STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155200	A. BUILDING 00 B. WING	06/28/2019

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UNIVERSITY NURSING CENTER	1564 S UNIVERSITY BLVD UPLAND, IN 46989

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 24, 25, 26, 27, and 28, 2019 Facility number: 000107 Provider number: 155200 AIM number: 100290330 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 3 Medicaid: 49 Other: 12 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 1, 2019.	F 0000	*Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. University Nursing Center is requesting Paper Compliance for the 2019 Recertification and State Licensure Survey. Thank You*	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or			

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

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	enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to assist residents with meals in a dignified manner for 1 of 2 meal observations (Resident 8). Findings include: During a meal observation on the secured unit, on 6/26/19 at 12:00 p.m., the following was observed:	F 0550	**F550-Resident Rights** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **· Resident #8 is assisted with meal service uninterrupted and immediately upon receiving meal tray, in a dignified manner per plan of care.**	07/28/2019

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	Meal tray service was in progress from a food cart. On 6/26/19 at 12:04 p.m., Resident 8's meal tray was sitting on the table, she was sitting in a Broda chair in the lounge area that was attached to the dining room. On 6/26/19 at 12:10 p.m., CNA 5 put a clothing protector on the resident then assisted her up to the table. She sat down next to the resident, then got back up to re-direct another resident to his table, and then washed her hands. On 6/26/19 at 12:12 p.m., CNA 5 sat down beside the resident, unwrapped the silverware, then handed plastic cups to Nurse 7 to get the resident some lemonade and water. On 6/26/19 at 12:16 p.m., CNA 5 offered the resident her first bite of food. The clinical record for the resident was reviewed, on 6/25/19 at 3:52 p.m. Her diagnoses included, but were not limited to, dementia in other diseases classified elsewhere with behavioral disturbance, major depressive disorder, recurrent severe without psychotic features, other schizophrenia, vascular dementia with behavioral disturbance, psychotic disorder with delusions due to known physiological condition, and generalized anxiety disorder. A 4/3/19, quarterly, Minimum Data Set (MDS) assessment indicated the resident required extensive assistance with eating. During an interview, on 6/27/19 at 1:38 p.m., the MDS coordinator indicated if someone needed assistance with the meal, once the tray was		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **·All resident's dependent on meal assistance have the potential to be affected.** **·An audit was completed by Director of Nursing Services to identify all residents who are dependent with meal assistance, by 7-11-2019.** **·Director of Nursing Services or designee completed meal service observation on all residents identified by audit, by 7-11-2019.** **·All Staff to be in-serviced on assisting dependent residents with meal service, by Director of Nursing Services or designee by 7-11-2019.** **·Clinical Education Coordinator or designee to complete EATING skills validation with all staff who assist with meal service, by 7-21-2019.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **·All Staff in-service was conducted by the Executive Director/Director of Nursing Services/Clinical Education Coordinator on 7-11-2019, education reviewed on**	

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	served, someone would sit to assist them at that time. During an interview, on 6/27/19 at 2:08 p.m., CNA 5 indicated the tray shouldn't have been sat in front of the resident until a staff member was ready to sit and assist her, "our feeds are last", we do all the other tables first. She checked the food temperature by checking the bottom of the tray, since it was still warm, the food would have been warm. Review of a current Resident Rights document, dated 11/16 and provided by the Administrator, on 6/28/19 at 12:15 p.m., indicated all staff members recognize the rights of residents at all times. 3.1-3(a)		**assisting dependent residents with meal service.** **·Clinical Education Coordinator to complete EATING skills validation with all new hired staff who may assist with meal service.** **·Weekly meal observations will be completed by Meal Manager to ensure dependent residents are assisted in a dignified manner.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; ·On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. ·Meal Assist CQI will be completed weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. ·If Threshold of 90% is not met, an action plan will be developed to ensure compliance.	
F 0656 SS=E Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable			

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	objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on observation, interview, and record review, the facility failed to ensure residents were assisted to participate in their preferred activities	F 0656	**F656-Develop / Implement Comprehensive Care Plans** What corrective action(s) will be	07/28/2019

