STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355079	A. BUILDING _____ B. WING _____	C 10/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA MARIA	3102 S UNIVERSITY DR FARGO, ND 58103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification and complaint survey started on October 27, 2014 and completed on October 30, 2014 the sample included five (5) residents for complete review, sixteen (16) residents for focused review, and three (3) closed records for review.	F 000	**Tag # 309 Swallowing:** 1. It is the practice of this facility to provide appropriate diet consistencies to the residents. For resident #5, based on surveyor finding, a meeting was held with the facility Dieticians, DON, Speech therapist, and Director of Quality on 10-31-14. A special instruction to drain fruit sauces was added to the cook's books for Resident #5. A "Just in Time" training was created related to resident #5's dietary concerns and this information was shared with the nurses on duty that evening, along with staff on duty and assigned to assist resident #5 with meal. Staff working in that resident's care area read and signed off their understanding of the safety precautions to be followed. The resident was monitored for s/s of dysphagia or aspiration. The speech therapist stated she would continue to work with the resident to evaluate swallowing concerns. 2. The cook's books were updated to include the special directions of draining all fruit sauces for residents on altered texture fluids based on report run from the EHR. 3. Education was done with Dietary staff and direct care staff on importance of assuring correct texture and fluid consistency. Nursing department staff were re-educated on the signs and symptoms of dysphagia and the need to report any observation of dysphagia symptoms to resident's nurse when this occurs.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: SWALLOWING 1. Based on observation, record review, review of professional reference, review of facility policy and procedure, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #5) observed aspirating during meals received the care and services necessary to attain the highest degree of safety possible at mealtime. Failure to ensure Resident #5 received the diet consistencies prescribed by her physician and recognize the signs/symptoms of dysphagia/aspiration resulted in Resident #5 aspirating during meals. Findings include:	F 309		

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

Michael J. Hoffman | President/CEO | 11/19/14

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

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F 309	Continued From page 1 Nancy B. Swigert, "The Source for Dysphagia: Third Edition," LinguiSystems, Inc, 2007, educational handouts identified, ". . . Signs of pharyngeal dysphagia are coughing or choking during a meal or a wet, gurgly vocal quality. . . . Thin liquids are the hardest thing to control in the mouth and keep together in a bolus. It is easier to aspirate thin liquids as they travel through the throat past the larynx because they break apart and some of the liquid can fall into the larynx. Thickened liquids are easier to keep together as a cohesive bolus. Thickened liquids also move more slowly through the larynx, giving the larynx more time to close and protect the airway. . . ." Review of the facility policy titled "Diet Orders" occurred on 10/30/14. This policy, dated November 2013, stated, ". . . Nectar thickened liquids (NTL) - Liquids that have slight thickening such as tomato juice or apricot nectar. Water, juice and coffee would need thickener to get appropriate thickness. . . ." Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia and dysphagia. The quarterly Minimum Data Set (MDS), dated 07/28/14, identified severely impaired cognitive skills, the need for extensive assistance of one person at meals, and a mechanically altered diet. The current physician's orders identified, ". . . Mechanical soft texture, nectar consistency. . . ." Resident #5's current care plan identified, ". . . Focus: . . . ADL [activities of daily living] self care performance deficits . . . . Interventions: . . . EATING: I require supervision and verbal cues to eat and occ [occasional] physical assist. . . .	F 309	4. A quality audit will be conducted to observe for proper draining of fruit sauces for altered texture fluids and assuring correct consistency of fluids and foods. This will be done weekly for one month, then monthly for rest of quarter, and quarterly as needed by the dietary manager. 5. The facility will have corrective actions implemented and be in substantial compliance by 12-3-14.	

