STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155187	A. BUILDING 00 B. WING	01/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	3175 LANCER ST PORTAGE, IN 46368

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00250787. Complaint IN00250787 - Unsubstantiated due to lack of evidence. Survey dates: January 16, 17, 18, 19, 22, & 23, 2018 Facility number: 000098 Provider number: 155187 AIM number: 100290980 Census Bed Type: SNF/NF: 138 Total: 138 Census Payor Type: Medicare: 5 Medicaid: 110 Other: 23 Total: 138 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/25/18.	F 0000	This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements The facility respectfully request paper compliance Thank you for your consideration, Respectfully, Jason Eastlund, BSW, HFA	
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.			

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

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	§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 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, record review, and interview, the facility failed to ensure each resident's dignity was respected related to the posting of confidential and/or personal care information in viewable areas for 1 of 3 residents	F 0550	Res Identified Patient 37 had personal care sign removed from the room	02/20/2018

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	reviewed for dignity. (Resident 37) Finding includes: On 1/17/18 at 2:03 p.m., there were 2 signs posted in Resident 37's room from the Speech Therapy department. Sign #1 indicated "STOP (Resident name) needs NECTAR THICK. Do NOT give her regular water. NO food." Sign #2 indicated "SWALLOWING PRECAUTIONS for (Resident name) liquid consistency: NECTAR, Food consistency NPO, NO THIN LIQUIDS, NO STRAWS, NO FOOD including pudding. NECTAR THICK ONLY. Thank you, Speech Therapy." The record for Resident 37 was reviewed on 1/19/18 on 9:36 a.m. Diagnoses included, but were not limited to, dysphagia, dementia, anxiety, and heart failure. The Medicare 5 day Minimum Data Set (MDS) assessment, dated 1/12/18, indicated the resident was not alert and oriented. The current plan of care indicated there was no care plan to have signs posted in the resident's room with confidential information for the public to see. Interview with the B-Wing Unit Manager, on 1/22/18 at 2:55 p.m., indicated those signs were not supposed to be hanging visibly on the walls or from the room doors in resident rooms. 3.1-3(t)		Others Facility searched all patient rooms to identify any personal care signs. All signs related to personal care were removed. Education Clinical leadership and therapy department were educated by staff development coordinator on F tag 550 Monitor Facility will monitor all patient rooms to identify any dignity issues 1 X per week for 4 weeks, 1 time per month for 3 months and then quarterly there after until 95% compliance is achieved. QAPI All negative findings will be reviewed in Monthly QAPI meeting.	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination.			

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	The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on record review and interview, the facility failed to ensure residents' and families' preferences were honored related to the right to have showers three (3) days a week for 1 of 1 residents reviewed for choices. (Resident 114) Finding includes: Interview with Resident 114's daughter, on 1/16/18 at 2:10 p.m., indicated upon her mother's admission she was asked about shower	F 0561	Patient 114 immediately had their shower times moved from evening to morning. Facility completed a 100% audit of preferences to identify optimal times. Licensed nursing staff educated by the SDC, prior to date of compliance, on resident rights, to include	02/20/2018

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	preferences. She preferred for her mother to be bathed three times a week and before 8:00 p.m. The resident's preferred bedtime was 7:00 p.m. The record for Resident 114 was reviewed on 1/19/18 at 11:13 a.m. The diagnoses included, but were not limited to, muscle weakness, hypertension, and diabetes. The Admission Minimum Data Set (MDS) assessment, dated 12/22/18, indicated the resident was severely cognitively impaired. She was totally dependent with bathing and her family participated in her care assessment. The Resident Preference Worksheet, dated 12/18/17, indicated the resident/daughter preferences were to have showers 3 days a week, in the morning time, and by a female caregiver. The C Wing Shower Schedule, indicated the resident was scheduled for 2 showers a week (Wednesday/Saturday) during the evening time. A Grievance Form, dated 1/21/18, indicated the resident's daughter had a concern related to her mother being bathed late at night, after 8:00 p.m. Interview with the Social Service Director (SSD), on 1/23/18 at 9:20 a.m., indicated she investigated the daughter's concerns, she wanted her mother to be bathed 3 days a week and before 8:00 p.m. The SSD followed up with the Unit Manager and had the resident's shower schedule updated. 3.1-3(u)(1)		honoring preferences. Facility will complete 5 preference sheets per week for 4 weeks, then 5 per month times 3 months, then 5 quarterly until 95% compliance is achieved. All negative findings will be reviewed in Monthly QAPI meeting.	
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment			