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	for 3 of 4 cognitively impaired residents reviewed for activities (Residents 24, 29, and 51). Findings include: 1. On 6/24/19 at 9:30 a.m. Resident 24 was in bed. The room was quiet. On 6/24/19 at 2:48 p.m., she was in bed, asleep. The room was quiet. On 6/25/19 at 1:50 p.m., she was in bed awake, looking at the wall next to her bed. The room was quiet. On 6/26/19 at 8:47 a.m., she was seated in the TV area near the nurses station, with an infomercial for beauty products on the TV. At 9:19 a.m., she was being assisted back to her room; at 9:52 a.m., she was in bed asleep. On 6/26/19 at 11:11 a.m., she was up in her wheelchair, being assisted to the TV area near the nurses station. On 6/27/19 at 11:13 a.m., she was in the main dining room, seated at her table. A small group of residents were near the doorway, engaged in chair exercises. Review of Resident 24's clinical record was completed on 6/24/19 at 3:37 p.m. Diagnoses included, but were not limited to, cognitive communication deficit, hemiplegia and hemiparesis following cerebral infarct affecting non-dominant side, vascular dementia, dysphagia, and type 2 diabetes. A 4/17/19, quarterly, Minimum Data Set (MDS) assessment indicated she was rarely/never		accomplished for those residents found to have been affected by the deficient practice; **·Residents #24, #29 and #51 have had their preference for Activities updated and are receiving activities per their preference. Care-Plans and Resident Profiles reflect preferences.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **·All residents with cognitive impairment have the potential to be affected.** **·An audit was completed by Social Services Director to identified cognitively impaired residents, by 7-11-2019.** **·All dependent residents identified by audit will have Activity preferences updated and care-planned by Activity Director /Social Services Director by 7-18-2019.** **·Activity Director to be in-serviced per Social Service Support Staff on utilizing Activity attendance log and Activities for cognitively impaired residents.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **·Activity Director to be in-serviced per Social Service**	

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	understood, and rarely/never understood others. She was dependent for transfers and required extensive assistance for mobility. She had a current, 5/2/19, care plan problem for activities, which indicated she enjoyed group activities including, but not limited to, musical concerts, church, bingo, ice cream social, hydration cart/menu, sensory activities, manicures, and exercise with music. She also enjoyed independent activities including, but not limited to, watching television in the common area, watching the fish tank, and sitting in the common area with others. Interventions included, but were not limited to, verbal reminders and assistance to activities, provide a calendar, and independent supplies for her room. The care plan was updated on 6/26/19 to include 1:1 visits when time allowed. Review of the June activities calendar indicated, but was not limited to, the following activities: On 6/24/19, the hydration cart was scheduled for 8:45 a.m. Sensory group was scheduled for 9:30 a.m. On 6/25/19, bingo was scheduled for 2:00 p.m. On 6/26/19, the hydration cart was scheduled for 8:45 a.m. A country drive was scheduled for 9:30 a.m. and walking at 10:30 a.m. Review of a 1/18/19, annual activity assessment indicated it was somewhat important to have reading materials available such as chicken soup books, somewhat important to listen to gospel and country music, and she liked groups of people, but also needed her rest. Review of June 2019 activities documentation		**Support Staff on utilizing Activity attendance log and Activities for cognitively impaired residents, by 7-20-2019.** **·Activity Director to utilize attendance logs for resident activity for weekly Executive Director review for accuracy and attendance.** **·Activity Preference will be updated quarterly per Activity Director.** **·Activity Director will make weekly rounds to ensure cognitively impaired residents are aware of Activity events for the week.** **·In-service by Executive Director/Director of Nursing Services/Clinical Education Coordiantor by 7-11-2019 for all staff on resident preferences and encouraging attendance to Activities.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; ·On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. ·Activity CQI will be completed weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved.	