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F 309	Continued From page 2 Focus: . . . nutritional problems . . . I have declines in swallowing and require altered textures. . . . Interventions: Provide, serve . . . mechanical soft food textures and nectar thick liquids as ordered . . . I require set up, supervision, and occasional assist as I will accept. . . ." The speech therapy plan of treatment, dated 10/14/14, identified, ". . . resident . . . referred to SLP [Speech Language Pathologist] for swallowing evaluation and treatment as indicated d/t [due to] staff reports of increased symptoms of intolerance for PO [oral] intake. . . . Pt [patient] accepted nectar-thick consistency juice and coffee from cup. No overt or subtle s/s [signs/symptoms] intolerance . . . SLP questioning if patient is receiving liquids of less than nectar consistency at meals (i.e.: Ensure supplement, coffee) that is resulting in increased s/s intolerance. . . . PT appears at elevated risk for diet intolerance and aspiration d/t exacerbation of dysphagia . . . continue nectar-thick liquids. Staff to ensure all liquids are thickened to nectar-consistency as appropriate. Communication slips sent to nursing and dietary regarding recommendations and thickening liquid supplement to nectar consistency before serving. Verbal communication completed with lane nurse regarding recommendations . . ." Observation showed the following: * On 10/28/14 at 10:25 a.m., a Certified Nursing Assistant (CNA) (#4) served Resident #5's morning meal before feeding another resident. Her tray included a cup-sized bowl containing chunks of mixed fruit with thin juice filled to the rim (a two-consistency food item). The resident finished the fruit, picked up the bowl, and drank	F 309		

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F 309	Continued From page 3 all of the remaining juice. She immediately began coughing (an indication Resident #5 had poor vocal fold closure and secretions had entered her airway) while drinking the fruit juice, and demonstrated a wet vocal quality (a further indication secretions had entered her airway). Resident #5 was also observed with a wet vocal quality following the meal. The CNA (#4) failed to drain the thin liquids from the fruit cocktail and identify/report Resident #5's signs/symptoms of dysphagia/aspiration. * On 10/28/14 at 4:35 p.m., a CNA (#5) served Resident #5's evening meal before feeding two other residents seated at the same table. Resident #5's tray included a cup-sized bowl containing peach slices with thin juice filled to the rim (a two-consistency food item). The resident finished the fruit, picked up the bowl, and drank all of the remaining juice. She immediately began coughing while drinking the peach juice, and demonstrated a wet vocal quality. She then drank half a glass of thin apple juice which had been placed next to her other beverages. She immediately began coughing while drinking the apple juice. The CNA (#5) glanced at Resident #5, stood, walked around the table, looked into the glass, and stated, "Oh, this is yours," before placing the half empty glass of thin apple juice in front of Resident #5's tablemate. Resident #5 was observed with a wet vocal quality following the meal. The CNA (#5) failed to drain the thin liquids from the peaches, serve the thin apple juice to the correct resident, and identify/report Resident #5's signs/symptoms of dysphagia/aspiration. During an interview on 10/29/14 at 8:00 a.m., a dietician (#6) confirmed the juice should be drained from canned fruits prior to being served to residents receiving nectar-thickened liquids.	F 309		

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F 309	Continued From page 4 During an interview on 10/29/14 at 9:15 a.m., a speech therapist (#3) confirmed Resident #5 "should not receive any liquid (i.e.: fruit juice) thinner than nectar." The facility failed to 1) determine the appropriateness of two consistency foods (i.e.: canned fruit) for a resident receiving nectar-thickened liquids, 2) drain the thin liquids from the fruit cocktail and/or peaches prior to serving them to Resident #5, 3) ensure thin liquids were not within Resident #5's reach, and 4) identify Resident #5's signs/symptoms of dysphagia/aspiration (i.e.: coughing, wet vocal quality). Failure to implement the above interventions resulted in Resident #5 aspirating during meals. TREATMENT FOR EDEMA 2. Based on observation, record review, and staff interview, the facility failed to provide care and services in accordance with physician's orders for 1 of 3 sampled residents (Resident #14) with TED (Thrombo-Embolic Deterrent) hose (a medically prescribed tight-fitting stocking used to help prevent the pooling of blood and formation of blood clots). Failure to ensure Resident #14 wore the TED hose as ordered may result in negative physical effects such as blood clot formation. Findings include: Review of Resident #14's medical record occurred on all days of survey and included diagnoses of peripheral vascular disease, hypertension, and an order for coumadin (blood thinner). The current Minimum Data Set (MDS),	F 309	**Tag # 309: Treatment for edema.** 1. It is the practice of this facility to provide care and services in accordance with physician's orders. For Resident #14, after assessment of resident's edema and in consultation with the practitioner, the order for TED hose was discontinued. 2. An audit of residents with current orders or CP entry for Ted hose was conducted to assess resident current condition and need for continued use of TED hose. Any resident continuing with order for TED hose after this assessment had the order entered on the E-TAR for nurses to check and assure placement daily. 3. Review of continued need to use support hose was added to the primary nurse care plan review notes worksheet and to the careplan prep sheet for review with MDS completions. Review of reason for use of TED and importance of use when careplanned, reporting if unable to apply and monitoring to assure use as ordered was conducted with facility nursing staff through inservice education. 4. A quality audit tool was developed to check on application of TEDS as ordered. This audit will be the responsibility of the RN Nurse managers. It will be done weekly for one month, then monthly for the rest of the quarter and quarterly as needed. 5. The facility will have corrective actions implemented and be in substantial compliance by 12-3-14.	