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	§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of			

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	comfortable sound levels. Based on observation and interview, the facility failed to provide a sanitary and functional environment related to urine odors, marred and gouged walls, doors, and frames, displaced sink stoppers, chipped and peeling paint, brown substances in toilets/sinks/faucets, displaced heating vents, loose and scuffed cove bases, holes in walls, dirty floor mats, food spillage, cracked plaster, and displaced wall guards for 3 of 3 units. (The 100, 200, and 300 Halls) Findings include: During the Environmental Tour, with the Maintenance Director, on 1/23/18 at 1:50 p.m., the following was observed: 1. 100 Hall a. Room 104, there was a strong urine odor. The room and bathroom doors were marred. Two residents shared the room and bathroom. b. Room 108, the room and bathroom doors were marred. One resident resided in the room. c. Room 125, the closet, room, and bathroom doors were marred. The cove bases were scuffed. One resident resided in the room. d. Room 127, the sink stopper was displaced. The bathroom door was marred and had peeling paint. Two residents shared the bathroom. e. Room 128, the bathroom door was marred and had peeling paint. Two residents shared the bathroom. f. Room 134, there was a brown substance along	F 0584	Res Identified All mentioned areas were addressed by maintenance and house keeping prior to date of compliance. Others Facility review was conducted to identify any areas not mentioned in 2567. Facility worked with sister facility to get increased coverage for environment needs. Education Maintenance, kitchen and housekeeping department were educated on F tag 584, by the SDC prior to date of compliance. Monitor ED/Designee will monitor the entire facility 1 X per week for 4 weeks, 1 time per month for 3 months, and then 1 X per quarter until 95% compliance is achieved. QAPI All negative findings will be reviewed in Monthly QAPI meeting.	02/20/2018

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	the inside of the toilet bowl. The bathroom wall was gouged. One resident resided in the room. 2. 200 Hall a. Room 217, there was a strong urine odor and the heating vent was displaced. Two residents resided in the room. b. Room 222, the bedroom walls were marred and gouged. The bathroom walls were scratched and marred. The cove bases were loose, and there was a hole in the wall. One resident resided in the room. c. Room 223, the bedroom walls were marred and gouged. The floor mat beside bed 2 was stained and dirty. The bathroom door was marred. Two residents resided in the room and shared the bathroom. d. Room 226, there was dried food spillage behind bed 2 and the wall was marred and gouged. Two residents shared the room. e. Room 227, the plaster underneath the window was cracked. The bedroom walls were marred. The bathroom walls were marred and gouged. Two residents resided in the room and shared the bathroom. f. Room 232, the bedroom walls were marred and gouged. The heating vent had peeling paint. The bathroom door and walls were marred and gouged. Two residents shared the room and bathroom. 3. 300 Hall a. Room 320, the plaster outside of the door was			

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	chipped and the resident name plate was missing. The walls were gouged and marred. Two residents resided in the room. b. Room 330, the bathroom door and frame were marred. There was a dried brown substance on the sink/faucet and the walls had peeling paint. Two residents shared the bathroom. c. Room 337, the plastic wall protector next to bed 1 was displaced. The bathroom door and frame were marred. Interview at the time, with the Maintenance Director, indicated the above was in need of cleaning and/or repair. 3.1-19(f)			
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 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. Based on observation, record review, and interview, the facility failed to monitor and/or assess skin discolorations for 3 of 3 residents reviewed for non-pressure related skin conditions. The facility also failed to monitor a resident for constipation for 1 of 4 residents reviewed for hospitalization. (Residents 5, 236, 286, & 11) Findings include:	F 0684	Res Identified Patient 236, 286 and 5 had Bruise monitoring and measurements completed prior to date of compliance. Patient 11 had a clinical review by the DNS regarding her BM's for a 2 week period prior to date of compliance.	02/20/2018