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	indicated she participated in the hydration cart when it was offered with the exception of one day. She participated in sensory activities all but one day it was offered. She was not available for participation in afternoon activities, with the exception of 9 of 26 days reviewed. During an interview, on 6/26/19 at 1:54 p.m., CNA 22 indicated Resident 24 occasionally attended music activities and church services. She would sometimes attend bingo, but did not actively participate; she would just look around the room. Activities staff would paint her nails while she was in her room. During an interview, on 6/26/19 at 2:28 p.m., CNA 32 indicated Resident 24 did not attend many activities in the evening during the week, as she was usually in bed before supper. She occasionally attended bingo. During an interview, on 6/27/19 at 1:39 p.m., the Activity Director indicated the resident was assisted to bed after meals, and couldn't always attend group activities. The activities staff would take sensory items to the resident's room when she was not able to attend. 2. On 6/24/19 at 10:15 a.m., Resident 29 was in bed asleep. On 6/24/19 at 2:50 p.m., he was in bed asleep. On 6/25/19 at 8:53 a.m., he was in bed. On 6/25/19 at 2:00 p.m., he was in bed asleep. On 6/26/19 at 8:47 a.m., he was in the TV area near the nurses station, with an infomercial for beauty products on the TV. He was assisted back to his		·If Threshold of 90% is not met, an action plan will be developed to ensure compliance.	

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	room at 8:51 a.m. On 6/26/19 at 10:33 a.m., he was in bed, turned toward the wall. On 6/27/19 at 10:14 a.m., he was in bed, turned toward the wall. His TV was on a stand, behind a curtain, and was unplugged from the wall. On 6/27/19 at 11:31 a.m., he was seated in his Broda chair in the main dining room. Review of Resident 29's clinical record was completed on 6/25/19 at 2:03 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, dysphagia, vascular dementia, and anxiety. A 4/15/19, significant change, MDS assessment indicated he rarely or never made himself understood and rarely or never understood others. It was very important for him to have music and pets, and somewhat important to keep up with the news, be with groups of people, and get fresh air outside. He required extensive assistance for ADLs and mobility, including eating. He had a current, 5/2/19, care plan problem of enjoying group activities which included, but were not limited to, outdoor socials, hydration cart/menu, sensory, music with exercise, and special events. Independent activities of preference included, but were not limited to, watching television, sitting by the aquarium, and sitting in the common area with others. Interventions included, but were not limited to, provide verbal reminders and assistance, provide a calendar for room, and independent activities supplies for room.			

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	Review of a 12/4/18 Activity Assessment indicated he enjoyed group activities including, but not limited to, sensory, hydration cart/menu, special events, church, music and exercise, and small objects to fidget with. His independent activities of preference included, but were not limited to, watching television, sitting by the aquarium, and sitting in the common area with others Review of June 2019 activities documentation indicated he passively attended activities such as music and exercise, and actively participated in sensory, Bible studies and the activity cart. During an interview, on 6/26/19 at 1:54 p.m., CNA 22 indicated Resident 29 would usually attend church services on the weekend. Activities staff would read to him in his room at times. During an interview, on 6/26/19 at 2:28 p.m., CNA 32 indicated staff tried to make sure he was included in church services on the weekends. He was usually still in bed during bingo, and he was not able to do much on his own. During an interview, on 6/27/19 at 1:39 p.m., the Activity Director indicated Resident 29 used to use a busy box, but didn't like it much anymore. He liked to stack the puzzle pieces in his lap, and liked sensory activities, such as hand lotions. He also enjoyed watching the Golden Girls on TV. She was not aware his TV was unplugged and not in his line of vision. 3. On 6/24/19 at 8:28 a.m., Resident 51 was in bed asleep, with her room darkened. On 6/24/19 at 2:49 p.m., she was in bed asleep.			

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	On 6/25/19 at 8:15 a.m., she was in the main dining room for breakfast, sleeping in her Broda chair. At 8:50 a.m., she was assisted to bed. On 6/25/19 at 1:53 p.m., she was in bed asleep. On 6/26/19 at 8:47 a.m., she was in the TV area near the nurses station, with an infomercial for beauty products on the TV. She was assisted back to her room at 9:11 a.m. On 6/26/19 at 11:26 a.m., she was in the main dining room, asleep, as a small group was engaged in chair exercises. On 6/27/19 at 10:16 a.m., she was in bed. On 6/27/19 at 11:16 a.m., she was sleeping in her Broda chair. Review of Resident 51's clinical record was completed on 6/25/19 at 2:26 p.m. Diagnoses included, but were not limited to, vascular dementia, dysphagia, recurrent depressive disorder, and late onset Alzheimer's disease. A 5/22/19, annual, MDS assessment indicated she was rarely/never understood and rarely/never understood others. It was very important to have things to read and to attend religious services, and somewhat important for music and being with groups of people and around animals. She required extensive assistance with ADLs and mobility. She had a current, 12/19/18, care plan problem of actively and passively enjoying activities such as, but not limited to, sensory, hand lotion, church, music programs, movie matinees, and music and			

