DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

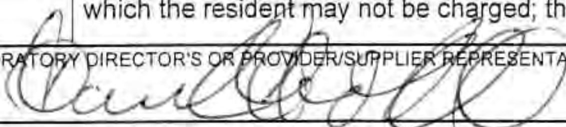
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055289	A. BUILDING ____ B. WING ____	08/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINE COUNTRY CARE CENTER	321 WEST TURNER ROAD LODI, CA 95240

Sphillips 9/26/11

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following represents the findings of the California Department of Public Health during a recertification survey conducted 8/15/2011 - 8/18/2011. Representing the Department: HFEN 17136 HFEN 17332 HFEN 18972 HFEN 27788 The facility census was 81 and the survey sample size was 17.	F 000	WE ARE HEREBY SUBMITTING OUR PLAN OF CORRECTION FOR THE SURVEY COMPLETED ON AUGUST 18, 2011. THIS IS OUR CREDIBLE ALLEGATION OF COMPLIANCE.	10/03/11
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those	F 156	THE MEDICAID FRAUD UNIT HAS BEEN ADDED TO THE CONSUMER BOARD AND THE MEDICARE DENIAL LETTER HAS BEEN AMENDED BY THE BUSINESS OFFICE. ONLY ONE DENIAL LETTER WILL BE USED HENCEFORTH WHICH THE CENTERS FOR MEDICARE AND MEDICAID REQUIRES. ALL POSTINGS OF CONSUMER INFO AND DENIAL LETTERS WILL BE MONITORED BY THE ADMINISTRATOR DURING POLICY AND PROCEDURE REVIEW.	10/3/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE: ADMINISTRATOR (X6) DATE: 09/07/11

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

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F 156	Continued From page 1 other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control	F 156		

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F 156	Continued From page 2	F 156		

unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and document review, the facility failed to:
1. Ensure residents received the correct

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F 156	Continued From page 3 notification letter, of their right to request submission of their bill to Medicare, following the determination by the facility that they no longer qualified for services under Medicare as required by Centers for Medicare and Medicaid Services (CMS). 2. Ensure information concerning the MediCal Fraud Control Unit was posted for a census of 81. Findings: 1. The notice issued to residents when Medicare no longer covers the stay was reviewed on 8/18/11. The notice being used by the facility was not the correct notice that CMS required. An interview was conducted with Business Office Staff on 8/18/11 at 10 a.m. She provided the notices currently being used by the facility. She stated she was unaware of the notice required by CMS. 2. Review of the facility's required federal postings was conducted on 8/15/11. Consumer information regarding how to contact the Medicaid Fraud and Abuse Unit was not posted. An interview was conducted with the Administrator on 8/15/11 at 9 a.m. The Administrator acknowledged the consumer information was not posted for public access.	F 156		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	F 221	A COMPLETE SIDERAIL ASSESSMENT OF ALL RESIDENTS WILL BE COMPLETED BY THE TREATMENT NURSE. RESIDENT 2 SIDERAILS ARE DOWN. AN ENTIRE REVIEW OF THE SIDERAIL ASSESSMENT AND	10/03/11

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F 221	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility failed to ensure 1 of 17 sampled residents (2) did not receive bilateral side rails in the raised position without an assessment and/or Physician's Order. Findings: Resident 2 was admitted to the facility on 7/27/11. She had diagnoses including rehabilitation for a fractured hip and dementia. An observation of Resident 2 was conducted on 8/15/11 at 8:40 a.m. She was lying in bed with both side rails in the raised position with padding on both side rails. A tab alarm was attached to the resident. An observation of Resident 2 was conducted on 8/18/11 at 9:20 a.m. She was lying in bed with the bed against the wall on one side and the side rail of the other side in the raised position with padding on the rail. A tab alarm was attached to the resident. Resident 2's clinical record contained no documented evidence of a Physician's Order for side rails in the raised position. There was no documented evidence of a Side Rails Assessment in the clinical record. There was a Physician's Order, dated 8/2/11, for "overlay padding both side rails." A concurrent interview was conducted with	F 221	CONTINUED FROM PAGE 4 IMPLEMENTATION OF SIDE RAILS WILL BE GIVEN TO THE NURSING STAFF BY THE DIRECTOR OF STAFF DEVELOPMENT. SIDERAIL PLACEMENT WILL BE AUDITED MONTHLY BY THE TREATMENT NURSE TO ENSURE UP AND DOWN RAIL ORDERS ARE FOLLOWED. SIDERAILS WILL BE MONITORED ON EACH SHIFT BY LICENSED NURSES TO ENSURE PROPER POSITIONING OF RAILS OCCURS. SIDERAIL AUDITS COMPLETED BY THE TREATMENT NURSE WILL BE REVIEWED BY THE QUALITY ASSESSMENT COMMITTEE QUARTERLY TO ENSURE SIDERAIL POSITIONING IS CORRECT.	10/03/11