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	1. On 1/17/18 at 9:45 a.m., Resident 5 was observed with two small areas of reddish purple discoloration to the top of her left forearm. On 1/19/18 at 1:45 p.m., the areas of reddish purple discoloration remained to the top of the resident's left forearm. The record for Resident 5 was reviewed on 1/18/18 at 1:06 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance and hypertension. The 1/19/18, Weekly Skin assessment, indicated the resident had no new skin issues at this time. There was no documentation related to the discoloration on the resident's left forearm in the Nursing progress notes. Interview with the Director of Nursing (DON), on 1/23/18 at 3:00 p.m., indicated the resident was seen by her Physician on 1/23/18, and the areas were identified as purpura (a rash of purple spots on the skin). The DON indicated the resident did not have a current diagnosis of purpura and the areas should have been identified on the Weekly Skin Assessment. 2. On 1/17/18 at 10:43 a.m., Resident 236 was observed in bed. At that time, she was observed with red, purple and blue bruising around her left eye and forehead. The resident indicated she had just fallen out of bed. The record for Resident 236 was reviewed on 1/19/18 at 3:10 p.m. Diagnoses included, but were not limited to, heart failure, chronic kidney disease, high blood pressure, hypothyroidism, retinal detachment, and glaucoma.		Others Facility audited all skin conditions and looked at the bowl patterns of all residents prior to date of compliance. Education Facility educated all licensed nurses and aides on Policy and procedure related to skin monitoring and bowel management prior to date of compliance Monitor Facility will audit all documented skin issues to ensure appropriate monitoring occurs. Facility will also audit 5 random residents per week, on all units to ensure appropriate bowl measures are in place. Audits will be done weekly for 4 weeks, then monthly for 3 months, then quarterly until 95% compliance is achieved. QAPI All negative findings will be reviewed in Monthly QAPI meeting.	

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	The Quarterly Minimum Data Set (MDS) assessment, dated 1/17/18, indicated the resident was alert and oriented. The updated, 1/2018 plan of care, indicated the resident was at risk for complications for anticoagulant or antiplatelet medication due to the use of Aspirin. The interventions were to observe for signs and symptoms of bleeding and bruising. The 1/10/18 weekly skin review, indicated the resident was a readmit and was noted with some bruising to the bilateral upper extremities. The 1/17/18 weekly skin review, indicated bruising remained to the left eye and cheek area. Nursing notes, dated 1/14/18 at 10:34 p.m., indicated the resident was found on the floor. The resident stated that she was reaching for her blanket and fell out bed. Bruising and swelling were noted to the left side of her forehead. Nursing notes, dated 1/15/18 at 6:05 a.m., indicated the resident had a hematoma to the left temple, with mild greenish bruising. Nursing notes, dated 1/15/18 at 6:45 p.m., indicated the resident had a bruise to the left eye. There were no measurements taken of the bruising to the resident's eye and forehead. Interview with the Director of Nursing (DON), on 1/23/18 at 9:00 a.m., indicated the bruise should have been measured when staff first assessed it as well as documenting the bruise on the wound flow sheet. She indicated the bruise would be monitored every week until gone.3. On 1/17/18 at 2:05 p.m., Resident 286 was observed lying in bed.			