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	exercise. Independent activities of interest include, but were not limited to, watching television, and sitting by the aquarium. Interventions included, but were not limited to, an activity calendar in room, encourage activity attendance, and provide verbal reminders. A 12/5/18 Activity assessment indicated her participation had been both active and passive. Review of June 2019 activities documentation indicated she participated in the hydration cart and sensory activities actively and exercise passively. She was usually not available during the afternoons for activities. During an interview, on 6/26/19 at 1:54 p.m., CNA 22 indicated Resident 51 did not participate in much; sometimes she would have a hand massage or her nails done. During an interview, on 6/26/19 at 2:28 p.m., CNA 32 indicated the resident did not participate in afternoon or evening activities, as she was usually in bed. She would sometimes attend church service on the weekend. During an interview, on 6/27/19 at 2:49 p.m., the DON indicated she did not realize having the residents assisted back to bed so quickly after meals would interfere with their activities programming. The residents were assisted back to bed so soon after meals to allow rest and to prevent skin issues. Review of a current facility policy titled "Activities," dated 1/2006 and provided by the Administrator on 6/28/19 at 9:38 a.m., indicated it was the policy of the facility to provide an ongoing program of activities designed to meet			

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	the interests and the physical, mental, and psychosocial well-being of each resident in accordance with the comprehensive assessment. 3.1-35(g)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview the facility failed to ensure medications were properly labeled in 1 of 3 medication carts observed (100 hall medication cart).	F 0761	**F761-Label / Store Drugs & Biologicals** What corrective action(s) will be accomplished for those residents found to have been affected by the	07/28/2019

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	Findings include: An observation of 100 hall medication cart, on 6/27/19 at 1:48 p.m., accompanied by LPN 71, the following was observed: A opened Humalog (insulin) KwikPen, with no open date on it. A open vial of Humalog, with no open date on it. During the observation, LPN 71 indicated they would normally date the insulin after it had been opened. A policy titled " Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles," provided by the Nurse Consultant on 6/27/19 at 2:50 p.m., indicated once any medications or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the dated opened on the medication container when the medication has a shortened expiration date once opened. 3.1-25(j)		deficient practice; **·Undated insulin was replaced with dated insulin upon opening.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **·An audit conducted of all medication carts by Director of Nursing Services or designee by 7-11-2019 to ensure proper dating was complete.** **·All nursing staff were Director of Nursing Services by 7-11-2019 on dating medication upon opening.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **·An all staff in-service conducted on 7-11-2019 by Director of Nursing Services, included Nurse specific training related to the policy for Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles.** **·Weekly Medication Cart audits will be completed per assigned Nurse Managers**. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; ·On going compliance with this	

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			corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. ·Medication CQI will be completed weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. ·If Threshold of 90% is not met, an action plan will be developed to ensure compliance.	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure meals were appetizing, palatable, and timely for 16 residents, and two resident representatives, interviewed for food quality (Residents 44, 38, 162, 39, 25, 39, 12, 7, 21, 48, 53, 16, 36, 32, 56, 6, 4, and 104). Findings include: 1. During an interview, on 6/24/19 at 9:39 a.m., Resident 44 indicated there was a poor selection of alternatives for meals. The food was served	F 0804	**F804-Nutritive Value / Appear, Palatable / Prefer Temp** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **·Identified residents were interviewed to determine dining preferences, including timing, taste and palatability with updating of tray cards as**	07/28/2019