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F 221	Continued From page 5 Certified Nurses Assistant (CNA) 1 and Licensed Nurse (LN) 1 on 8/18/11 at 9:20 a.m. CNA 1 stated Resident 2's side rails were not supposed to be in the raised position. She stated some of the staff automatically put the rails up after caring for the resident. She stated Resident 2 had an order to have a tab alarm attached. LN 1 stated she had discussed with other staff members the conflicting order of "overlay padding both side rails" while not having an order for the side rails to be in the raised position. An interview was conducted with LN 2 on 8/18/11 at 9:25 a.m. She stated she had conducted many Inservices regarding the use of side rails. She stated she is "constantly reminding staff" about keeping side rails down.	F 221		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure appropriate body coverage during transport from the shower for 1 of 4 unsampled residents (21). Findings: On 8/15/11 at 9:40 a.m., Resident 21 sat in a shower chair during transport from the shower to her room. Approximately 4 inches across	F 241	THE RESIDENT RIGHTS POLICY AND PROCEDURE WILL BE RE-VIEWED TO NURSING STAFF BY THE DIRECTOR OF STAFF DEVELOPMENT SPECIFICALLY, RESIDENT PRIVACY DURING SHOWER TRANSPORT. THIS REVIEW WILL ENCOMPASS ALL RESIDENTS. THE LICENSED STAFF AND SUPERVISORS WILL MONITOR RESIDENT PRIVACY DAILY. LICENSED STAFF WILL REPORT RESIDENT PRIVACY COMPLIANCE QUARTERLY TO THE QUALITY ASSESSMENT COMMITTEE FOR REVIEW. THIS INSERVICE PLUS CONTINUED MONITORING WILL ENSURE RESIDENT PRIVACY AND DIGNITY IS MAINTAINED AT ALL TIMES.	10/03/11

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F 241	Continued From page 6 Resident 21's entire buttocks were exposed. The exposed area could be viewed by other people who were in the hallway. An interview was conducted with the Administrator on 8/15/11 at 9:41 a.m. When asked what could be seen as Resident 21 continued down the hallway, the Administrator responded it was "something you're not supposed to," referring to Resident 21's buttocks.	F 241		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to ensure a consultation appointment was arranged for 1 of 17 sampled residents (3). Findings: Resident 3 was admitted to the facility on 3/9/11. She had diagnoses including anemia. Resident 3 had a Physician's Order, dated 7/2/11, for a consultation appointment with a hematologist (physician who specializes in disorders of the blood). There was no documented evidence a consultation appointment had been arranged for Resident 3.	F 250	A CONSULT HAS BEEN REQUESTED FOR RESIDENT 3 FOR A HEMATOLOGIST CONSULT. AN AUDIT OF PHYSICIAN VISITS WILL BE COMPLETED BY THE MEDICAL RECORD DEPARTMENT FOR ALL RESIDENTS. AN INSERVICE WILL BE GIVEN BY THE DIRECTOR OF STAFF DEVELOPMENT TO NURSING STAFF ON REVIEWING THE SOCIAL SERVICE REQUEST FORM SPECIFICALLY, THE SCHEDULING OF DOCTOR APPOINTMENTS. A NEW MONTHLY AUDIT OF PHYSICIAN CONSULT REQUESTS WILL BE COMPLETED BY THE MEDICAL RECORDS DEPARTMENT TO MONITOR PHYSICIAN CONSULTANT VISITS FOR RESIDENTS. THIS AUDIT WILL ENSURE NO DOCTOR APPOINTMENTS ARE MISSED. MONTHLY DOCTOR VISIT AUDITS WILL ALSO BE REVIEWED BY THE QUALITY	10/03/11

