STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056495	A. BUILDING _____ B. WING _____	04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA COLOMA HEALTH CARE CENTER	10410 COLOMA RD RANCHO CORDOVA, CA 95670

PCC acceptable 6/15/17 /S Pinkham HFES

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Federal Recertification Survey. Representing the Department of Public Health: HFEN, 36244 HFEN, 32515 HFEN, 36570 HFEN, 38178 HFEN, 38518 HFEN, 38669 Nutrition Consultant, 31472 The facility census was 129. The sample size was 24.	F 000	This Plan of Correction constitutes a credible allegation of compliance.	
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (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. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 371		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah M. Patula	Administrator	May 6, 2017

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 371	Continued From page 1 (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility failed to: 1. Ensure expired nutritional supplements were not available for use for a census of 129. This failure had the potential to expose residents to expired supplements. 2. Store food in accordance with professional standards for food service safety for 123 of 129 residents receiving meals from the kitchen when left over food was stored in the kitchen refrigerator beyond the use by date. This failure had the potential to cause foodborne illness in a highly susceptible population. Findings: 1a. Medication Room/Storage 1 inspection was conducted with Licensed Nurse (LN) 1 on 4/3/17. Four cans of a nutritional supplement, with an expiration date of May 1, 2016, were found. LN 1 acknowledged the finding and stated, "It was overlooked. We don't use it anymore." 1b. Medication Room/Storage 2 inspection was conducted with Licensed Nurse (LN) 1 on 4/3/17. One box of glucose control supplement [nutritional supplement], with an expiration date of 2/22/17, was found. LN 1 acknowledged the finding and stated, "This should be taken out [removed from the room]."	F 371	Temporary and Permanent Correction It is the policy of this facility to follow practices To maintain safe refrigerated storage including: Labeling, dating and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by-date, or frozen (where applicable) or discarded. All open food items will have an open date and use-by-date per manufacturer's guidelines. After opening, (the food is) dated, labeled and discarded after 72 hours. Blueberries were immediately discarded by the Certified Dietary Manager. Dietary was informed that blueberries should have been discarded. To ensure that future residents are not affected by this deficient practice, In-Service was provided by the Dietary Manager to all kitchen staff on proper Food Storage practices including but not limited to, dating, labeling and monitoring of refrigerated food items insuring they are discarded by "use by date", "manufacturers best by" date or 72 hours after prepared, labeled and stored in refrigerator. Certified Dietary Manager will monitor and log Above mentioned practices for 3 months to Insure proper Food Storage practices are being followed. If staff follow facility policies during monitoring period with 100% compliance, monitoring will be reduced to routine monitoring that is conducted by Dietary Manager and Dietician	

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F 371	Continued From page 2 2. The initial kitchen tour observation was conducted on 4/3/17 at 8:10 a.m. with the Certified Dietary Manager (CDM). One foil covered container of blueberries was noted on a shelf inside the walk-in refrigerator. The dates 3/28/17 and 3/31/17 were hand written in black ink on the foil. The CDM validated the observations and stated, "The 3/31/17 on the bottom is the use-by-date and this should've been discarded." The facility Policy and Procedure Manual for Dietetic Services titled "Food Storage Management Storage of Food and Non-Food Supplies Policy No. 510," dated 2012, included "...Practices to maintain safe refrigerated storage include: labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by-date, or frozen (where applicable) or discarded...All open food items will have an open date and use-by-date per manufacturer's guidelines...After opening, [the food is] dated with use-by-date and labeled. Discard after 72 hours."	F 371	Continued F371 through written audits that are completed and reported to the Administrator monthly in Dietician's reports. Inservices were conducted 05/02/2017 and 05/04/2017. Expired nutritional supplement was discarded by the Director of Nursing. Nutritional Supplement that was expired was not a product that was currently being used by the facility, and was in the far, back of a cupboard not easily visible. To insure that this deficient practice does not occur and that future residents are not affected by this deficient practice, Inservice will be provided to all licensed nursing staff by the Director of Nursing on checking nutritional supplements for expiration dates. Pull out racks will be installed by maintenance to make it easy to see all nutritional supplement that is stored at nursing station. Inservices were conducted on May 3, 2017 and May 4, 2017 by the Director of Nursing and the Asst. Director of Nursing. If 100% compliance is maintained during monitoring period, monitoring will be reduced to monitoring that is conducted through pharmacy consultant audits that are conducted monthly and reported to the Director of Nursing and Administrator monthly and the Pharmacy Committee quarterly.	May 6, 2017
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide	F 431		

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F 431	Continued From page 3 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431	F 431 Temporary and Permanent Correction It is the policy of this facility to insure that residents receive pharmaceutical services to meet the needs of each resident (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals). Pinkish and whitish creams were immediately removed from resident areas by licensed staff. Licensed staff was informed by Director of Nursing that cream should not be left at bedside. Triamcinolone cream was removed by licensed nurse and discarded. Director of Nursing removed expired medication from medication cart and informed pharmacy that they had sent medication that expired before the card was completely used. New medication was received by facility. To insure that this deficient practice does not reoccur and that future residents are not affected. Inservice will be provided by the Director of Nursing or the Asst. Director of Nursing on Drug handling and storage including but not limited to, "not leaving creams at bedside", and "discarding expired medications and supplements".	