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F 309	Continued From page 5 dated 09/19/14, identified severely impaired cognition and extensive assistance from one person for dressing. Observation on October 28-29, 2014 showed Resident #14 failed to wear TED hose. Resident #14's current physician's order, stated, ". . . bilateral TED socks on in AM and off at HS [hour of sleep] two times a day for Edema" Resident #14's current care plan stated, ". . . Focus I have ADL [activities of daily living] performance deficits related to : Parkinsons disease . . . Interventions . . . DRESSING: I have adaptive devices of Teds on in AM and take off at HS . . ." Review of Resident #14's progress notes identified the following: * 05/08/2014, ". . . Res [resident] has +2 pitting edema to bilat [bilateral] L/E [lower extremities] . . ." * 07/03/14, ". . . Resident is noted to have +2 pitting edema present to the tops of his bilateral feet but bilateral ankles/lower legs are noted to have +1. . . ." * 08/06/14, ". . . Skin review: Resident continues to utilize bilateral TEDs for edema . . . " * 09/04/14, ". . . Resident has +1 pitting edema present to the tops of his feet but ankles and the rest of lower extremities have no noted edema . . ." * 09/18/14, ". . . Res has +2 nonpitting edema present to bilat L/E's . . . " * 10/02/14, ". . . Resident has +1 non-pitting edema to the tops of his feet but none noted throughout the rest of his legs . . . Teds as ordered . . . "	F 309		

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F 309	Continued From page 6 * 10/16/14, ". . . Resident is noted to have +1 non-pitting edema present to bilateral tops of feet . . . Resident has teds as ordered. . . " During an interview on 10/28/14 at 1:00 p.m., a certified nursing assistant (CNA) (#12) stated Resident #14 does not wear TED stockings. During an interview on 10/29/14 at 4:45 p.m., a nurse manager (#11) stated, Resident #14 does have a physician order for TED stockings, but doesn't always want to wear them.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: FACILITY VAN TRANSPORT 1. Based on observation, record review, and staff interview, the facility failed to provide the necessary assistance to prevent a fall with injury for 1 of 1 sampled resident (Resident #6) who experienced a fall in the facility van. Failure to secure Resident #6 in the van prior to transport, ensure qualified staff assessed Resident #6 prior to moving/repositioning him immediately after his fall, and ensure staff had been trained on the proper use of the van equipment, resulted in	F 323		

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F 323	Continued From page 7 Resident #6's abrasion to the back of his head/subsequent headaches, and increased the risk of injury to all residents transported via the facility's van. Findings include: Review of Resident #6's medical record occurred on all days of survey. Medical diagnoses included cerebrovascular accident (CVA) with hemiplegia, and pain. The admission Minimum Data Set (MDS), dated 08/01/14, identified intact cognitive skills. Resident #6's current care plan identified, ". . . Focus: . . . ADL [activities of daily living] self care performance deficits . . . . Interventions: . . . MOBILITY: I use a wheelchair for locomotion. . . ." A progress note, dated 09/16/14 at 1:19 p.m., identified, ". . . res [resident] had incident on bus and hit back of head, see fall note. . . ." The fall assessment, dated 09/16/14 at 1:22 p.m., ". . . Location and time of fall: 11:30 a.m. [facility] bus . . . Describe fall . . . w/c [wheelchair] tipped back resident bumped head . . . Pain rating: 5 [out of a 10 point scale] . . . Comments: c/o head ache . . . Describe injury: medium sized abrasion area to back of head, no bleeding or swelling, no bruising . . . Intervention(s) implemented related to fall: safety precaustions [sic] with w/c and res in bus. . . ." The progress notes identified the following: * 09/16/14 at 2:48 p.m., ". . . ACETAMINOPHEN . . . Resident states his head feels better. . . ." * 09/16/14 at 5:48 a.m., ". . . Scrapes noted to	F 323	**Tag # 323 Facility Van Transport:** 1. It is the practice of this facility to assure resident safety during van transport. The van bus driver was re-educated on importance of assuring each resident is secured correctly in the vehicle, and if there is an occurrence with a resident while being transported, the driver was educated to assure immediate safety and then call either the facility staff nurse or 911 for further instruction related to any medical condition. Driver was also educated on completing the new safety check-off log with each transport. 2. All staff who drive facility vehicles for resident transport were re-educated on proper method of securing residents in the vehicle, what to do when an occurrence happens and a resident may be injured, and on how to complete the safety check off with each transport. 3. The Facility Vehicle policy was updated to include completing a resident transportation safety checklist and what to do if there is an occurrence involving a resident while in transport. Employees who drive the facility vehicles were educated on the use of the checklist and the procedure to follow if there is an occurrence. Employees using the facility vehicles for resident transport will have an annual check-off that includes demonstration of how to safely secure w/c in the transport vehicles and what to do if there is an occurrence with a resident during transport. A check-off for employees using the facility vehicles for transport was created and will be done with orientation for those positions and annually with evaluations.	