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	There was an area of large fading purple bruising on her right upper shoulder/arm. The record for Resident 286 was reviewed on 1/19/18 at 11:21 a.m. Diagnoses included, but were not limited to, humerus fracture, malnutrition, major depression, Alzheimer's, adult failure to thrive, and dehydration. The Admission Minimum Data Set (MDS) assessment, dated 1/10/18, indicated the resident was severely cognitively impaired. A Physician's order, dated 1/4/18, indicated the resident was to receive Aspirin 81 mg (milligrams) daily. The Clinical Health Status form, dated 1/3/18, indicated the resident had the following: 1. blue/green bruise to right lower arm measuring 3 x 1 centimeters (cm) 2. blue/green/purple bruise to right upper arm band and upper arm measuring 12 x 10 cm If skin condition present, initiate Interim Plan of Care (IPOC) and Weekly Skin Report (WSR). There was no WSR for the week of 1/7 - 1/13. The WSR, dated 1/17/18, indicated no documentation related to the monitoring of the bruising. Interview with the Director of Nursing (DON), on 1/23/18 at 11:30 a.m., indicated the areas of bruising should have been monitored weekly until healed on the WSR. The "Weekly Skin Review UDA" policy, dated 12/19/17 and provided by the DON as current on 1/23/17 at 9:00 a.m., indicated "If a skin alteration			

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	is identified the licensed nurse is to initiate/update the Wound Evaluation Flow UDA, one UDA for each area identified."4. The record for Resident 11 was reviewed on 1/19/18 at 10:48 a.m. Diagnoses included, but were not limited to, Alzheimer's Disease, pelvic fracture, reflux disease and colon cancer. The Discharge Minimum Data Set (MDS) assessment, dated 9/9/17, indicated the resident required extensive assist with toileting and personal hygiene. A Nurses' note, dated 9/9/17 at 10:51 a.m., indicated the resident was alert and oriented to self only and was incontinent of bowel and bladder. A Nurses' note, dated 9/9/17 at 1:20 p.m., indicated the resident had vomited two times after her daughter had made several attempts to feed her. The resident's daughter felt there was something wrong, she informed the Nurse and asked for the resident be sent to the hospital for evaluation. The Nurse contacted the resident's doctor and the resident was transferred to the emergency room. An abdominal CT scan completed at the hospital, dated 9/9/17, indicated the resident had a "large amount of stool in the rectosigmoid colon (section of the bowel near the rectum). Correlate clinically for possible constipation/fecal impaction." A "Resident Continence by Day Report" provided by the Medical Records Designee, on 1/22/18 at 4:18 p.m., indicated the resident had not had a bowel movement on 9/5/17, 9/6/17, 9/7/17, 9/8/17 and 9/9/17. Interview with the Director of Nursing (DON), on			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	1/23/18 at 10:27 a.m., indicated if the resident had not had a bowel movement after the third day, the Physician should have been contacted for orders and the bowel management program should have been followed. A Bowel Management (Retraining) Program, provided by the In-Service Director on 1/23/17 at 9:14 a.m., indicated "...Procedure Details: ...4. After third day, if resident has not had a bowel movement, a laxative should be given as ordered by the physician..." 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision for a resident with swallowing guidelines for 1 of 4 residents reviewed for nutrition. (Resident 96) Finding includes: On 1/19/18 at 12:12 p.m., Resident 96 was observed in her room in bed. The head of the resident's bed was elevated and she was leaning to the right side. The resident's lunch tray was taken into her room at this time. The resident's	F 0689	Res Identified Resident 96 was evaluated and picked up on occupational and speech therapies prior to date of compliance Others Facility audited and developed a list of residents that require	02/20/2018

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	tray was set up on the over bed table and CNA 2 left the resident's room and proceeded to pass other trays. At 12:18 p.m., the resident was making no attempts to feed herself. The following swallowing guidelines, dated 9/14/17, from Speech Therapy were posted above the resident's bed: -Thin liquids -Mechanical soft diet -1:1 assist with all meals -small bites/sips -upright for meals -slow rate/double swallow -pills whole in puree -no straws On 1/22/18 at 12:00 p.m., the resident was observed in her room in bed. At 12:08 p.m., the resident received her lunch tray in her room. The resident's tray was set up on her over bed table, her head of bed was elevated and the CNA proceeded to leave the resident's room. At 12:12 p.m., the resident was observed to be eating her stuffing with her fingers. The swallowing guideline sheet remained above the resident's bed. Interview with the Director of Nursing (DON), on 1/23/18 at 9:30 a.m., indicated the swallowing precautions above the resident's bed were old. She indicated the resident was instructed on swallowing guidelines at the time of her Speech Therapy discharge. The record for Resident 96 was reviewed on 1/19/18 at 2:22 p.m. Diagnoses included, but were not limited to, cerebral infarct (stroke), hemiplegia		supervision when eating, prior to date of compliance. Education Facility educated all nursing personnel on supervision guidelines prior to date of compliance. Monitor Facility will monitor 5 residents being supervised during meal time. Audits will be conducted 1 time per week for 4 weeks, then 1 time per month for 3 months, then quarterly until 95% compliance is achieved QAPI All negative findings will be reviewed in Monthly QAPI meeting.	