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F 250	Continued From page 7 An Interview was conducted with Social Services Staff (SSS) on 8/16/11 at 3:45 p.m. He stated he had not received notification to arrange a consultation appointment for Resident 3. He stated Nursing was supposed to fill out a referral slip and place it in his box. He stated no such notification had been placed in his box.	F 250	CONTINUED FROM PAGE 7 ASSESSMENT COMMITTEE QUARTERLY TO ENSURE COMPLIANCE.	10/03/11
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to ensure a quarterly Minimum Data Set (MDS - an assessment tool) was completed on time for 1 of 17 sampled residents (12). Findings: Resident 12 was admitted to the facility on 8/18/10. He had diagnoses including Alzheimer's dementia. Resident 12's clinical record contained a quarterly MDS, dated 10/1/10. The next quarterly MDS was dated 2/1/11, four months later. An interview was conducted with the MDS Coordinator on 8/17/11 at 10:50 a.m. She stated the quarterly MDS, dated 2/1/11, was one month	F 276	RESIDENTS 12 QUARTERLY ASSESSMENT WAS COMPLETED. AN AUDIT WILL BE DONE OF ALL RESIDENTS TO DETERMINE IF ANY OTHER ASSESSMENTS NEED COMPLETION WITHIN 3 MONTHS. A NEW AUDIT WILL OCCUR MONTHLY OF ALL MINIMUM DATA SETS ASSESSMENTS TO AUDIT TIMELY MINIMUM DATA SETS ASSESSMENTS. THE AUDITS WILL BE REVIEWED MONTHLY BY THE MEDICAL RECORDS CONSULTANT TO MONITOR TIMELY MINIMUM DATA SETS ASSESSMENTS SPECIFICALLY, QUARTERLY ASSESSMENTS. MINIMUM DATA SETS ASSESSMENTS WILL BE ADDED TO THE QUALITY ASSESSMENT COMMITTEE MONITORING MINIMUM DATA SETS ASSESSMENTS QUARTERLY.	10/03/11

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F 276	Continued From page 8 late and was done when she discovered it had been missed.	F 276		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility failed to ensure Januvia (a diabetic medication) was administered to 1 of 4 unsampled residents (18) as ordered by the Physician. Findings: Resident 18 was admitted to the facility on 5/20/11 with diagnoses including juvenile onset diabetes. A medication regimen review completed by the consultant pharmacist dated 5/25/11 was reviewed. The pharmacist recommended that Client 18's oral diabetic medication (Actos) be changed to Januvia because Actos was not recommended in patients with symptomatic congestive heart failure or cardiac risk factors. On 5/25/11 facility staff faxed the medication regimen review to Resident 18's physician. On 5/28/11 Resident 18's physician responded with an order to change the Actos medication to Januvia 100 mg daily. Resident 18's May 2011 Medication Record and Profile was reviewed. The documentation	F 333	AN AUDIT OF ALL NEW MEDICATION ORDERS WILL BE COMPLETED BY THE MEDICAL RECORDS DEPARTMENT. THE DIRECTOR OF NURSING AND THE DIRECTOR OF STAFF DEVELOPMENT WILL PROVIDE INSERVICE TO LICENSED NURSES ON MEDICATION ADMINISTRATION. THE IN-SERVICE WILL INCLUDE FAX, VERBAL, AND PHONE PHYSICIAN ORDERS; FOR CONTROLLED AND NON-CONTROLLED MEDICATIONS, INCLUDING RECAPPING OF PHYSICIAN ORDERS ON MEDICATION RECORDS. THE PHARMACIST WILL REVIEW MONTHLY MEDICATION ADMINISTRATION AND DOCUMENTATION OF ALL MEDICATION INCLUSIVE OF DIABETIC MEDICATION. THE PHARMACIST WILL REPORT HIS FINDINGS TO THE QUALITY ASSURRANCE COMMITTEE QUARTERLY. DAILY MONITORING OF NEW ORDERS WILL OCCUR BY THE MEDICAL RECORDS DEPARTMENT ENSURING MEDICATION DOCUMENTATION OCCURS FROM PHYSICIAN ORDERS. THIS	10/03/11

