STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555427	A. BUILDING _____ B. WING _____	07/20/2018

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LIFE CARE CENTER OF ESCONDIDO	1980 FELICITA ROAD ESCONDIDO, CA 92025

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F 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health, during an annual recertification survey conducted 7/17/18 through 7/20/18. For purposes of scope and severity, the resident census at the time of survey was 105, and the sample size was 23. Representing the California Department of Public Health, Health Facilities Evaluator Nurses 38443, 38630, 31919, 39448, 39397, and Nutritional Consultants 10933 and 38924. One facility self reported Incident was incorporated into the survey Facility Self Reported Incident # CA00594139 No deficiencies were identified. Definitions: DON-Director of Nursing CNA-Certified Nursing Assistant MDS-Minimum Data Set ADON- Assistant Director of Nursing LN- Licensed Nurse SSD-Social Services Director LA- Laundry Aide DSD- Director of Staff Development MS- Maintenance Supervisor	F 000		
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	F 657		8/10/18

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

Electronically Signed | 08/10/2018

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.

8-22-18 38445 approved —

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F 657	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop a care plan for a medication pump for 1 of 23 sampled residents (73). As a result, there was the potential for inaccurate assessments and miscommunication related to Resident 73's medication pump. Findings: Resident 73 was admitted on 7/3/15 with diagnoses which included, contracture (a permanently bent joint) of muscle, right hand,	F 657	F000 Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in this statement of deficiencies. The Plan of Correction is prepared and or executed solely because it is required by the provision of federal and state law. F 657 483.21 Care Plan Timing and Revision	

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F 657	Continued From page 2 contracture, right ankle, and contracture, right knee, per the facility's Face Sheet. On 7/17/18 at 9:45 A.M., Resident 73 was observed lying in bed. She was propped up with pillows, on her left side. Her left and right hands were contracted from the wrist to her fingers. Her left and right arms were contracted at the elbows. On 7/18/18 at 10 A.M., Resident 73's record was reviewed. The History and Physical, dated 11/7/17, indicated, the resident had a Baclofen (a muscle relaxing medication) pump (a device surgically inserted in the abdomen to deliver a set dose of Baclofen into the spinal canal). On 7/19/18 at 10:10 A.M., a joint interview and record review of Resident 73's chart was conducted with the MDS1 and the ADON. The MDS1 and the ADON said there was no care plan for the Baclofen pump. The ADON said there should have been a care plan on care of a Baclofen pump. Per the facility's policy titled, Care Planning and Interventions, revised 7/23/09, "Practice Guidelines: The Care Plan addresses, ... Resident-specific interventions. Standards of current professional practice. Treatment objectives with measurable outcomes. A time frame. Parameters for monitoring."	F 657	A) How corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. On July 19, 2018 the MDS Coordinator updated the care plan of Resident 73 to reflect the presence, use and potential risks of the Baclofen pump. The DON conducted an in-service on July 31, August 2, 3 and 6, 2018 to educate Licensed Nursing Associates on the facility Policy and Procedures for Care Planning and Interventions, and Baseline care plan. B) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents who are in the facility have the potential to be affected. On August 5, 2018, a random audit of care plans of 13 residents were done to identify other residents for care plans which are not complete and updated. No other resident was noted to be affected. C) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. DON, QA nurse or designee will perform a random audit of resident care plans on a monthly basis x 3 months to monitor for the presence of baseline and comprehensive care plans, and to ensure that care plans are updated accordingly.	

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F 657	Continued From page 3	F 657	Non-Compliance will be immediately corrected. On July 31, August 2, 3 and 6, 2018, DON provided an in-service to licensed nursing associates on Policy and Procedures for Care Planning and Interventions, and Baseline care plan. D) How the facility plans to monitor its performance to make sure that solutions are sustained. DON will present audit findings, involving care planning and updates to the care plan, to monthly QAPI for discussion and review by the QA Committee This will be ongoing until compliance has been achieved for 3 consecutive months.	
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and document reviews, the facility failed to ensure the care plans for two residents were completed by an individual who possessed the educational qualifications in accordance with regulatory requirements. This failure had the potential to negatively affect	F 659	F659 Qualified Persons A)After assessment/reassessment, the RD will establish nutritional goals such as individualized target weight goals and estimated assessed %PO needs with specific measurable outcomes in care plan. FSM will not establish nutritional	8/10/18

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F 659	Continued From page 4 the nutritional status, quality of life, and health of these residents. (R51, 42) Findings: According to the Academy of Nutrition and Dietetics (AND), Commission on Dietetic Registration, " ...the Registered Dietitian (RD) or registered dietitian nutritionist (RDN) has completed multiple layers of education and training established by the Accreditation Council for Education in Nutrition and Dietetics and is qualified to provide medical nutrition services, including a nutritional assessment, nutrition education, individual counseling, ...and care planning to address specific dietary needs and preferences ..." (www.eatright.org) According to the CMS Standard Operations Manual (SOM), dated 11/22/17, section §483.60(a)(1), "A qualified dietitian or other clinically qualified nutrition professional is either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose ..." The facility Food Service Manager (FSM) completed a Dietetic Services Supervisor (DSS) certificate program, which allows oversight of food production, sanitation procedures, resident food preferences, and allergy information within a dietary/food and nutrition services department. The facility FSM also holds a food safety manager's certificate that is a requirement for	F 659	goals on care plan. FSM will only list pertinent approaches already put in place by Physician s Order, RD and/or IDT. RD will ensure different or additional pertinent approaches are considered and implemented when goals are not met. B)RD will randomly check care plans to ensure the RD has established nutritional goals, for any Resident specific interventions and complete the parameters of monitoring and interventions. RD will initial and date comprehensive care plan upon completion. C)The RD has retrained the FSM on scope of practice and the responsibility of data collection information only in clinical charting on August 9, 2018. RD will complete comprehensive care plans and initial and date upon completion. D)A QAPI will be established by the facility s RD and Corporate (Regional) Crandall RD to ensure that all comprehensive care plans have nutritional goals established by the RD. This will be reviewed by the Executive Director or assigned designee and presented at the monthly QAPI Committee Meeting for review and recommendations as warranted until compliance has been achieved for three consecutive months. The Corporate (Regional) Crandall RD along with the Executive Director will be responsible to ensure review, execution, and compliance of this plan.	