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F 323	Continued From page 8 back of head. No other injuries noted. . . ." The final investigation report, dated 09/17/14, identified, at 7:50 a.m. "[Director of Resident Services] (DRS) visited with [bus driver] in regards to the previous day incident when [Resident #6] tilted back in his w/c. . . . He said he locked down the back wheels of the w/c and had placed the seat belt on [Resident #6]. He shut the lift door. [Bus Driver] stated he was pulling out of the roundabout at the [Clinic] when he heard a noise. He immediately stopped the bus to check. At this time he saw that [Resident #6's] w/c had tilted back. Resident had hit his head. Resident did not fall out of wheel chair [Bus Driver] stated that he must of not locked the front wheels down. [Bus Driver] stated that this has never happened but was distracted visiting with res. Brother. He states that he usually will do a visual check and count to make sure all wheels are locked." The report further identified, at 7:58 a.m., "DRS talked to [Resident #6] . . . Asked him to describe what happened. He said that [Bus Driver] had arrived at [Clinic] to pick him up after his apt [appointment]. He said that he tilted back when [Bus Driver] put the gas on and was turning. . . . [Resident #6] said we should do a double check like pilots do, check and then check again. Talked with [Bus Driver] about doing a double check prior to leaving with a resident. He stated that he would do this." The progress notes identified the following: * 09/29/14 at 1:38 p.m., ". . . Head CT [scan] scheduled d/t [due to] headaches. . . ." * 10/08/14 at 12:43 p.m., ". . . received CT scan results of the brain, no indication of acute intracranial abnormality." The medical record showed no further evidence	F 323	4. The Director of Resident Services will complete a Quality audit to assure the transport safety log is being completed. She will audit the log weekly for one month, monthly for the rest of the quarter and then quarterly as needed. 5. The facility will have corrective actions implemented and be in substantial compliance by 12-3-14.	

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F 323	Continued From page 9 of Resident #6 complaining of continued headaches following the CT scan. During an interview on 10/28/14 at 5:10 p.m., a environmental services manager (#14) was unable to provide proof of staff education (prior to and/or following the 09/16/14 incident). He stated each wheelchair is secured in the facility van with J-hooks and a shoulder strap, but was "unsure if [the hooks and/or strap had been] secured [at the time of the incident]." He reported "checking" the van equipment following Resident #6's fall, and found "everything was good." Observation on 10/29/14 at 8:50 a.m., showed wheelchairs are secured in the facility van with a J-hook to each of the front wheels, a J-hook to each of the back wheels, and a shoulder strap. During the observation, this surveyor asked the bus driver questions regarding Resident #6's fall. When asked where the incident occurred, the bus driver (#13) reported, "As I crossed 19th Avenue, that's when it happened." He described pressing the gas to cross the street, hearing a noise, and turning to find Resident #6 had fallen backwards in his wheelchair. When asked what steps were taken after Resident #6 fell, he stated, "I just picked him up. When we got back to the facility I told the nurse, "Check him. He hit his head. He has a reddish bump on his head. Keep an eye on him." During an interview on 10/30/14 at 9:00 a.m., a social service manager (#15) confirmed she was unable to provide proof of staff education (prior to and/or following the 09/16/14 incident). She also reported the facility does not have a protocol for falls that occur off campus. She stated, "If someone falls internally, we'd immediately talk to	F 323		