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	either burnt or soggy, and was cold. The toasted cheese sandwiches offered as an alternative were made ahead of time, and were soggy. The sloppy joes looked like meatloaf. 2. During an interview, on 6/24/19 at 10:52 a.m., with a representative for Resident 25, they indicated the food at the facility was not good and the menu was odd. 3. During an interview, on 6/24/19 at 11:41 a.m., with a representative for Resident 104, they indicated the food at the facility was not good. The potato soup looked like mashed potatoes. The food had gone from bad to worse. 4. During an interview, on 6/24/19 at 12:20 p.m., Resident 162 indicated the food looked okay, but tasted badly. The alternatives weren't any better than the menu items. 5. During a meal observation in the main dining room, on 6/24/19 at 11:58 a.m., the first meal tray was served. The posted meal time for the dining room was 11:45 a.m. Fish sandwiches were served, and the fish patties would fall apart when lifted from the plate. The cheese on the sandwiches remained not melted. There was no visible steam from the plates and bowls served to the residents. 6. During an interview with resident council representatives, on 6/25/19 at 11:30 a.m., the following was observed: The Resident Council had met "many times" with the Dietary Manager with concerns about the facility meals. They had voiced concerns with the food not tasting good and not being hot enough when served. Many of the residents had to buy		**needed.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **·All residents utilizing meal service had the potential to be affected.** **·All Dietary staff to be in-serviced by Certified Dietary Manager/Executive Director on 7-11-2019 on food presentation, palatability and timeliness of meal service.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **·An all staff in-service conducted on 7-11-2019 included education regarding providing appetizing, palatable and timely meals for all residents.** **·Food Committee will be held monthly with concerns to be given to Executive Director for timely follow up.** **· Meal observation by assigned management member to be completed weekly ongoing.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;	

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	microwavable meals to supplement what the facility provided. The residents had to eat a lot of toasted cheese sandwiches, but most of the time, they were served burnt. The facility had menus with food choices, but did not usually honor the choices made by the residents. The consistency of the entrees made it difficult to chew them. The meals were served late almost daily. The Dietary Manager had responded to the group by telling them the cooks had to follow the recipes for the posted menus. 7. During an interview, on 6/25/19 at 1:56 p.m., Resident 39 indicated the food served at the facility looked okay, but was not good when eaten. The residents had tried telling the Dietary Manager, but nothing ever changed. They were told they followed the recipes. 8. During a meal observation, on 6/26/19 at 11:59 a.m., the first tray was served. The posted meal time was 11:45 a.m. Review of Resident Council meeting minutes, dated 2/16/19, indicated the residents were concerned with late meal service. They had addressed the issue at Food Committee meetings, but nothing had changed. Hall trays had not been passed until after 1:30 p.m. on some days for lunch. Review of Resident Council meeting minutes, dated 6/12/19 indicated they felt the Dietary Manager needed to listen to the resident concerns and act on them. The minutes indicated a formal grievance was forwarded to the Administrator on 6/12/19 due to lack of response from the Dietary Manager. Review of Food Committee Meeting minutes,		·On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. ·Dietary Food CQI will be completed weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. ·If Threshold of 90% is not met, an action plan will be developed to ensure compliance.	

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	dated 12/5/18, indicated, but was not limited to, the following: a. The CNAs complained about the meal being served late. b. The hall trays were served with plastic cutlery. c. The triangle potatoes tasted like cardboard. d. The food was not served hot. No corrective action was indicated on the document. Review of Food Committee Meeting minutes, dated 4/9/19, indicated, but was not limited to, the following: a. The mashed potatoes were not good the past few times. b. The food "sucked bad," but no specific feedback was offered. No corrective action was indicated on the document. Review of Food Committee Meeting minutes, dated 6/12/19, indicated the residents did not have any special requests for meals for the month. During an interview, on 6/27/19 at 9:02 a.m., the Dietary Manager indicated she could not locate any other minutes for the Food Committee. During an interview, on 6/27/19 at 9:25 a.m., the Dietary Manager indicated the Food Committee met monthly, but she couldn't find the minutes. The frequent complaints from the residents were about food temperatures and seasoning of foods. The facility kitchen followed the recipes they were given. The residents only provided her with general information about the food and she had			