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F 659	Continued From page 5 FSM/DSS's managing a dietary/food service department, per the regulation. However, nutrition assessments, weight estimations, and goal setting in resident care plans is out of the FSM/DSS's scope of practice and could negatively impact the resident's nutrition and health status. Findings: 1. Resident 51 was admitted to the facility on 8/30/16, with diagnoses to include weakness, glaucoma, and hypothyroidism (a condition where the thyroid gland does not produces enough thyroid hormone which may affect heart beat and metabolism), per the facility's Face Sheet. On 7/17/18 at 11:45 A.M., during the dining room observation, R51 was seen eating at a table without assistance from nursing. R51 lunch meal tray ticket stated "Reg, Gr Meat, Ground Meat", and she received two ounces of ground BBQ chicken, four ounces of green & gold beans, a slice of cornbread, and four ounces of milk in a cup. At 11:50 A.M. an interview with R51 was conducted. R51 was asked why she spit her food out and didn't swallow it and she stated "the food is cold and difficult to chew so I chew a little bit then put it back on my napkin or plate". R51 was missing several teeth on the top and bottom of her mouth and did not have dentures. A review of the R51's current diet order dated 6/8/18, states "Regular, Ground meat, Fortified cereal with breakfast"; previous diet order dated 2017 was "Regular, Ground texture, Thin liquids"; and initial diet order from Physician Orders dated August 2016, states "Mechanical soft chopped, PO TID FYI".	F 659		

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F 659	Continued From page 6 Review of R51's initial "Nutrition Care Plan" dated 8/13/16, completed by the FSM, stated " ...Problems- Resident at nutrition risk related to variable food intake, ...as evidenced by chewing problem and disease ..." On 7/18/18 at 8:24 A.M., during another breakfast dining observation and concurrent interview, R51 was eating without assistance from nursing. She received scrambled eggs, 2 slices of French toast, ground sausage links, and bowl of oatmeal cereal. R51 took two bites of the French toast, chewed for about five seconds, placed the food in her hand, then back on her plate. She repeated this with the eggs and did not touch the ground sausage. The oatmeal was about half consumed. R51 stated "I do not like thick bread or ground meat." A review of the meal intake record for eating and drinking of breakfast, lunch, and dinner meals from 7/8/18-7/18/18, indicate meal consumption between 25-50 percent of meals. A review of R51's "Quarterly Nutrition Documentation", dated 3/20/18 completed by the facility Dietitian, stated the resident says 'food is cold ...I eat slow' ..." Review of R51's "Nutrition Care Plan" revised and updated by the FSM on 4/24/18, stated " ...Problems- Resident at nutrition risk related to variable food intake ...had 6 pound (5.7 percent) weight loss in a month on 2/4/18, ...as evidenced by chewing problem and disease ...Goals- Resident will sustain no significant weight loss through next review date 5/30/18 ..."	F 659		

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F 659	Continued From page 7 A review of "Nutrition Care Plan" revised and updated by the FSM on 7/4/18, stated " ...Problems- Resident at nutrition risk related to variable food intake, ...had 6 pound (5.7 percent) weight loss in a month on 2/4/18 ...as evidenced by chewing problem and disease ...Goals- Resident will sustain no significant weight loss through next review date 8/30/18 ..." On 7/20/18 at 12:05 P.M., a lunch dining observation was conducted. R51 was sitting at the table eating without nursing assistance. R51 was seen taking chewed bread out of her mouth and placing it on her plate. At 12:09, in an interview with RNA 1 while in the dining room, RNA 1 stated she has noticed R51 taking food from her mouth an placing it on her plate. She also stated R51 was on the restorative nursing program for 12 weeks but it was discharged in May 2018 ...R51 is a slow eater." A review of the facility documents titled "Restorative Administration Record" for the months of April, May, and June 2018, stated R51 was placed on the RNA Feeding program for breakfast, lunch, and dinner 3 times daily for 12 weeks. Meal intake percentage ranged from 50-100 percent, on average, for April-June 2018. RNA feeding program was discharged 6/9/18. On 7/20/18 at 11:00 A.M., an interview was conducted with SLP. The SLP stated she observed R51 eating in the dining room, and she was chewing her food then putting it in her hands and back on her plate. SLP stated R51 had not been seen by the speech program previously but would be screened due to her coughing and spitting food out during meals.	F 659		

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F 659	Continued From page 8 An interview was conducted on 7/20/18 at 12:58 P.M. with LN 7 about R51's RNA feeding program. LN 7 stated there would be a physician's order to discharge the feeding program but she was unable to locate it. At 1:15 P.M., in an interview with the DON, she stated an interdisciplinary team meeting was conducted with the ADON and ADR in June and they decided R51 no longer needed feeding assistance. The DON was unable to locate the documentation but stated R51's eating may have improved if the RNA feeding program was renewed. As a result of the gaps in R51's nutrition care plans and feeding program assistance, R51 did not receive the proper meal assistance leading to her spitting her food out making her meals less pleasurable. With a qualified professional making appropriate nutrition care plan recommendations and setting goals, the eating and swallowing challenges may have negatively affected her quality of life and contributed to her reduced meal intake. 2. Resident 42 was admitted to the facility on 5/9/18, with diagnoses to include acute cholecystitis (inflammation of the gallbladder), dysphagia (swallowing difficulty), and chronic obstructive pulmonary disease (COPD- a condition of that causes airflow blockage to the lungs), per the facility's Face Sheet. On 7/18/18 at 3:43 P.M., a review of R42's initial MDS assessment dated 5/16/18 and concurrent interview with the MDS coordinator was conducted. R42's BIMS=15 and 'no difficulty swallowing or chewing difficulty' was checked off in section K- Nutrition. The MDS coordinator	F 659		

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F 659	Continued From page 9 stated this section was completed by Dietary. On 7/18/18 at 4:15 PM, an observation and interview was conducted with R42 and her family member. R42 was lying in bed watching T.V. with a cup of jello and large drink from a restaurant on her bedside table. R42 and relative stated she had not eaten much of her lunch meal because it was difficult to chew and she does not have her dentures. R42 also stated she likes "broccoli and cheddar soup, and clam chowder, cranberry juice, cut up fruit, and baked potatoes from Wendy's." R42's family member stated "my mom dislikes the soups here because "they're too salty and the vegetables are overcooked ...she also doesn't' like milk". On 7/19/18 at 9:55 A.M., an observation and interview was conducted with R42 and her family member. R42 was lying in bed watching T.V. Her breakfast plate with scrambled eggs, toast, jello, applesauce, and apple juice was on the bedside table covered with a dome. R42 stated she did not each much of the breakfast and the family member estimated she ate about 25 percent of her meal. The family member stated she goes out to buy soups and oatmeal for R42 to eat because R42 does not like the food. R42 stated no one has spoken to her about her food preferences since she has been there. A review of the physician's orders dated 6/18/18, stated "NAS, Mechanical soft diet, fortified food with non-dairy products with meals, thin liquids". A review of the RD's progress note dated 7/12/18, stated "Plan: MedPlus 2.0, 120 ml, BID with medication pass".	F 659		