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F 431	Continued From page 4 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to provide proper storage of medications when: 1. Pinkish and whitish colored creams in medicine cups were found in resident rooms 74, 76, and 79; and 2. Expired medications were available for use. These failures had the potential to result in the use of medications that were ineffective and/or contaminated. Findings: 1. The initial tour of the facility was conducted with the Director of Nursing (DON) on 4/3/17 beginning at 8:15 a.m. The following were observed: a. A whitish colored cream in a small medicine cup on top of Resident 4's bedside table. Resident 4 stated, "That is for my backside." The DON acknowledged the finding and stated, "That is a barrier cream. It is not suppose to be left here." b. A whitish colored cream in a small medicine cup on top of a roll of toilet paper on top of Random Resident (RR) C's nightstand. The DON acknowledged the finding and stated, "That is a calmoseptine [barrier cream]. It should not be left here." c. A pinkish and whitish colored cream in a small	F 431	Inservices were conducted on May 3, 2017 and May 4, 2017 by the Director of Nursing and the Asst. Director of Nursing. The Director of Nursing or Asst. Director of Nursing will monitor medication carts and medication rooms daily 5 days per week for one month to insure that 100% compliance is maintained. If 100% compliance is maintained during monitoring period, monitoring will be reduced to monitoring that is conducted through pharmacy consultant audits that are conducted monthly and reported to the Director of Nursing and Administrator monthly and the Pharmacy Committee quarterly. May 6, 2017	

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F 431	Continued From page 5 medicine cup on top RR E's nightstand. RR E stated, "That cream is for my bottom." The DON acknowledged the finding and indicated the cream should not be left at the bedside. 2. The Medication Room/storage inspection was conducted with Licensed Nurse (LN) 1 on 4/3/17 beginning at 2 p.m. One jar of triamcinolone (topical cream for itching) cream with an expiration date of 2/3/17, was found. LN 1 acknowledged the finding and stated, "It should be taken out [of the medication room]." 3a. The Medication Cart, Station 1 inspection was conducted with LN 2 on 4/4/17 beginning at 10:16 a.m. RR F's bubble pack of omeprazole (medication for heartburn) had an expiration date of 3/31/17. LN 2 acknowledged the finding and stated, "We should not use expired medications." 3b. The Medication Cart, Station 2 inspection was conducted with LN 3 on 4/4/17 beginning at 10:30 a.m. RR G's bubble pack of omeprazole (medication for heartburn) had an expiration date of 3/31/17. LN 3 acknowledged the finding and stated, "I will not give the medication. I will throw it away."	F 431	Temporary and Permanent Correction F441 It is the policy of this facility to establish an Infection prevention and control program as required. Humidifier bottles found on floor, not labeled or empty were replaced and labeled and dated by the Director of Nursing. Tubing and masks not dated were replaced by the Director of Nursing and labeled and dated. Resident urinals will be labeled and dated. Urinal was immediately discarded by Director of Nursing 04/04/2017 and CNA was provided inservice on facility Hand-Washing and Urinal Policy. Inservice was provided by Staff Development Coordinator on 04/28/2017 and 05/05/2017.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and	F 441	To insure that compliance is maintained. Director of Nursing or Staff Developer will monitor oxygen masks, humidifiers and tubing daily 5 days each week for one month to insure 100% compliance with facility policy. After one month of 100% compliance, monitoring will be reduced to monthly May 6, 2017	

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F 441	Continued From page 6 communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 441	F 441 continued infection control surveillance that is conducted by the Asst. Director of Nursing and reported to the Infection Control Committee quarterly to insure continued compliance with facility policies May 6, 2017	

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F 441	Continued From page 7 contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility record review, the facility failed to ensure: 1. a. A humidifier bottle was stored properly, b. Oxygen tubing's were dated, c. Nebulizer masks were dated and covered, 2. a. A humidifier bottle was changed when it became empty, b. A humidifier bottle was dated, 3. Hand washing was performed after patient care; and 4. A used, uncleaned, and unlabeled urinal was on the floor in the bathroom between rooms 57 and 59. These failures had the potential to cause infection and/or cross-contamination. Findings: 1. An initial tour was conducted with the Director of Nursing (DON) on 4/3/17 beginning at 8:15	F 441		