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	asked about certain meals, but received no feedback. The residents didn't like like spicy foods. She had reached out to the company's home office, but was told she "can't please everyone." Review of a current facility policy, titled "Menu Planning," dated 11/2016 and provided by the Administrator on 6/27/19 at 1:44 p.m., indicated the menus would reflect, based on the facility's reasonable efforts, the religious, cultural, and ethnic needs of the resident's population, as well as input received from residents and resident groups. Review of a current facility job description for the Dietary Services Manager, updated 12/2014 and provided by the Social Service Consultant, on 6/28/19 at 8:58 a.m., indicated an essential function of the position was to ensure meals were served in scheduled time frames. They would also communicate resident concerns and responses to interventions to the interdisciplinary team and direct care staff. They would also identify ways to accommodate resident's choices, preferences, and customary routines in manners of eating. 3.1-21(a)(1) 3.1-21(a)(2)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §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			

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	directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure leftover foods were labeled and expired items were disposed of, in the facility kitchen. Findings include: During the initial tour of the facility kitchen, on 6/24/19 at 8:42 a.m., accompanied by the Dietary Manager, the following was observed: In the dry storage room, two unlabeled clear round containers of a white substance, and an unlabeled clear bag lying on top of one of the unlabeled clear containers. The Dietary Manager indicated it was thickner and it should have been labeled and dated. In the back freezer, an unlabeled container with a lid, that was slightly elevated off the container, contained meat. The Dietary Manager indicated	F 0812	**F812-Food Procurement, Store, Prepare, Serve - Sanitary** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **·No residents were identified to be affected.** **·All unlabeled/dated food items have been disposed of, in the facility kitchen.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **·All residents receiving dietary services had the potential to be affected.** **·Certified Dietary Manager to be in-serviced by 7-13-2019, on Food Production policy which includes label, dating and storage.** **·A complete audit has been**	07/28/2019

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	the meat was left over pork roast and it should have been labeled and dated. In the front refrigerator, an unlabeled clear plastic bag, dated 5/31, the Dietary Manager indicated it was mushrooms and they would normally keep them for about 2 weeks after they receive them and she was going to throw them away. A policy, titled "Food Production, " provided by the Dietary Manager, on 6/26/19 at 11:26 a.m., indicated sufficient storage facilities are provided to keep foods safe, wholesome and appetizing. Food is stored, prepared and transported at an appropriate temperature and by methods designed to prevent contamination... containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must be accurately labeled and dated... leftover prepared foods are to be stored in covered containers or wrapped securely. The food must clearly be labeled with the name of the product, the date it was prepared and marked to indicate the date by which the food shall be consumed or discarded. Leftover foods can be held at 41 degrees Fahrenheit or less for no more than 3 days. The day the food was prepared shall be counted as Day 1... refrigeration, all foods should be covered or wrapped tightly, labeled and dated... frozen foods, should be covered or wrapped tightly, labeled and dated. 3.1-21(i)(3)		**conducted to ensure all food is properly labeled and/or disposed of, no other items were identified to be non-labeled.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **·Certified Dietary Manager to be in-serviced by 7-13-2019, on Food Production policy which includes label, dating and storage.** **·Registered Dietitian to complete monthly short form sanitation reviews and quarterly long form sanitation reviews.** **·Certified Dietary Manger or designee to audit daily for proper label, storage and dating is completed.** **·Dietary staff were in-service on 7-11-2019, by Certified Dietary Manager/Executive Director on proper food procurement, storage and labeling.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; ·On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.	