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F 323	Continued From page 10 the nurse. Yes, it makes sense to call the nurse (from the facility van; prior to moving the resident)." The facility failed to ensure Resident #6 received the care and services necessary to attain the highest degree of safety possible while being transported via the facility van. They failed to secure Resident #6 in the van prior to transport, ensure qualified staff assessed Resident #6 prior to moving/repositioning him immediately after his fall, and ensure the bus driver had been trained on the proper use of the J-hooks/shoulder strap prior to/following Resident #6's fall. STAND LIFT TRANSFERS 2. Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to ensure staff used mechanical lifts appropriately for 2 of 4 sampled residents (Resident #4 and #5) observed during sit-to-stand lift transfers. Failure to ensure staff used a mechanical lift appropriately placed Resident #4 and #5 at risk for a fall and/or injury during transfers. Findings include: Review of the facility policy titled "Mechanical Lifts" occurred on 10/30/14. This policy, revised October 2014, stated, ". . . A standing lift is available for residents that require more than one person to assist with a transfer and is used for residents capable of bearing weight. . . . Follow operating instructions for the lift used. . . ." - Review of Resident #4's medical record occurred on all days of survey. Medical diagnoses	F 323		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA MARIA	3102 S UNIVERSITY DR FARGO, ND 58103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 included Parkinson's disorder, dementia, osteoarthrosis, and pain. The quarterly Minimum Data Set (MDS), dated 09/20/14, identified severely impaired cognitive skills and extensive assistance of two or more persons for transfers. Observations on 10/28/14 at 11:08 a.m. and 1:22 p.m., showed two certified nursing assistants (CNAs) (#7 and #8) transferred Resident #4 from his wheelchair to the toilet and from the toilet to his recliner using a sit-to-stand lift. The resident did not bear weight and was in a seated position as he hung from the harness. As the harness straps pulled upward into Resident #4's axillae (armpits), his shoulders raised to ear level. During the 1:22 p.m. observation, Resident #4 told the CNAs, "Oh, put me down." Staff failed to ensure Resident #4 was able to bear weight throughout the stand lift transfers and report his inability to bear weight to the nurse. Resident #4's current care plan identified, ". . . Focus: . . . ADL [activities of daily living] self care performance deficits . . . . Interventions: . . . TRANSFER: I require 1 staff assistance with transfers, I require cueing and encouragement with transferring . . ." The current care plan failed to reflect his need for a two person assist or his use of a sit-to-stand lift. - Review of Resident #5's medical record occurred on all days of survey. Medical diagnoses included dementia, arthritis, and osteoporosis. The quarterly MDS, dated 07/28/14, identified severely impaired cognitive skills and extensive assistance of one person for transfers. Observations on 10/28/14 at 10:10 a.m. and 12:40 p.m., showed a CNA (#7) transferred	F 323	**Tag # 323 Stand Lift Transfers:** 1. It is the practice of this facility to complete resident transfers using the safest method possible. Residents # 4 and #5 were evaluated by therapy for appropriateness of standing lift transfers. 2. Residents currently using standing lifts were observed by nurses for appropriateness of standing lift transfer. Those residents they felt may have a concern were referred to therapy for further evaluation. 3. Standing lift transfers will be re-assessed by staff nurses with MDSs that have a care plan scheduled and when it is reported there is a concern with transfers. This was added to the care plan prep sheet and a specific progress note template was created in the EHR. The mechanical lift policy was updated. This process was educated to the nurses at the Dec 1 nurses meeting. The importance of cuing the resident during a transfer to stand and of reporting difficulty with transfers was also educated to nurses and RAs at inservices and nurses meeting. 4. A quality audit tool was designed to check on completion of standing lift transfer observations completed with MDSs that have a care plan scheduled or when a concern is expressed with transfers. The clinical support nurse will be responsible to complete this audit monthly for 3 months and then quarterly as needed. 5. The facility will have corrective actions implemented and be in substantial compliance by 12-3-14.	