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F 659	Continued From page 10 A review of the meal intake record for eating and drinking for breakfast, lunch, and dinner from 6/8/18-7/18/18 indicate meal consumption of 0-25 percent of meals. Review of R42's initial "Nutrition Care Plan" dated 5/9/18) completed by the FSM, stated " ...1) Problems- Resident at nutrition risk related to significant weight loss ...10 pound (9.3 percent) since admission ...as evidenced by ...leaves 50 percent of food uneaten at most meals ...disease diagnosis ...2) Goals- Resident's weight range between 125 +/- 3 pounds in one month ...no significant weight changes ...target date 7/18/18 ..." A review of R42's Nutrition Care Plan revised and updated on 6/18/18 signed by the FSM, stated " ...1) Problems- Resident at nutrition risk related to significant weight loss ...10 pound (9.3 percent) since admission ...as evidenced by ...leaves 50 percent of food uneaten at most meals ...disease diagnosis ...2) Goals- Resident's weight range between 125 +/- 3 pounds in one month ...no significant weight changes ...target date 7/18/18 ..." As a result of the gaps in R42's nutrition care plans, weight loss, and eating difficulty, R42 did not receive foods that met her preferences within her therapeutic diet, which strongly contributed to her poor meal intake. With a qualified professional making appropriate nutrition care plan recommendations and setting goals, the eating and swallowing challenges may have been addressed more timely by the interdisciplinary team. Therefore, R42's overall quality of life was negatively impacted when it came to eating her meals.	F 659		

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F 659	Continued From page 11 In an interview with the FSM regarding her typical daily duties on 7/19/18 at 11:24 A.M., the FSM stated she spends "about 1.5 hours on Tuesdays and Thursdays completing resident care plans and as needed if there are diet order changes. The FSM then stated she completes the initial "basic assessment component" of the Nutrition care plan which includes the problems, goals, and approaches sections. The FSM also stated CK1 collects food preference and allergy information for her from the new admits and other residents, at least twice a week, or as needed. On 7/20/18 at 9:10 A.M., in an interview was conducted with the FSM and FA about the FSM's care planning duties. The FSM stated she uses the nurse's notes, weight histories, and other reports to update the 'goals and approaches' sections every quarter. Additionally, the FSM stated she was advised by the facility's corporate dietitian to "be more specific when formulating and entering the resident's weight goals in the care plan ...and to include a (+/-) 3 pound weight change, as well as, a weight range for each resident". The FSM then stated she had not visibly seen or talked to all of the residents that she had entered care plan data in the computer system on. In an interview with the Facility Administrator (FA) on 7/20/18 at 9:20 A.M., the Administrator stated he was new to the facility and was unaware the FSM had been completing all of the sections of the Nutrition Care plan. The FA also stated he had not reviewed the staff qualifications or job descriptions of the staff, including the FSM, for the care planning task.	F 659		

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F 659	Continued From page 12 Review of facility job description titled "Food Service Director-Certified Dietary Manager", revised 5/17/16, states " ...Essential functions-must be able to assist the Registered Dietitian in the collection of nutrition information ..." The Food Service Director job description does not state the FSM is responsible for completing and updating the resident nutrition care plans. Review of the facility's policy revised 7/23/09, titled "Care Planning and Interventions", states " ...Practice Guidelines: The Care Plan addresses ...Resident-specific interventions. Standards of current professional practice. Treatment objectives with measurable outcomes. ...Parameters for monitoring. ...If nutritional goals are not achieved, different or additional pertinent approaches are considered and implemented ..."	F 659		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on Interview and record review, the facility failed to ensure a hospice agency documented care and treatment according to the plan of care for 1 of 23 sampled residents (50). As a result, there was the potential for	F 684	F 684 483.25 Quality of Care A) How corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice.	8/10/18

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F 684	Continued From page 13 miscommunication of care and treatment between the facility and the hospice agency for Resident 50. Findings: Resident 50 was admitted to the facility under hospice care (services provided to a terminally ill individual) on 2/27/18, with diagnoses to include dementia (a brain disease that affected a person's thinking and daily functioning), per the facility's Face Sheet. On 7/19/18 at 4:03 P.M., Resident 50's medical record and separate hospice binder were reviewed with LN 10. LN 10 stated "I think the hospice nurse (HN) comes once a week." LN 10 stated the hospice Facility Visit Sign-In Log indicated the HN signed-in to visit Resident 50 on 3/2/18, 3/9/18, 3/16/18, 4/2/18, 4/16/18, 4/27/18, 5/11/18, 6/8/18, 6/22/18, 7/10/18, and 7/17/18, for a total of 11 times. LN 10 was able to find only 1 HN visit note, dated 7/10/18, in Resident 50's medical record or hospice binder. On 7/20/18 at 8:43 A.M., an interview and record review of Resident 50's medical record and hospice binder was conducted with the DON. The DON acknowledged there was 1 HN visit note, dated 7/10/18, in Resident 50's medical record. The DON was unable to locate documentation to reflect the care provided by the HN for the additional 10 HN visits, in accordance with the plan of care and the hospice agreement. On 7/20/18 at 9:45 A.M., a telephone interview was conducted with the DON and the Hospice Team Manager (HTM). The HTM stated Resident 50's HN was not available. The HTM stated the	F 684	On July 20, 2018, the DON placed a call to the contracted hospice provider and requested for the hospice notes for Resident 50. Hospice representative came to the facility and delivered the requested hospice notes. Multiple hospice representatives from that contracted agency came in that day to review all hospice records for the affected resident and other residents in their care to ensure compliance. B) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents who are on hospice care have the potential to be affected. On August 3 and August 7, 2018, an audit of the medical records of all residents in hospice services (6 residents) was done by the QA nurse to identify residents who do not have hospice notes in their medical record. No other resident was noted to be affected. C) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. On August 2, 2018, a fax was sent to all contracted hospice agencies with notification on what is expected of the agencies as partners of the facility which includes maintaining all hospice medical record/documentation. They were informed that all hospice notes are to be	