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			·Dietary Label/Date CQI will be completed weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. ·If Threshold of 90% is not met, an action plan will be developed to ensure compliance.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §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 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			

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	identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct 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			

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	necessary. Based on observation, interview and record review, the facility failed to ensure glucometers were disinfected after use according to the manufacturer's instructions for 2 of 2 accuchecks (Resident 48 and 39). Based on observation, interview, and record review, the facility failed to ensure meals were delivered in a safe and sanitary manner, for 2 of 2 meal observations. The facility failed to develop and implement a water management program to reduce the likelihood of water-borne illnesses caused by opportunistic pathogens, such as Legionella. Findings include: 1. During an observation of a blood glucose monitoring, on 6/25/19 at 11:05 a.m., with LPN 76, the following was observed: At 11:05 a.m., a Nursing Policy and Procedure-Skills Validation paper was on top of the medication cart, it indicated to obtain single-use germicidal wipe, wipe entire external surface of the blood glucose meter with wipe for 3 minutes, place cleaned meter on paper towel, in a plastic cup or clean barrier, allow meter to completely dry. At 11:07 a.m., LPN 76 cleansed the glucometer for 30 seconds with a Clorox Healthcare Bleach germicidal wipe and indicated she was going to let it dry for 3 minutes and sat the glucometer on a facial tissue on top of the medication cart.	F 0880	**F880-Infection Control** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; **·Residents #48 and #39 have been assigned personal glucometers and are cleaned per facility policy.** **·Facility has developed and implemented a water management program** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; **·All residents with blood glucose monitoring orders had the potential to be affected.** **·All residents have the potential to be affected by water borne illnesses.** **·An audit was completed to identify all resident with daily glucose monitoring orders, residents identified were assigned individual glucometer by 7-11-2019.** **·An audit was completed per Director of Nursing Services by 7-11-2019 to identify resident presenting infectious signs and systems of water borne illness in the past 30 days, no residents were identified.** **·All nurses were in-serviced by Director of Nursing Services on 7-11-2019 on glucose**	07/28/2019

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	At 11:10 a.m., she gathered supplies to obtain Resident 48's blood sugar and entered Resident 48's room. At 11:12 a.m., Resident 48's blood sugar was 194. At 11:15 a.m., LPN 76 wiped the glucometer with a Clorox Healthcare Bleach germicidal wipe for 10 seconds and sat it on a facial tissue on top of the medication cart. At 11:17 a.m., LPN 76 indicated she thought she was supposed to let it dry for 3 minutes, not wipe the glucometer for 3 minutes and all the residents on the 300 hall used the same glucometer. At 11:23 a.m., LPN 76 moved the medication cart to Resident 39's room. She wiped the glucometer for 3 minutes with a Clorox Healthcare Bleach germicidal wipe. At 11:31 a.m., LPN 76 gathered supplies to obtain a resident's blood sugar and entered resident 39's room. She inserted the test strip into the glucometer, the glucometer did not work. At 11:38 a.m., LPN 76 retrieved a new glucometer from the DON/ADON's office. At 11:45 a.m., LPN 76 wiped the glucometer for 3 minutes with a Clorox Healthcare Bleach germicidal wipe.		**monitoring per policy.** **·Clinical Education Coordinator to complete Skills validation for glucose monitoring on all nurses by 7-21-2019.** **·Executive Director and Maintenance Director in-serviced per RDSC on Water Management policy, by 7-20-2019.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **·An audit was completed to identify all resident with daily glucose monitoring orders, residents identified were assigned individual glucometer by 7-11-2019.** **·Clinical Education Coordinator to complete Skills validation for glucose monitoring on all nurses upon hire, and according to QAPI Skills Validation calendar for ongoing training.** **·Nurse manager to observe weekly glucometer cleaning for four weeks, then present results during QAPI to determine if further observation is needed.** **·Executive Director and Maintenance Director in-serviced per RDSC on Water Management policy, by 7-20-2019.** **·Executive Director to review**	

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	155200	A. BUILDING 00 B. WING	06/28/2019