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F 333	Continued From page 9 indicated Resident 18 received Actos daily from 5/20/11 thru 5/28/11. Documentation indicated from 5/29/11 thru 6/3/11 the nurse's initials were circled, which indicated the Actos medication had not been administered to Resident 18. Further review of Resident 18's Medication Record and Profile for June 2011 revealed Resident 18 did not begin receiving the Januvia medication until 6/4/11, six days after the physician ordered it to begin. An interview was conducted with the Director of Staff Development (DSD) on 8/18/11 at 9:30 a.m. The DSD stated the Actos medication was discontinued on 5/28/11 as ordered by the physician. The DSD stated the Januvia medication was received from the pharmacy on 5/28/11, however staff did not note the new medication order and did not begin administering the Januvia medication until 6/4/11. The DSD acknowledged Resident 18 was not administered her oral diabetic medication for six days.	F 333	CONTINUED FROM PAGE 9 PROCESS WILL RESULT IN NO MEDICATION ERRORS OCCURRING.	10/03/11
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356	UPON SURVEY COMPLETION, THE DIRECTOR OF NURSING AND THE DIRECTOR OF STAFF DEVELOPMENT AND THE ADMINISTRATOR MET TO DISCUSS STAFF POSTING RESPONSIBILITY. THE DIRECTOR OF STAFF DEVELOPMENT WILL POST NURSE STAFF DIRECT CARE HOURS DAILY AT THE CONSUMER BOARD. THE DIRECTOR OF NURSING AND THE DIRECTOR OF STAFF DEVELOPMENT AND ADMINISTRATOR	10/03/11

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F 356	Continued From page 10 The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to post daily nurse staffing information. Findings: On 8/15/11 at 9 a.m. the Administrator was asked where the facility posted the daily nurse staffing information. This information reflected the number of actual hours worked by nursing staff responsible for direct resident care for each shift. The Administrator stated the facility had not been posting daily nurse staffing information.	F 356	CONTINUED FROM PAGE 10 WILL MONITOR STAFF POSTING DAILY DURING RESIDENT ROUNDS. RECORDS OF NURSE STAFFING WILL BE KEPT FOR 18 MONTHS.	10/03/11
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides	F 366	RESIDENT 20 FOOD PREFERENCE HAS BEEN UP-DATED BY THE DIETARY SERVICE SUPERVISOR.	10/03/11

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	055289	A. BUILDING ______ B. WING ______	08/18/2011

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F 366	Continued From page 11 substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and facility record review, the facility failed to ensure food preferences were honored for 1 of 4 unsampled residents (20). Findings: Resident 20 was observed in the Social Dining room on 8/15/11 at 12:53 p.m. Creamed corn was on Resident 20's plate. A review of Resident 20's food preference card was conducted on 8/15/11 at 12:53 p.m. The card indicated that corn was one of Resident 20's dislikes. An interview with Resident 20 was conducted on 8/15/11 at 12:53 p.m. Resident 20 stated she didn't like corn off the cob. An interview with Certified Nurses Assistant (CNA) 2 was conducted on 8/15/11 at 12:56 p.m. After looking at Resident 20's food preference card, CNA 2 stated Resident 20 should not have corn on her plate.	F 366	CONTINUED FROM PAGE 11 THE DIETARY SERVICE SUPERVISOR WILL COMPLETE AN ASSESSMENT OF ALL RESIDENT FOOD PREFERENCE TO ENSURE ACCURATE PREFERENCES ARE RECORDED. AN INSERVICE WILL BE GIVEN BY THE DIETARY SERVICE SUPERVISOR TO ALL COOKS ON ABIDING BY FOOD PREFERENCES ON TRAY CARDS. THE REGISTERED DIETITIAN WILL MONITOR FOOD PRE-FERENCES MONTHLY DURING CONSULTING VISITS. THE QUALITY ASSURANCE COMMITTEE REVIEWS REGISTERED DIETITIAN REPORTS QUARTERLY FOR RESIDENT FOOD PREFERENCE COMPLIANCE.	10/03/11
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371	THE REGISTERED DIETITIAN ON AUGUST 16, 2011 INSERVICED ALL DIETARY STAFF ON FOLLOWING THE DEFROSTING OF FOOD POLICY AND PROCEDURE. THE REGISTERED DIETITIAN WILL	10/03/11