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F 441	Continued From page 8 a.m. The following were noted: a. A humidifier bottle connected to a concentrator was noted on the floor in room 71. b. Oxygen tubing's were not dated in rooms 71 and 79. c. Nebulizer masks were not dated and not covered in rooms 71, 73, 78, and 79. The DON acknowledged the finding and stated, "The nebulizer masks should be covered. Oxygen tubing's are not dated. It's signed off on the MAR." The facility policy titled Oxygen Administration, dated 8/94, indicated, "...3. Label and date the holder bag...9. Assure that the tubing is changed every 7 days." 2. An initial tour was conducted on 4/3/17 beginning at 8:15 a.m. The following were noted: a. A humidifier bottle, dated 3/22/17 and connected to a concentrator, was empty in room 36 B. A concurrent interview was conducted with the Minimum Data Set (MDS, an assessment tool) Coordinator on 4/3/17 at 8:58 a.m. She stated the humidifier was supposed to be changed every 7 days and when the fluid level was low. She acknowledged the humidifier bottle was empty. 2. b. A humidifier bottle was not dated in room 38 A. A concurrent interview was conducted with Licensed Nurse (LN) 4 on 4/3/17 at 9:15 a.m. When asked if the facility needed to date the	F 441		

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F 441	Continued From page 9 humidifier, she stated, "Yes, we have to date the humidifier." The facility policy titled Pre-Filled Oxygen Humidifier, dated 8/94, indicated, ...Procedure 11. "Change every 7 days or when the fluid goes below the acceptable line." 3. An observation was conducted of Resident 6's room on 4/3/17 at 1 p.m. Certified Nurse Assistant (CNA) 2 was observed to not wash her hands after assisting Resident 6 using the commode. CNA 2 then poured a glass of water for the resident. A concurrent interview was conducted with CNA 2. CNA 2 acknowledged she had not washed her hands and indicated that she was supposed to wash her hands after cleaning the resident and handling the commode. Review of the facility policy titled Handwashing, dated 8/94, indicated, ...Procedure: "Handwashing will be performed after resident care is rendered and after handling contaminated articles..." 4. During the initial tour on 4/3/17 at 8:45 a.m., a used, uncleaned, and unlabeled urinal was noted lying on the floor underneath the handwashing sink in the bathroom located between rooms 57 and 59. The bathroom was shared by six male residents. CNA 3 validated the finding and stated he did not know who it belonged to or why it was on the floor. An interview was conducted with the Assistant Director of Nurses (ADON) on 4/4/17 at 2:15 p.m. The ADON stated the urinal should not have been	F 441		

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F 441	Continued From page 10 stored that way, but should have been cleaned and put back into the owner's drawer located at their bedside. She stated it was not the facility's policy to put the resident's name on their urinal. The facility policy titled Urinal Cleaning, dated 6/96, indicated, "It is the policy of this facility that all urinals (disposable and reusable) will be cleaned after each use and stored properly...Urinals will never be stored...in the bathroom..."	F 441	Temporary and Permanent Correction F456 It is the policy of this facility to maintain all mechanical, electrical, and patient care equipment in safe operating condition. Facility policy was updated by the Administrator to follow manufacturers recommendation for cleaning and sanitizing the ice machine. Products necessary were purchased and ice machine was clean and sanitized by housekeeping. To insure that this deficient practice does not reoccur and future residents are not affected, inservice will be provided by the Administrator to housekeeping and maintenance staff on facility policy including but not limited to how the clean and sanitize the ice machine. To insure that good compliance is maintained Administrator will review cleaning log every month for 3 months. If 100% compliance monitoring will be reduced to monthly surveillance by Infection Control Nurse which is documented and reported to the Infection Control Committee quarterly for continued compliance. May 6, 2017	
F 456 SS=F	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to sanitize the ice machine according to the manufacturer's recommendation. This failure had the potential to increase the risk of foodborne pathogens for a census of 129. Findings: An interview was conducted with Housekeeper 1 on 4/3/17 at 2:05 p.m. She stated she used only "Nickel-Safe" (a product for removing scale deposits) to clean the interior and exterior of the ice machine. She stated she did not use any	F 456		