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F 684	Continued From page 14 expectation was the HN communicated with the facility about Resident 50's condition at the time of the visit, and brought the written visit note on the next visit to be placed in Resident 50's medical record. The HTM stated, "They [the HN] should leave something after the visit." According to the facility's policy, Terminal Illness, Death, and Dying, revised 2/19/13, " ... Document all services provided in the Social Services section of the medical record." According to the Hospice Agreement Addendum, co-signed by the facility's Executive Director on 5/6/09, and the hospice Chief Executive Officer on 4/16/09, "1. Communication. Hospice and Facility will communicate with each other either verbally weekly or at each hospice visit .... Documentation of such communication shall be included in the patient's medical record." . "Should leave something after the visit." Agency is faxing visit notes to update. Spoke with DON-advised facility was responsible to oversee agency provided written documentation of visits.	F 684	filed and/or faxed to the facility within 24 hrs. after the visit. Hospice agencies were also requested to perform a weekly audit of the chart to ensure compliance. On August 2, 2018 the DON called all contracted hospice agencies by the facility to verify that they received the notification and to reinforce facility s expectation. The DON, QA nurse or designee will perform an audit of all hospice charts to ensure the presence of complete and current hospice notes on a weekly basis x 3 months to ensure compliance. Non-Compliance will be immediately corrected. On July 31, August 2, 3, and 6, 2018, DON provided in-services to Licensed Nursing Associates on Hospice services, Collaboration with hospice, Ensuring notes, calendar and care plan are present in the hospice binder and its purpose. D) How the facility plans to monitor its performance to make sure that solutions are sustained. The DON will present audit findings, to monthly QAPI for discussion and review by the QA Committee This will be ongoing until compliance has been achieved for 3 consecutive months and quarterly thereafter.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		8/10/18

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F 758	Continued From page 15 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and	F 758		

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F 758	Continued From page 16 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the target behavior monitored for the use of psychotropic (affecting mental activity) medications were specific for 1 of 23 sampled residents (87). This failure had the potential for staff to inconsistently monitor Resident 87's behaviors and to affect the physician's ability to determine the effectiveness of the medication. Findings: Resident 87 was admitted to the facility on 6/21/18 with diagnoses, which included dementia (a loss of mental abilities that lead to impairments in memory, reasoning, planning and behavior) and psychosis (a severe mental disorder, where there has been some loss of contact with reality), per the facility's Face Sheet. Resident 87's physician ordered Seroquel (a medication to treat psychosis) 25 mg twice a day, "FOR PSYCHOSIS M/B (manifested by) BEING MEAN TO STAFF" and to monitor episodes of psychosis manifested by being mean to staff. A review of the Behavior Intervention Monthly Flow Record indicated nursing recorded multiple episodes of Resident 87 being, "mean to staff" on	F 758	F 758 483.45 Free from Unnec Psychotropic Meds/PRN Use A) How corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice. On July 19, 2018, the RN supervisor clarified the behavior monitoring for the Seroquel as angry outburst to people around her. The DON conducted an in-service on July 31, August 2, 3 and 6, 2018 to educate Licensed Nursing Associates on the facility Policy and Procedures for Psychopharmacological Medication Management, 14 day PRN Psychotropic Medication Review and behavior monitoring of specific behaviors. B) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents who are taking Psychotropic medications have the potential to be affected. On August 10, 2018, the Pharmacist	

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F 758	Continued From page 17 the evening shift. There was no documentation of how Resident 87 manifested this behavior. On 07/19/18 at 9:13 A.M., an interview was conducted with LN 1. LN 1 stated Resident 87, "Yells and ignores me." LN 1 stated she interpreted ignoring staff as being mean to staff. LN 1 stated being mean to staff was not a specific behavior to monitor. On 07/19/18 at 9:37 A.M., an interview and record review was conducted with the ADON. The ADON stated, "being mean to staff," was vague and not a specific behavior to monitor. On 07/19/18 at 9:51 A.M., an interview and record review was conducted with the SSD. The SSD reviewed Resident 87's Behavior Intervention Monthly Flow Record, which listed, "being mean to staff." The SSD stated, "I don't know what that means, ... this behavior is not specific." Per the facility's policy titled, Psychopharmacological Medication Management, dated 8/23/17, " ...The facility will establish ongoing processes of assessing the resident's behavior indicators ..."	F 758	Consultant reviewed all residents who are on Psychotropic medications for appropriateness of diagnosis and monitoring of specific behaviors. He recommended to clarify behavior monitoring for 2 other residents. The behavior monitoring for the 2 residents was immediately changed per Pharmacist Consultant s recommendation. C) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. On July 31, August 2, 3 and 6, 2018, DON provided an in-service to licensed nursing associates on the facility Policy and Procedures for Psychopharmacological Medication Management, 14 day PRN Psychotropic Medication Review and behavior monitoring of specific behaviors. The charts of newly admitted residents will be reviewed during clinical meetings each week day to ensure appropriateness of psychotropic medication orders and behavior monitoring. Pharmacist consultant will continue to review the appropriateness of diagnosis and monitoring of specific behaviors each month. DON, QA nurse or designee will perform a random audit of 5 residents who are on psychotropic medication on a weekly basis x 3 months for appropriateness of	

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F 758	Continued From page 18	F 758	diagnosis and monitoring of specific behavior. Non-Compliance will be immediately corrected. D) How the facility plans to monitor its performance to make sure that solutions are sustained. DON will present audit findings, involving Monitoring of specific behaviors for Psychotropic medication usage to monthly QAPI for discussion and review by the QA Committee This will be ongoing until compliance has been achieved for 3 consecutive months.	
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition	F 803		8/10/18

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F 803	Continued From page 19 professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and document reviews, the facility failed to ensure the menus for the regular, puree, dysphagia (difficulty swallowing), cardiac, and low sodium diets were followed for residents when a starch was not served and an appropriate substitution was not provided; as well as, the alternative menu for the grilled cheese sandwich was not nutritionally adequate as an entree, per menu guidelines. This failure led to residents not receiving food on the menu or a substitution, as planned, which reduced nutrient intake that could potentially result in nutrient related diseases. The facility census was 107 residents. Findings: 1. On 7/17/18 at 11:00 A.M., an observation of the lunch preparation and trayline, and review of the diet menu spreadsheet signed by the RD titled "Life Care Centers Menu #3- Spring/Summer 2018, Week 4 Day 24" was conducted. Four (4) ounces of potato salad was listed to be served to the regular, mechanical soft, pureed, and dysphagia diets; and 2 ounces served to the cardiac (diet for heart disease), and low sodium diets. On 7/17/18 at 11:40 A.M., a dining observation was conducted of the lunch meal service. After all residents were served in the dining room, it was	F 803	F803 Menus Meet Resident Nds/Prep in Adv/Followed A)Staff was provided in-service training by RD and FSM on ensuring that the menus and modified spreadsheets for the regular, puree, dysphagia (difficulty swallowing), cardiac, and low sodium diets are followed and appropriate substitutions are being provided. This included ensuring the alternative entr¿e menu is nutritionally adequate and equivalent to the regular menu guidelines. Facility has implemented the TrayLine Checklist before each meal, to be filled out by the cook or FSM. In-servicing was given to the Checker position to ensure all trays are checked before passing on August 9, 2018. FSM will notify RD of menu substitutions. RD will review menu substitutions as to nutritional adequacy. RD and/or FSM will initial and date menu substitutions. B) RD and FSM will observe dietary staff performance and trayline accuracy for corrective actions and retraining needs. C) RD will observe dietary staff and trayline accuracy for one meal/per consulting day for one month to ensure spreadsheet menus are followed and	

