly inside and outside with a detergent and followed by a sanitizer at least once every month, or as needed. Spills and leaks will be wiped up as they are noticed. For walk-in refrigerators, also mop floors, clean drains and wash walls and ceilings monthly. On 01/02/19 at 10:18 AM, an interview and observation during the initial tour of the kitchen, with the Dietary Supervisor (DS), revealed the walk-in cooler and freezer had four (4) loose small tomatoes on the floor, with one (1) tomato crushed on the rubber mat located on the floor. Also noted, was debris and dirt on the floor beside the rubber mat, and in the holes of the rubber mat. The DS confirmed, the floor was "grungy and needed to be swept, mopped and scrubbed." On 1/03/19 at 10:30 AM, an interview and kitchen observation with the Dietary Consultant (DC), revealed cleaning of the kitchen had been an issue. The DC confirmed, the tomatoes on the floor inside the cooler, and the rubber mat were dirty and needed a deep cleaning.	F 812	Dietician provided direct oversight and directed dietary staff on 1/3/2019 related-to ensuring that the Dietary Department's walk-in cooler/freezer was appropriately cleaned and sanitized, and verified that the cooler/freezer is in fact appropriately clean and sanitary. 2. All residents have the potential to be affected by the same deficient practice. 3. (A.) On, 1/5/2019, the Registered Dietician conducted in-service training for all Dietary Staff related-to relevant policies/procedures concerning the cleaning and appropriate sanitization in order to ensure execution of proper kitchen cleaning and sanitization procedures. (B.) Beginning on 1/7/2019, the Dietary Manager will complete a kitchen cleaning and sanitization audit at least five times weekly for at least thirty days, then at least once weekly thereafter, in order to ensure that the kitchen is continuously clean and sanitary. (C.) The Quality Assurance Nurse will receive result(s) of all audit(s) and in-service(s) on a monthly basis in order to ensure that the kitchen is continuously clean and sanitary, and will report the same result(s) to the Quality Assurance Committee on a monthly basis. 4. The Quality Assurance Committee will, on a monthly basis, review the results of all scheduled data collection, audit(s), and in-service(s) presented by the Quality Assurance Nurse and Dietary Manager in	

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F 812	Continued From page 14	F 812	order to determine pertinent corrective action(s) as well as the continued frequency of all scheduled data collection, audit(s), and in-service(s) based-upon results achieved.	

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to properly maintain exit egress as per NFPA 19 2.2.2.4. This standard deficiency affected one (1) of six (6) exits and eight (8) of 59 residents in the facility on the day of survey. Findings include: On January 11, 2019 at 10:15 AM, observation and interviewing revealed the staff did not contain nor had access to the key for the lock on the gate to the egress from the 400 Hall of the facility. This same deficient practice was observed and cited on last year Life Safety Code survey on September 6, 2017.	K 211	1. The lock on the gate to the egress from 400 Hall was removed on 01/04/2019 by Facility Maintenance Supervisor and replaced with caribiner. (Exh. K2111) 2. All resident have potential to be affected. 3. (A.) In-service for new maintenance supervisor was done on 01/29/2019 by Field Maintenance Supervisor on importance of means of egress and fire safety.(Exh. K2112) (B.) Laird Maintenance Supervisor will audit monthly to ensure exit egress is maintained.(Exh. K2113)	2/2/19

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

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K 211	Continued From page 1	K 211	4. QA will review findings monthly to ensure continued compliance.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to properly perform fire drills in accordance NFPA 101 sections 19 .7.1.6 and 19.7.1.7. This deficiency affected all 59 of the residents in the facility on the day of survey. Findings Include: On January 11, 2019 at 11:10 AM, record review revealed the documentation provided by the facility indicated the fire alarm system was not set off during all fire drills performed between 6AM - 9PM. This fire drill procedure occurred during the 3rd and 4th quarters of 2018. An interview with the Administrator revealed the facility staff was unaware that fire drills must be audible from during the hours of 6AM thru 9PM. On January 11, 2019 at 11:15AM, record review	K 712	1. The new maintenance supervisor has been in-serviced on 01/29/2019 on properly performing fire drills in accordance with NFPA 101 sections 10.7.1.6 and 19.7.1.7. (Exh. K7122)and audible fire drills were done on 1/14/2019, 1/15/2019, 1/16/2019, 1/17/2019, 1/19/2019 and 1/21/2019.(Exh. K7121) 2. All residents have the potential to be affected by improper fire drills as required. 3. (A.) In-service on new Facility Maintenance Supervisor by Field Maintenance Supervisor, to require audible fire drills between 6AM-9PM and documentation required when performing fire drills. (Exh. K7122) (B.) Facility Maintenance Supervisor at	2/2/19

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K 712	Continued From page 2 also revealed the facility could not provide documentation of a fire drill being performed during the 2nd shift in the 3rd quarter of 2018 and the 3rd shift in the 4th quarter of 2018.	K 712	the time was terminated on 01/18/2019. (C.) Laird Maintenance Supervisor will audit fire drills to ensure monthly compliance.(Exh. K7123) 4.QA will review findings monthly to ensure continued compliance.	

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 1/11/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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