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	(weakness) affecting right dominant side and dysphagia (difficulty swallowing). The Speech Therapy progress note, dated 9/19/17, indicated the resident tolerated the session well and was provided discharge recommendations including swallowing precautions to utilize with intake such as double swallow, small bites and sips, and alternate liquids and solids. Documentation indicated the resident verbalized understanding. The Quarterly Minimum Data Set (MDS) assessment, dated 9/17/17, indicated the resident's Brief Interview for Mental Status (BIMS) score was 5, which indicated cognitive impairment. The Annual MDS assessment, dated 12/18/17, indicated the resident's BIMS score was now a 3, which indicated cognitive impairment. Interview with the DON, on 1/23/18 at 3:00 p.m., indicated the resident would be reassessed related to her swallowing guidelines and being able to eat alone in her room based on the resident's cognitive status. 3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable			

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	parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure dietary supplements were provided as ordered for a resident with a history of weight loss for 1 of 4 residents reviewed for nutrition. (Resident 100) Finding includes: On 1/19/18 at 11:39 a.m., the lunch trays were delivered to the D Wing. Resident 100's tray was observed on the cart at this time. The resident's tray card indicated that she was to receive fortified foods, a magic cup and fortified pudding with her meals. There was no magic cup or fortified pudding on the resident's tray. At 11:47 a.m., the resident's tray was taken to her room by CNA 1. The CNA did not request a magic cup or fortified pudding for the resident. Interview with CNA 1, on 1/19/18 at 11:50 a.m., indicated fortified pudding was sometimes kept on the unit but the magic cups usually weren't. She indicated if they didn't have fortified pudding on the unit, they would give yogurt instead. The record for Resident 100 was reviewed on 1/18/18 at 1:50 p.m. Diagnoses included, but were	F 0692	Res Identified Patient 100 had the magic cup placed on her try prior to date of compliance. Others All other resident supplements were reviewed to ensure they received the appropriate additions to their diets. This was completed prior to date of compliance. Education Facility educated nursing and dietary staff related to ensuring supplements are given with meals when ordered. This was completed prior to date of compliance. Monitor Facility will audit 5 random trays per week, on all meals to ensure supplements are given	02/20/2018

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	not limited to, dementia without behavioral disturbance, dysphagia (difficulty swallowing), major depressive disorder, anxiety disorder, diabetes, anemia, and abnormal weight loss. The Annual Minimum Data Set (MDS) assessment, dated 12/19/17, indicated the resident was cognitively impaired and needed assistance with eating. The resident had an unplanned weight loss. A Physician's order, dated 12/27/17, indicated the resident was to receive fortified pudding three times a day with meals. The plan of care, dated 1/12/18, indicated the resident was at risk for inadequate oral intake and/or weight loss related to diagnoses of dementia and a history of weight loss. Received mechanically altered diet due to difficulty chewing/swallowing regular consistency food items and diagnosis of dysphagia. Has had recent weight loss over 180 days and now body mass index (BMI) was below healthy range for height. Multiple supplements in place. The interventions included, but were not limited to, diet as ordered and supplements as ordered. Interview with the Registered Dietician, on 1/23/18 at 1:15 p.m., indicated magic cups and fortified pudding came from the kitchen. She was informed at this time, that the resident did not receive her supplements on 1/19/18 during lunch. 3.1-46(a)(1)		appropriately. Audits will be completed 1 time per week for 4 weeks, then 1 time per month for 3 months, then quarterly until 95% compliance is achieved. QAPI All negative findings will be reviewed in Monthly QAPI meeting.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements.			