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F 803	Continued From page 20 noted that none of the residents received the starch for the day, potato salad. CK 2 was interviewed on 7/17/18 at 11:58 A.M. about the reason the residents did not receive the potato salad and she stated she forgot it was in the refrigerator cooling. CK 2 went to remove the potato salad for the regular diets and pureed diets, from the refrigerator and took the temperature. The temperature was 45 degrees Fahrenheit for the regular potato salad and 39 degrees Fahrenheit for the pureed potato salad. The FSM then told CK 2 to discard the regular potato salad because it was not at appropriate serving temperature, but to serve the puree potato salad because it was "ok to serve". CK 2 discarded both the regular and pureed potato salads, as well as, the other preparations for the other therapeutic diets without taking the temperatures. CK 2 was asked when she began preparing the potato salad and she said "earlier this morning...around 11:00". On 7/17/18 at 12:25 P.M., an interview was conducted with CK 2 and the FSM. CK 2 stated she misunderstood the instruction from the FSM regarding what to do with the potato salad and thought she said to discard it all. The FSM stated CK 2 should have served the pureed potato salad, took the temperatures of the other potato salad preparations, and then served it if they were at appropriate temperatures. However, the FSM did not state what should have been served as a substitution in place of the regular potato salad that was not served. On 7/17/18 at 12:30 P.M., in an interview, RD 1 stated the lunch menu should have been followed which included serving the potato salad to residents. And that proper food preparation	F 803	alternates appropriate. FSM will monitor trayline during mealtime during her work shift. D) A QAPI will be established by the facility s RD and Corporate (Regional) Crandall RD to ensure that the menus and modified spreadsheets for the regular, puree, dysphagia (difficulty swallowing), cardiac, and low sodium diets are followed or appropriate substitutions are being provided. This will be reviewed by the Executive Director or assigned designee and presented at the monthly QAPI Committee Meeting for review and recommendations are warranted until compliance has been achieved for three consecutive months. The Corporate (Regional) Crandall RD along with the Executive Director will be responsible to ensure review, execution, and compliance of this plan.	

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F 803	Continued From page 21 including cooling in time for lunch service should have occurred. Further, a substitution should have been provided during meal service if an item was not served. Review of the facilty recipe titled "Production Recipe, Potato Salad w/Egg SCR NAT FRSH....", dated 6/18/18, states "1)...Bring potatoes to boil....cool slightly,...3)add to chilled potatoes..., 7) chill in refrigerator at least 1 hour before serving until internal temperature reaches 41F or below..." 2. During the lunch dining observation on 7/17/18 at 11:30 A.M., at least two residents requested the grilled cheese sandwich as their entree. CK 3 prepared the grilled cheese sandwiches using two slices of white bread and 1 slice of American cheese for the sanwiches. On 7/17/18 at 12:10, an interview was conducted with CK 3. CK 3 was asked did he follow a recipe to make the grilled cheese sandwich and he stated "no". The FSM stated CK 3 should have used the recipe which states to use 4 slices of cheese. A review of the undated facility recipe document titled "Production Recipe, Grilled Cheese Sandwich 3 oz....", printed 7/18/18, states "1)...Place 4 oz. of cheese on 1 slice of bread. Top with second slice...heat sandwich until cheese melts..." The recipe further states two slices of cheese (0.67 ounces) provides 1 ounce of protein and four slices would provide 2 ounces of protein. Review of the facility document titled "Life Care Centers Menu #3- Spring/Summer 2018, Week 4 Day 24" used for meals on 7/17/18, states the	F 803		

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F 803	Continued From page 22 entree for the regular and all other diets would provide 4 ounces of protein. Serving the residents a grilled cheese sandwich with 1 slice of cheese reduces their protein intake by more than half, which could further compromise their health and nutritional status. Review of the facility's policy titled "Menus", revised 11/11/16, " ...stated menus are followed as written in order to meet the nutritional needs of the residents in accordance with established national guidelines, ... menus are served as written and the Director of Food and Nutrition Services/Registered Dietitian documents the substitution on the extended menu and menu substitution form ..." extended menu and menu substitution form."	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		8/10/18

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F 812	Continued From page 23 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure food was stored and prepared in a sanitary manner when: 1) Dried, crusted white food substances were found on serving utensils and plates stored as clean, inside storage drawers, and the reach-in refrigerator racks and 2) Dark brown food stains were found inside 3 large bulk dry food storage bins, a refrigerator door gasket had sticky food spills, and 2 glass light covers inside the walk-in refrigerator had tannish cream colored hard food stains 3) Unlabeled and misdated food items were found in an unclean reach-in refrigerator 4) Water dripped on milk cartons from copper pipes with ice condensation buildup inside the walk-in refrigerator (Cross reference F908) 5) Molded vegetables were stored inside large clear open bins and a dented can was found in the dry storage room 6) Poor overall kitchen cleanliness and sanitation These failures had the potential to place residents at risk for widespread foodborne illnesses from consuming food from unsanitary equipment that may be contaminated; and in severe instances, result in harm. The facility census was 107 residents. Findings: 1. During the kitchen observation and kitchen walk-through tour on 7/17/18 at 8:20 A.M., an observation and concurrent interview was conducted with the Food Service Manager (FSM) of the kitchen. During the kitchen tour, a review and check of food storage temperatures,	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary A) FSM has expanded the cleaning schedule to ensure overall kitchen cleanliness and sanitation is assigned and monitored. The following in-services and retraining for competency in safe food storage has been provided to FNS staff on August 9, 2018: Food Storage in sanitary manner and not near proximity to water lines, drains, or condensation drippings from pipes or ceiling; Appropriate dating and labeling of food items; Monitoring and removal of molded, rotten, or unusable vegetables; At time of delivery, removal of dented cans to a designated area in the dry storage room for return to vendor. B) FSM and RD will monitor staff practices for the safe food storage to ensure other vulnerable, immune impaired residents are not impacted. C) FSM will monitor the initialing of the Cleaning Schedule to ensure effective cleaning of the kitchen as assigned. Blank spaces without initialing will be reviewed with the appropriate staff and retraining provided. FSM will inspect storage areas after delivery of foods and	