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	At 11:53 a.m., LPN 76 gathered supplies to obtain Resident 39's blood sugar and entered Resident 39's room. She inserted the test strip into the glucometer, the glucometer did not work. LPN 76 indicated she was going to get a glucometer from the 100 hall medication cart. At 11:55 a.m., LPN 76 indicated she was going to wipe the glucometer, she retrieved from the 100 hall cart with alcohol prep pads and was going to ask for new wipes because they are too wet and the glucometers would not work. She wiped the glucometer for 2 minutes with alcohol prep pads. At 12:02 p.m., LPN 76 gathered supplies to obtain Resident 39's blood sugar and entered Resident 39's room. The resident's blood sugar was 152. At 12:05 p.m., LPN 76 wiped the glucometer with alcohol prep pads for 2 minutes and indicated it had been 3 minutes. At 2:06 p.m., the Nurse Consultant indicated they do not have a policy for glucometer cleaning, they refer to the skills validation. During a review of the Evencare G3 blood glucose monitoring system, user's guide, provided by the DON at 1:57 p.m., indicated the following products had been approved for cleaning and disinfecting the Evencare G3 meter: Dispatch Hospital Cleaner Disinfectant Towels with Bleach, Medline Micro-Kill Disinfecting, Deodorizing, Cleaning Wipes with Alcohol, Clorox Healthcare Bleach Germicidal and Disinfectant Wipes and Medline		**Water Management implementation monthly during QAPI meeting**. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; ·On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director. ·Infection Control CQI will be completed weekly x 4 weeks, monthly x 3 months, and quarterly there after until compliance is achieved. ·If Threshold of 90% is not met, an action plan will be developed to ensure compliance.	

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	Micro Kill Bleach Germicidal Bleach Wipes. At 2:15 p.m., a Nursing Policy and Procedure-Skills Validation titled "Glucose Meter Cleaning and Testing," provided by the DON, indicated to obtain single-use germicidal wipe, wipe entire external surface of the blood glucose meter with wipe for 3 minutes, place cleaned meter on paper towel, in a plastic cup or clean barrier and allow meter to completely dry. 2. During an observation of meal service on the secured unit, on 6/24/19 at 11:21 a.m., CNA 12 removed her hair net, adjusted her pony-tail, then began putting ice in glasses from the ice chest, for a resident, then patted the resident's back. On 6/24/19 at 11:28 a.m., CNA 12 put ice in a glass from the ice chest, opened a can of coke, and took it to a resident, the resident asked for a straw, the employee got her a straw, as she walked away, she wiped her upper lip. CNA 12 asked a resident what she wanted to drink, she retrieved two glasses, scooped ice in them, poured water in one glass, and poured tea in the other one, she removed the ice scoop from a plastic bag, she dropped the plastic bag on the floor, kicked bag under the cart containing the ice chest. On 6/24/19 at 11:36 a.m., CNA 12 opened the ice chest, pulled the scoop out and scooped ice in a glass, scratched her forehead, then scooped ice in another glass, and poured water in it. On 6/24/19 at 11:37 a.m., CNA 12 pushed her eye-glasses up, she moved the drink cart and rolled it to in front of the ice chest. She went to a cabinet, pulled out a bag with a small red item in it, removed the red item from the bag, pulled ice scoop out of ice chest, and placed scoop inside of			

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	the bag. On 6/24/19 at 11:53 a.m., CNA 12 was holding a gentleman's hand while assisting him into the dining room. On 6/24/19 at 11:55 a.m., CNA 12 washed her hands. During a follow-up meal observation on the secured unit, on 6/26/19 at 12:12 p.m., CNA 5 sat beside Resident 8, she pushed her bangs away from her forehead, unwrapped the silverware, handed two plastic cups to Nurse 7 for them to be filled with lemonade and water, she had two fingers inside of the cups to hand them over to the nurse. During an interview, on 6/24/19 at 12:14 p.m. CNA 12 indicated the ice scoop was usually kept in the ice chest, she had dropped the bag, and did get another bag from the cabinet, removed the red chip clip, and used it to store the ice scoop. She would wash her hands after every other tray and while passing drinks she would wash her hands when they were visibly dirty. Review of a current facility policy, titled "Dietary Personal Hygiene," dated 7/15, and provided by the Social Service Consultant, on 6/27/19 at 3:46 p.m., indicated employees will maintain good personal hygiene to prevent food contamination. 3. During an interview, on 6/28/19 at 11:57 a.m., the Maintenance Director indicated the facility had no testing results or an assessment regarding water management. Review of a current facility policy, titled "Water Borne Pathogen Prevention Policy," dated April			

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	2018, and provided by the Administrator, on 6/28/19 at 11:47 a.m., indicated the facility will conduct a risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system. No additional information was provided. 3.1-18(a)(l)			