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	The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to ensure food was stored, prepared and served under sanitary conditions related to, the improper use of gloves during meal service, dirty ovens, steam tables, cereal racks, floors, and cooler and freezer floors for 1 of 1 kitchens. (The Main Kitchen) Findings include: 1. On 1/16/18 at 9:10 a.m., during the Brief Kitchen Sanitation tour, with the Dietary Food Manager (DFM) and the Registered Dietitian (RD) the following was observed: a. There was dried food splattered on the outside of the plate warmer. b. There were large amounts of dried onion peels	F 0812	Res Identified The employee who handled the toast inappropriately was educated on food handling policy and procedure prior to date of compliance. All mentioned areas were addressed and fixed by the kitchen manager prior to date of compliance. Others Facility completed an internal audit of the kitchen to identify any areas of concern. All findings were addressed prior to date of compliance.	02/20/2018

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	on the floor in the walk in cooler, as well as dirt and food debris under the racks. The two plastic crates holding the milk crates were dirty with a large amount of dried food spillage. c. There was a moderate amount of dirt and food debris, including ice cream cups on the floor in the freezer under the racks. d. There was a large amount of dried food and dirt under all of the food prep tables. 2. On 1/23/18 at 7:25 a.m., during the Full Kitchen Sanitation tour with the DFM, the following was observed: a. There was adhered dirt and food spillage under the tilt skillet, stove, kettle and convection ovens. b. The outside of the tilt skillet had a large amount of grease and dried food spillage. c. The steam jacketed kettle had food crumbs all around the outside of it. d. The shelves on the cereal rack had a large amount of dried spillage and were sticky to touch. e. There was dried grease and food spillage on the outside of the convection ovens. There was a large amount of burned food inside both ovens. The bottom rack in the second oven was broken. Both oven doors were dirty inside and out. f. There was dried food spillage under the top of the steam table, and on top of the rollers on the steam table. Interview with the DFM at that time, indicated all of the above was in need of cleaning.		Education Facility educated all kitchen staff on proper food handling and sanitation expectations prior to date of compliance. Monitor Kitchen meal pass and sanitation will be audited 1 time per week to ensure guidelines are being met. Audits will be conducted 1 time per week for 4 weeks, then 1 time per month for 3 month, then quarterly until 95% compliance is achieved. QAPI All negative findings will be reviewed in Monthly QAPI meeting.	

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	3. On 1/23/18 at 8:05 a.m., Dietary Cook 1 was observed wearing gloves to both of her hands while placing food on the plates for the residents' breakfast meal. At that time, she was observed touching plates, utensils, lids, and other items with her gloved hands. She was serving scrambled eggs and coffee cake and the diabetics were to receive toast. The cook was observed to pick up the toast with those same gloved hands after touching everything else. After the fifth piece of toast, she had touched with her hands, the DFM was informed and instructed the cook to get tongs to serve the toast. The current 8/17/17 "Infection Control-Disposable Gloves" policy, provided by the DFM, on 1/23/18 at 11:00 a.m., indicated gloves should be changed after touching items, equipment, utensils, trash can lids or soiled work areas. Interview with the DFM at that time, indicated the Cook should have used tongs to place the toast on the plates. 4. On 1/23/18 at 10:00 a.m., Dietary Cook 2 was observed preparing the pureed green beans. After the preparation of the pureed green beans, the cook was going to prepare pureed lasagna. The DFM took the food processor and lid and ran it through the dishwasher. The cook indicated the lasagna was prepared in layers and the first layer was the noodles. After the noodles were pureed, the cook took the processor and lid to the dish room and rinsed it out in the three compartment sink, however, there was no sanitizer. She brought the processor back and completed the next 3 layers, each time only rinsing out the food processor and not sanitizing it or running it through the dish machine.			