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	555427	A. BUILDING _____ B. WING _____	07/20/2018

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F 812	Continued From page 24 equipment cleanliness and overall kitchen sanitation, food production, and portion sizes, was conducted. At 8:30 A.M., the floor underneath the dish storage unit with a stack of ten dirty ceramic plates and eight water pitchers were found near the drink machine. The ceramic plates had light brown stains crusted stains on them. Also, three drawers underneath the Cook's prep station were full of dirty cooking and serving utensils including scoops, ladles, spatulas, measuring spoons, and a whisk with several noticeable old crusted dried white colored food stains. Other utensils had black spots and sticky grime, along with the inside of the drawers. CK 1 stated the utensils were cleaned daily and the drawers were cleaned weekly. The FSM stated the drawers are deep cleaned on a weekly basis. The FSM then acknowledged the plates, utensils, and drawers were dirty. Review of undated facility policy titled "Cleaning and Caring for Equipment", states "1) ...equipment must be cleaned and sanitized ...after its last use ...accumulated food, grease, and dirt encourage bacteria and mold growth ...2) ...clean equipment and utensils thoroughly after each use ..." According to the 2017 Federal FDA Food Code, food-contact surfaces and utensils are to be clean to sight and touch and are to be free of accumulation of dust, dirt, food residue and other debris. 2. On 7/17/18 at 8:40 A.M., during the same initial kitchen tour, an observation of a food storage area was conducted. Three large white rolling bulk food storage bins had dried brown spots and food spills inside each bin. The	F 812	RD will inspect storage areas during monthly kitchen inspection and report any deficient areas. Maintenance has been notified and will continue to be notified of need for repair of this issue. No foods will be stored by water lines, drains, or condensation drippings from pipes or ceiling. D) A QAPI will be established by the facility s RD and Corporate (Regional) Crandall RD to ensure effective cleaning of the kitchen and staff practices ensure safe food storage. This will be reviewed by the Executive Director or assigned designee and presented at the monthly QAPI Committee Meeting for review and recommendations as warranted until compliance has been achieved for three consecutive months. The Corporate (Regional) Crandall RD along with the Executive Director will be responsible to ensure review, execution, and compliance of this plan.	

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F 812	Continued From page 25 granulated sugar bin dated 7-5-18 had brown stains inside the right side and cover, the oatmeal bin dated 7-7-18 had several spots down the left and right side, and the potato pearls bin dated 7-9 -18 had sticky liquid substance on the lid. The FSM acknowledged the spots and stains on the bins. The rubber gasket in the reach-in refrigerator door that sealed the door was covered with a significant amount of black-greenish colored sticky grime and detaching from the door. When the area was wiped with a paper towel, black residue wiped off. The FSM confirmed the black residue wiped off. Additionally, the reach-in refrigerator racks and air vent inside the top of the refrigerator ceiling had brown dirt stains on them. Furthermore, the gaskets inside the refrigerator door lining were stained with large sticky brown spots. The FSM acknowledged the unclean racks and door gaskets inside the reach-in refrigerator. Review of undated facility policy titled "Cleaning and Caring for Equipment", states "1) ...all equipment must be kept in good repair ...2) monitor equipment for denting ...and excessive wear ..." According to the 2017 Federal Food Code, nonfood contact surfaces shall be cleaned at a frequency necessary to preclude the accumulation of soil residues. In addition, nonfood contact surfaces of equipment shall be kept free of dust, dirt, food residue, and other debris. 3. On 7/17/18 at 8:25 A.M., an observation and concurrent interview with the FSM of the reach-in refrigerator was conducted. During the observation, the following foods were found in the	F 812		

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F 812	Continued From page 26 reach-in refrigerator mislabeled or expired: a. Unlabeled American cheese slices with the opened written date 7-11-18 inside an opened quart size Ziploc bag; b. A 32 ounce container of Sour cream with the opened written date 7-6-18, and no visible manufacturer's date The FSM stated the written date on the food items was the open date and the dating system was "the products are good for one year after they are opened, for most foods, which is the use-by date". The FSM stated the use-by date for the sour cream was one week but then acknowledged the food items were mislabeled and/or misdated. The standard of practice is to have a labeling system that allows for the proper identification of food and for food safety purposes. Review of the undated facility policy titled "Use by Date" Guide states "1) ...Ready-to-Eat Potentially Hazardous Foods, included but not limited to: ...sour cream- opened ...7 days ...2) ...processed cheese- 30 days after opening and placed in enclosed container ..." 4. On 7/17/18 at 8:54 A.M., during the initial kitchen tour, an observation and concurrent interview was conducted in the walk-in refrigerator with the FSM. The floors and corners were dirty with trash and old food particles underneath the shelves. The ceiling light covers had hard brownish tan colored sticky food stain on them. The center aisle had cases and boxes of food stacked up and the back wall had 8 to 10 crates of 4-ounce milk cartons pushed against it. In the upper right corner were exposed copper	F 812		

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F 812	Continued From page 27 pipes with foam and ice build-up, as well as, an ice frosted condenser. The ice build-up measured approximately eight inches long and ranged from 3 to 4 inches in width and had small blackish-green particles that resembled mold. Additionally there was ice build-up on the majority of the pipes leading to the condenser. The surveyor pointed out the substance and all the areas affected to the FSM. The FSM stated the substance could be mold and that a maintenance request was reported by phone to the MDR "a few days ago" to repair the pipes. The FSM stated the walk-in refrigerator was on a weekly deeply cleaning schedule that included the shelves and floors, but not the lights. (Cross reference F908) Review of facility policy revised 1/1/17, titled "Safe Food Handling", states " ...Food is not stored, prepared, handled ...in any area in which food may be contaminated, ...particularly around hazardous chemicals ..." Review of facility policy revised 1/1/17, titled "Food Safety", states " ...Food is stored away from all ...water lines, drains, condensation drippings from pipes or ceiling ..." According to the Federal Food Code, 2017, the standards of practice would be to ensure food is protected from contamination including toxic residues due to drip, drain, fog, splash or sprays ...on the food. 5. On 7/17/18 at 9:05 A.M., during the kitchen tour, an observation of the dry storage room and interview with the FSM and DA 1 was conducted. The dry storage room was excessively packed, cluttered, and unclean with large boxes and	F 812		