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F 456	Continued From page 11 sanitizing agent in her cleaning process. A concurrent interview was conducted with the Assistant Administrator (AA) on 4/3/17 at 2:05 p.m. The AA acknowledged "Nickel-Safe" had no chlorine in the ingredients and they were not using a sanitizing chemical as part of the cleaning and sanitizing of the ice machine. The manufacturer's undated instructions titled Cleaning and Maintenance, indicated two separate processes, one titled Cleaning Procedure and one titled Sanitizing Procedure. The facility undated policy and procedure titled Operating and Cleaning Dietary Equipment: Cleaning Ice Machine, Scoop, and Ice Chests, indicated the ice machine storage area was to be emptied, cleaned with a detergent solution, rinsed, drained, then sprayed with a sanitizing solution.	F 456		
F 458 SS=C	483.90(e)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT (e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and facility document review, the facility failed to ensure there was at least 80 square feet (sq. ft.) of living space per resident in 32 resident bedrooms. This failure had the potential to result in a lack of privacy and inadequate space for provision of care. Findings:	F 458		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056495	A. BUILDING _____ B. WING _____	04/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA COLOMA HEALTH CARE CENTER	10410 COLOMA RD RANCHO CORDOVA, CA 95670

(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 458	Continued From page 12	F 458		

The required square footage for each of the 32 resident bedrooms provided less than 80 sq. ft. per resident.

Room	Beds	Square Feet Per Room	Square Feet Per Resident
21	3	218.4	72.8
22	3	218.4	72.8
23	3	218.4	72.8
24	3	218.4	72.8
25	3	218.4	72.8
26	3	218.4	72.8
27	3	218.4	72.8
28	3	223.9	74.6
29	3	218.4	72.8
31	3	219.6	73.2
32	3	220.8	73.6
33	3	219.6	73.2
34	3	220.8	73.6
35	3	219.6	73.2
36	3	220.8	73.6
37	3	226.9	75.6
38	3	226.3	75.4
40	3	230.2	76.7
42	3	217.2	72.4
43	3	220.8	73.6
44	3	217.2	72.4
45	3	220.8	73.6
46	3	217.2	72.4
47	3	220.8	73.6
48	3	217.2	72.4
49	3	220.8	73.6
53	3	218.4	72.8
55	3	218.4	72.8
56	3	218.4	72.8
57	3	218.4	72.8
58	3	225.7	75.2
59	3	225.7	75.2

Request continued waiver.

May 6, 2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 458	Continued From page 13 Observations revealed the residents had a reasonable amount of privacy and storage space. The rooms were clutter free and there appeared to be adequate space for residents to ambulate. Residents had clear access to the bathroom and exit doors. There was sufficient room for the provision of nursing care and services. During random interviews with staff and residents throughout the survey process, no complaints regarding inadequate space were voiced. The Department recommends the room waiver be granted.	F 458		
F 465 SS=D	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide and maintain a safe, homelike environment when the exterior of the building was found to be in disrepair. Findings:	F 465		

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F 465	Continued From page 14 An environmental tour of the facility, accompanied by the Assistant Administrator/Director of Maintenance, was conducted on 4/5/17 at 10 a.m. The following observations were made and acknowledged concurrently by the Assistant Administrator/Director of Maintenance: 1. Resident Room 29 - the glass was cracked on the sliding glass door and covered with black duct tape on an area 3 feet long x 2 feet wide. 2. Resident Room 25 - the window screen was torn and closing mechanism bent. 3. Dining Room #2 - the window screen was frayed with a tear approximately 1 foot long. 4. Resident Room 41 - the window screen had a small tear. The downspout was rusted and previously held to the gutter with wire which had fallen away and dead leaves were protruding through the tear. 5. Resident Room 49 - the screen was missing on the patio door. The gutter above the window was broken open in an area approximately 3 feet long. 6. Resident Room 60 - the window screen was bent and there was a small gap at the closing mechanism, preventing the screen from closing tightly. 7. Dining Room #3 - the downspout outside was connected to the gutter with duct tape. The downspout on the outer corner of the building was broken away from the gutter.	F 465	Temporary and Permanent Correction F465 It is the policy of this facility to provide A comfortable sanitary environment. All Gutters will be repaired by Maintenance Department. All screens will be repaired by Mainenance Department. Cracked window will be replaced. Administrator will oversee repairs to insure that they are completed. To ensure that deficient practice does not reoccur and that future residents are not affected by this deficient practice. Plant Operations Supervisor will conduct monthly surveillance of the outside of the building, including but not limited to screens, gutters and windows to ensure that facility is maintained in good repair. Surveillance, reports will be reviewed by Administrator to insure that repairs are made in a timely manner. Surveillance reports are reviewed by Quality Assurance Committee. May 6, 2017	

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F 465	Continued From page 15 8. Gutters on all sides of the facility had tears and were in disrepair.	F 465		