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	The 2/12/15 current "Cleaning Food Processors" policy provided by the DFM, on 1/23/18 at 11:00 a.m., indicated wash in hot, soapy water; may be washed and sanitized by running through the dish machine. Rinse, sanitize and allow to air dry. Interview with the DFM at that time, indicated the processor should have been placed in the dishwasher to clean in between each pureed food item. 3.1-21(i)(3)			
F 0880 SS=E 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;			

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	§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. (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			

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	of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure an infection control program was followed related to the lack of a water management policy and plan to protect high risk residents residing in the facility. This had the potential to affect the 55 high risk residents residing in the facility. Finding includes: On 1/23/18 at 1:25 p.m., the Maintenance Director provided a binder with the copy of the guide (CMS toolkit) for developing a water management program to reduce Legionella (bacteria) growth and spread in a building. A practical guide to implementing industry standards. He indicated this was the water management program and a contracted company had been hired to come out and do all the testing, however, nothing had been completed thus far. Interview with the Administrator, on 1/23/18 at 1:35 p.m., indicated the toolkit was their water management policy. At 1:40 p.m., the Administrator provided a copy of the "Legionella Water Management System" policy, dated 6/21/17, which indicated "See the attached toolkit to help develop and implement a water management program to reduce the (facility name) risk for growing and spreading Legionella. If a program is already in place this toolkit will help to assess and strengthen the program." The Administrator indicated no water testing had been done in the facility and a contracted agency was	F 0880	Res Identified Facility had Legionella testing completed prior to date of compliance, with no negative findings. Others Facility identified key areas of risk thru out the physical plant and had testing completed. Facility also instituted a Policy for Legionella Testing that included Bi Annual testing. Education Executive director and maintenance department educated on F tag 880 Monitor Facility will have testing completed Bi-Annually for an indefinite time. QAPI All negative findings will be reviewed in Monthly QAPI meeting.	02/20/2018

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	coming out tomorrow 1/24/18. Observation during the survey indicated there were no whirlpool tubs or fountains at the facility. The Resident Census and Condition form indicated there were 52 of 138 residents receiving respiratory therapy and 3 residents receiving chemotherapy. Interview with the Social Service Director, on 1/23/18 at 3:00 p.m., indicated there were no residents who smoke and there were 3 residents who were 50 years old or younger. 3.1-18(b)(1)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review, and interview, the facility failed to ensure the kitchen was clean and in good repair related to dirty floors, cracked wall tile, dirty ceiling vents, dirty walls, holes in ceilings, and dirty grease traps for 1 of 1 kitchens. (The Main Kitchen) Findings include: 1. On 1/16/18 at 9:10 a.m., during the Brief Kitchen Sanitation tour with the Dietary Food Manager (DFM) and the Registered Dietitian (RD), the following was observed: a. There was dried adhered dirt along the baseboard under the dish machine and the white PVC pipes were dirty with dried food spillage	F 0921	Res Identified All mentioned areas were addressed by dietary department prior to date of compliance. Others Facility completed an internal audit of the kitchen to identify any areas of concern. All findings were addressed prior to date of compliance. Education	02/20/2018

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	noted. b. The outside of the dish machine had dried food spillage noted. c. There was a large hole in the ceiling by the window in the dish room. There was gray duct tape holding up a piece of plastic that was bulging from the ceiling. The DFM indicated the ceiling had been like that for quite sometime. d. There were several wall tiles on the floor under the 3 compartment sink which had fallen off of the wall, . e. The grease trap under the 3 compartment sink was dirty and greasy. f. The grease trap under the food prep table was dirty and greasy. 2. On 1/23/18 at 7:25 a.m., during the Full Kitchen Sanitation tour with the DFM, the following was observed: a. The wall in the ice machine area was dirty and marred. b. The ceiling vent in the ice machine area had a large amount of dirt and dust noted. c. The red electric box was dirty and greasy under the food prep table. Interview with the DFM at that time, indicated all of the above was in need of cleaning. 3.1-19(f)		Facility educated all kitchen staff on proper food handling and sanitation expectations prior to date of compliance. Monitor Kitchen meal pass and sanitation will be audited 1 time per week to ensure guidelines are being met. Audits will be conducted 1 time per week for 4 weeks, then 1 time per month for 3 month, then quarterly until 95% compliance is achieved. QAPI All negative findings will be reviewed in Monthly QAPI meeting.	