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F 812	Continued From page 28 cases of food on the floor. Two large clear storage bins containing molded, foul smelling foods (i.e. yellow onions and brown russet potatoes), were found in the center of the room. The first bin was full of yellow onions and had several non-food items scattered throughout the bin, including a 3 oz. box of cereal, 2 metal fork utensils, and other debris. There were more than ten rotten, molded onions found with tiny insect that resembled gnats, were flying inside the bin. The second bin with the large brown russet potatoes had three packages of individual graham crackers, plastic utensils, and other debris scattered throughout the bin. Most of the potatoes were sprouting with more than 12 rotten and molded found at the bottom center of the bin. In an interview with DA 1 at 7/17/18 at 9:10 A.M., DA 1 stated he is responsible for keeping the dry storage clean and organized twice a week on delivery days. DA 1 stated he should have practiced the first in first out (FIFO) procedure with the onion and potato bins, and routine cleaning to prevent the molded foods from occurring. The FSM and the FA acknowledged the presence of the molded food items and unsanitary condition of the dry storage room. FSM stated the dry storage room is supposed to be cleaned Tuesdays and Thursdays by DA 1 and she checks it daily for cleanliness. A #10 dented can of Cubed Beef w/broth was found on the shelf in the dry storage. The FSM stated the dented cans are kept in her office and are not supposed to be stored in the dry storage. Review of facility policy dated 1/1/17, titled "Food Safety", states " ...Dented cans that could affect food safety ...stored in a designated area away	F 812		

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F 812	Continued From page 29 from other food ..." A review of food and nutrition services department document created by the FSM titled "Cleaning Schedule", weekly and daily cleaning tasks are listed and indicates " ...Position C is responsible for sweeping, mopping ...storage area daily ..." However, a review of the facility document titled "Cleaning Schedule for 'C' Position- Daily" for July 2018, indicated " ...sweep and mop ...storage area ...after lunch ..." and was initialed on July 8, 2018, by the DSW 1, and not DA 1. DSW 1 confirmed her initials on the July 2018 monthly schedule and FSM acknowledged the initials. Review of facility policy revised 1/1/17, titled "Cleaning Schedule", states " ...1) the Director of Food and Nutrition Services (FNS) develops a cleaning schedule to include all equipment and areas to be cleaned ... 2) "the Director of FNS monitors the cleaning schedule to ensure tasks are completed timely and appropriately ..." 6. In the kitchen on 7/17/18 beginning at 8:20 A.M., the floors, drawers, storage equipment, cooking equipment, walls, and dry storage room were all visibly soiled with oily, grimy food residue, dirt, and debris. The drawers underneath the cook's prep and trayline station area in the kitchen had several dirty cooking utensils inside. During the kitchen tour, an observation was conducted at 10:00 A.M. of the FSM's office window seal. The inside and outside of the FSM's office window seal had a brown, rust like substance, along with bubbling, puffy, cracking white paint that was peeling from water damage and moisture build up. The FSM did not	F 812		

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F 812	Continued From page 30 recognize the rust-like substance as unclean prior to the surveyor pointing it out. A review of the monthly audit report completed by the Registered Dietitian titled "RD Monthly Facility Visit Report" dated 6/30/18, did not identify this lapse in cleaning. The report identified the dietary office floor and Janitor's closet as needing "cleaning". The built-up dried on food splatter on the bulk food storage bins and crumbled up paper and food debris on the floor underneath the beverage machine and coffee machine counter were observed on 7/17/18 and 7/18/18. The FSM stated on 7/17/18 at 10:05 A.M., there was a cleaning schedule with tasks that food service staff were assigned to ensure that the kitchen was clean. The FSM stated she inspects all the kitchen areas on the cleaning schedule on a daily basis for cleanliness and completion. A review of the "Cleaning schedule" for June 2018 showed several blank spaces for the initials of dietary department staff for many daily and weekly cleaning tasks including the walk-in refrigerator, reach-in refrigerator, and drawers underneath the cook's prep area. The presence of food on the floor, and dirt and grime on food service equipment could attract pests.	F 812		
F 813 SS=D	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(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	F 813		8/10/18

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F 813	Continued From page 31 by: Based on observations, interviews, and record reviews the facility failed to ensure the policy for food brought from the outside for residents was implemented. This failure had the potential to result in the facility's 107 residents consuming food that could cause foodborne illnesses. Findings: On 7/18/18 at 10:24 A.M., an observation of station 3 nourishment refrigerator and interview with LN 5 was conducted. A sign that stated 'Resident food only, discard after 48 hours' was posted on the front of the refrigerator. A medium sized container of beans with a lid dated 7-17-17, was found inside. LN 5 stated the facility policy for resident food included it could be kept in the refrigerator for 3 days. LN 5 then stated the charge nurse checked the refrigerators daily to determine if food should be thrown out. LN 5 said she had not been trained on food safety risks for storing or reheating resident foods brought from outside. Another interview was conducted at 11:46 on 7/18/18, was conducted with CNA 1 about resident food brought from the outside. CNA 1 stated she throws any food in the resident refrigerator out that is older than 72 hours or does not have a name or date. CNA 1 stated she would reheat food for about 30 seconds if residents wanted their food warmed but she had not received training on proper reheating temperatures for food brought in from the outside for residents. During a subsequent observation of the station 1	F 813	F813 Personal Food Policy A) RD, DON and/or DSD in-serviced nursing as to facility policy Food Brought into Facility from Outside Sources on use and storage of foods brought to Residents by family and other visitors on July 31, August 2, 3, 6, and August 9, 2018. Families will be given information on safe food handling and transport. B) Food not prepared by facility will be given to nursing for proper storage. The food will be labeled with Resident s name and dated when brought into facility and use by date for leftover food. Residents, family members, and other visitors will be informed of the policy and receive education in safe food handling. C) Food will be stored and reheated in accordance with professional standards for food safety. Any potentially hazardous food not eaten within four hours should be discarded if not stored properly in the refrigerator. Date/labeling will ensure these foods are discarded. D) A QAPI will be established by the facility s RD and Corporate (Regional) Crandall RD to ensure staff is following the facility s policy on Food Brought into Facility from Outside Sources. This will be reviewed by the Executive Director or assigned designee and presented at the monthly QAPI Committee Meeting for review and recommendations as warranted until compliance has been	