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F 371	Continued From page 12 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy and procedure review, the facility failed to ensure food was stored under sanitary conditions according to facility policies and procedures. The failure resulted in frozen chicken breasts being improperly thawed. Findings: Initial tour of the facility's kitchen was conducted on 8/15/11 at 8:30 a.m. Observations of refrigerator #2 revealed a metal bin that contained multiple plastic bags containing chicken breasts. The bin was labeled as being taken from the freezer on 8/14 and was to be used on 8/15. The bags of chicken breasts were submerged in water and the breasts were not frozen. The facility's policy and procedure titled "FOOD PREPARATION-MEAT, POULTRY, FISH POLICY NO. 524" dated 9/08 indicated "POLICY: ... Dietary personnel use methods that ensure safe, sanitary food preparation to prevent food borne illness. ... PROCEDURE: ... 2. Recommended method of thawing frozen meat is in the refrigerator. This may take one to three days. ... c. Frozen food may be thawed by completely submerging under running cold water	F 371	CONTINUED FROM PAGE 12 CONTINUE PERIODIC INSERVICES ON DIETARY POLICY AND PROCEDURE SPECIFICALLY, FOOD DEFROSTING. THE DIETARY SERVICE SUPERVISOR WILL MONITOR FOOD DEFROSTING DAILY AND THE REGISTERED DIETITIAN WILL MONITOR FOOD DEFROSTING MONTHLY DURING CONSULTING VISITS. THE QUALITY ASSURRANCE COMMITTEE WILL REVIEW REGISTERED DIETITIAN REPORTS FOR IMPLEMENTATION OF DIETARY POLICY AND PROCEDURE INCLUDING FOOD DEFROSTING.	10/03/11

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F 371	Continued From page 13 (70 [degrees] F or less). Place in colander and allow water to immediately drain. Do not pool water in sink or immerse food. Thaw food within two hours, then immediately begin preparation and cooking." The facility's Dietary Services Supervisor (DSS) was present during the above observations. The DSS stated, "I don't know why they're in water." A follow-up interview was conducted with the DSS on 8/15/11 at 1:45 p.m. regarding the chicken breasts described above. The DSS stated the chicken breasts were discarded according to the facility's Registered Dietician's instructions, "Our [plan of correction]."	F 371		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must 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 and staff interview, the facility failed to ensure seven resident rooms measured at least 80 square feet per resident for a census of 81. Findings: Required versus actual square (sq.) feet (ft.) measurements: Room Required/Actual sq. ft. Occupancy 3 160/143 2 residents 7 240/216 3 residents	F 458	WE ARE HEREBY REQUESTING OUR BEDROOMS MEASURING LESS THAN 80 SQUARE FEET PER RESIDENT BE WAIVED FOR THE CURRENT CERTIFICATION PERIOD. EACH RESIDENT WILL HAVE REASONABLE AMOUNT OF PRIVACY AS WELL AS APPROPRIATE FURNISHINGS AND STORAGE SPACE IN THE AFFECTED ROOMS. THE ROOMS ALTHOUGH SMALLER THAN 80 SQUARE FEET, PROVIDE SUFFICIENT SPACE FOR NURSING STAFF TO PROVIDE CARE AND FOR RESIDENTS TO AMBULATE AND USE ASSISTIVE DEVICES. SINCE THE HEALTH AND SAFETY OF RESIDENTS IS NOT AFFECTED, WE ARE REQUESTING WAIVER REMAIN.	10/03/11

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F 458	Continued From page 14 41 240/226 3 residents 43 240/224 3 residents 44 160/156 2 residents 45 240/226 3 residents 47 240/228 3 residents Observations made during the initial facility tour on 8/15/11 revealed each resident had appropriate furnishings, personal belongings, and storage space. There was sufficient space for nursing staff to provide care and for residents to ambulate or use assistive devices in their rooms. The residents' health and safety were not affected by the variances from required to actual square footage. No complaints were received from residents regarding the size of their living space in their rooms. The Administrator acknowledged the room waivers and agreed to a continuance. The Department recommended the continuation of the room waivers for the above listed rooms.	F 458		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure handrails were free from splintering for a census of 81.	F 465	ALL HANDRAILS HAVE BEEN SANDED DOWN BY THE MAINTENANCE DEPARTMENT AND ARE FREE OF SPLINTERS. HANDRAIL INTEGRITY WILL BE PLACED ON THE MONTHLY MAINTENANCE ROUND SHEET COMPLETED BY THE MAINTENANCE DEPARTMENT. THE ROUND SHEET WILL BE REVIEWED MONTHLY BY THE ADMINISTRATOR TO ENSURE HANDRAILS ARE FREE OF SPLINTERS.	10/03/11

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F 465	Continued From page 15 Findings. During the Initial and Environmental tours, handrails throughout the facility were rough at randomly selected areas. An interview was conducted with the Maintenance Supervisor (MS) on 8/16/11 at 1:10 p.m. The MS acknowledged the handrails were rough and could be sanded.	F 465		