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F 813	Continued From page 32 refrigerator on 7/18/18 at 2:08 P.M., a case of undated yogurt was found inside. The same sign was posted on the refrigerator in station 3 was posted on the refrigerator in station 1. In an interview with LN 10 about food brought from outside, LN 10 stated most food could be kept for 72 hours but drinks and ice cream can be kept longer. LN 10 also stated the foods could be reheated for 1 or 2 minutes but she had not received training on the re-heating process for food brought in from outside for residents. A review of the facility policy dated 11/17/17, titled "Food Brought into Facility from Outside Sources", states " ...1) Any potentially hazardous food not eaten within four hours should be discarded if not stored properly in the refrigerator ...2) food is stored, prepared, and distributed in accordance with professional standards for food safety ...3) education for visitors will include safe cooling/reheating processes, hot/cold temperatures, preventing cross contamination, proper storage ..." The standard of practice for food safety would be to ensure that food which is reheated will be conducted in a manner to ensure that all parts of the food reach a temperature of at least 165 degrees Fahrenheit for a minimum of 15 seconds (Food Code, 2017).	F 813	achieved for three consecutive months. The Corporate (Regional) Crandall RD along with the Executive Director will be responsible to ensure review, execution, and compliance of this plan.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		8/10/18

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F 880	Continued From page 33 development and transmission of communicable diseases and infections. §483.80(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: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and 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; §483.80(a)(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.	F 880		

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F 880	Continued From page 34 (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 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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, interview, and record review, the facility failed to ensure clean linens were stored in a sanitary manner for 2 of 2 clean linen storage units. As a result, there was the risk of resident exposure to contaminated linens. Findings: On 7/19/18 at 7:52 A.M., an observation and interview was conducted with the LA. Two clean linen storage units in the clean linen room had bottom shelves made of metal bars. Gowns, blankets, and pillow cases were stored unwrapped on the bottom shelves. The LA stated, at the end of each shift they would mop the floor,	F 880	F880 Infection Prevention & Control A)On 8/10/18, all exposed linen was taken off the racks and rewashed before placing back into circulation. The linen racks was cleaned and sanitized. B)The Plant Manager will inspect all linen racks and identify any infection control issues that will need to have linen pulled and washed and sanitized before it is placed back into circulation. C)On 8/7/18, a plastic barrier was placed on all identified racks with metal bars on the bottom rack so that there cannot be any transmission of mopping from	

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F 880	Continued From page 35 including under the clean linen storage units. On 7/19/18 at 8:10 A.M., an interview was conducted with the MS. The MS stated, the clean linen room floor was mopped under the clean linen storage shelving routinely. The MS acknowledged liquid from mopping the floor under the bottom shelves could have splashed onto the clean linen. Per the undated facility policy and procedure, entitled Daily Laundry Room Cleaning, Procedure step 17, "Mop the entrance floor. Remember to get under all the equipment."	F 880	underneath to linen on rack to avoid contamination of linen. D)The ED/PM or Designee will inspect each rack identified to ensure that transmission cannot occur. This will be reported at quarterly QA meeting under infection control for the next two quarters.	
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure the walk-in refrigerator was maintained in safe operating conditions. This failure led to the inappropriate storage of food in a refrigerator with faulty leaky pipes that could support the growth of bacteria that could lead to food borne illnesses in 107 residents who consume food from the kitchen. (Cross reference F812) Findings: On 7/17/18 at 8:54 A.M., during the initial kitchen tour, a concurrent observation and interview of	F 908	F908 Essential Equipment A)The two copper pipes with foam and ice build-up from condensation were fixed on 7/18/18 by defrosting the accumulated ice on the pipes and changing the insulation on them. B)On 7/18/18 an outside contractor checked the unit for proper operation and recommended the replacement of the walking refrigeration unit that was replaced on 8/11/ 18. C)The maintenance personnel will be in-serviced by the Executive Director on	8/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555427	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 908	Continued From page 36 the walk-in refrigerator was conducted with the FSM. The back wall had 8 to 10 crates of 4-ounce milk cartons pushed against it. In the upper right corner there were two exposed copper pipes with foam and ice build-up from condensation, as well as, an ice frosted condenser. The ice build-up measured approximately 8 inches long and ranged from 2 to 3 inches wide, with small blackish-greenish particles that resembled mold. Additionally there was ice build-up on the majority of the pipes, and a blackish-green colored substance resembling mold going through the wall. The surveyor pointed out the ice build-up and mold resembling substance to the FSM. The FSM stated the substance she did not know the ice build-up and mold resembling substance was on the pipes or the cause of the ice build-up. The FSM further stated a maintenance request was reported to the maintenance director (MDR) by phone a few days ago for the pipes. In a subsequent observation and interview on 7/17/18 at 3:30 P.M. with the MDR with the Administrator present, the MDR stated he had received the maintenance repair request but had not had a chance to check on it. The MDR stated the ice build-up may have been due to issues with the connection of the walk-in freezer pipes to the walk-in refrigerator pipes. On 7/19/18 at 3:50 P.M., an interview was conducted with the FSM. The FSM stated the MDR replaced the coolant (freon) in the walk-in refrigerator and was waiting on a refrigeration company to come out to check it. The FSM stated she was also waiting for the paperwork from the MDR to confirm the refrigerator was repaired with the the condensation ice build-up on the copper	F 908	8/13/18 on the importance that it is to follow and executed Life Care Center of Escondido policies related to the prevention and maintenance of the walking refrigerator. D)Compliance will be monitored by the Environmental Services Director and Executive Director via monthly rounds and review of the maintenance logs located at the kitchen, all findings will be discussed on the Safety and QAPI Meetings. Any necessary actions will be implemented and executed.	

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F 908	Continued From page 37 pipes. On 7/20/18 at 8:11 A.M., in an interview with the MDR, he stated the ice build up was caused by to much moisture inside the pipes. MDR also stated an outside company was contacted to assess the piping insulation and other issues. According to refrigeration research, ice build-up on the interior freezer components may be the result of issues within the evaporator or issues with the defrost cycle of the unit (Humitec Corporation, 2013). According to the Federal Food Code, 2017, standards of practice would be to ensure food is protected from cross-contamination including toxic residues due to drip, drain, fog, splash or sprays on food. Review of facility policy revised 1/1/17, titled "Safe Food Handling", states "...Food is not stored, prepared, handled ...in any area in which food may be contaminated, ...particularly around hazardous chemicals..." Review of facility policy revised 1/1/17, titled "Food Safety", states "...Food is stored away from all ...water lines, drains, condensation drippings from pipes or ceiling..."	F 908		