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F 323	Continued From page 12 Resident #5 from her wheelchair to the toilet and back again using a sit-to-stand lift. The resident did not bear weight and was in a seated position as she hung from the harness. As the harness straps pulled upward into Resident #5's axillae, her shoulders raised to ear level. During the 10:10 a.m. observation, Resident #5 told the CNA, "Ah. That's not very comfortable." Staff failed to cue Resident #5 to stand, ensure she was able to bear weight throughout the stand lift transfers, and report her inability to bear weight to the nurse. During an interview on the morning of 10/30/14, administrative nursing staff (#9 and #10) confirmed a resident should be able to bear his/her own weight if a sit-to-stand lift is used.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, the facility failed to prepare and store food in a safe and sanitary manner in 1 of 1 kitchen. Failure to follow safe food sanitation practices has the potential to	F 371		

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F 371	Continued From page 13 increase the risk of food borne illness and can affect all residents who eat food prepared and stored in these areas. Findings include: Review of the following facility's policies occurred on the morning of 10/30/14: *The policy titled "Use of Gloves," dated October 2014, stated, ". . . Remove disposable gloves between handling of food and handling all utensils (especially ladles or scoops), telephone, garbage, etc. . . ." *The policy titled "Meat Storage Responsibilities," dated October 2014, stated, "Meat will be pulled from the freezer as needed and placed in the cooler for a thawing period of two days. It will be thrown after the fifth day of being thawed to prevent contamination; unless otherwise an extended shelf life is established by the producer . . . The cooks will date and label all meat stored in the refrigerator. . . " *The policy titled "Sanitation/Physical Environment, " dated October 2014, stated, ". . . Ingredient Bins: 1. To prevent food contamination, ingredient bins are kept clean and covered. . . ." An initial tour of the kitchen occurred on 10/27/14 at 12:35 p.m. with an administrative dietary staff member (#1). Observation showed a dietary staff member (#2) touched the plastic handle of an oven door with her gloved hands then used these same gloved hands to prepare cold sandwiches for the next day without changing her gloves between tasks. Observation of the walk-in cooler showed the	F 371	**Tag # 371 Food Sanitation:** 1. It is the practice of this facility to prepare and store food in a safe and sanitary manner. Undated and outdated food and uncovered food was immediately removed from the cooler and discarded. Employee #2 was educated on importance of removing gloves and performing hand hygiene after touching non-food items. The cracked storage bins were removed from service on 10-31-14. 2. All storage bins were inspected for any cracks and sanitized. A shelf was placed under the compressor fans in the freezer that will hold pans to catch any condensation drips from the ceiling to prevent getting on stored cardboard food cases. 3. New storage bins were ordered for use as needed. Inservice education of the dietary staff was conducted to include dating, labeling and covering all foods, the importance of appropriate use of gloves during food preparation, and inspection of storage bins when sanitizing. A sticker was designed to apply to storage bins to show date storage bins are inspected and cleaned when new product is opened. 4. Audit tools were developed to check storage and sanitary practices and glove usage compliance. These audits will be completed weekly for one monthly, then monthly for the rest of the quarter and quarterly as needed by the dietary manager and/or dieticians. 5. The facility will have corrective actions implemented and be in substantial compliance by 12-3-14	

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F 371	Continued From page 14 following: *Two pounds of sliced deli ham stored in an open bag, not dated. *Three pounds of sliced salami stored in an open bag, not dated. *One pound of corned beef stored in an open bag, not dated. *One pound of sliced deli turkey in an open container, dated "10/18" (8 days prior). *Two pounds of corned beef in a kryo vac bag not opened, labeled by the manufacturer "use or freeze by 04/30/14" not labeled with the date thawed. *Two quarts of cut melon cubes, not dated. *One pound of precooked ground sausage pieces in an open bag, not dated. *Four shelves with sticky, coffee splatters on their surfaces. Observation of the walk-in freezer showed the following: *Ice build-up formed into a mound on a case of eight ounce juice cups. Observation showed the outside of the cardboard had wet areas that had frozen. *Thirty, one half cups of ice cream and sherbet in dessert dishes on trays stored beneath another shelf of food, not covered. A dietary tour of the kitchen occurred on 10/29/14 at 4:00 p.m. with an administrative dietary staff member (#1). Observation of the walk-in cooler showed the following: *One open, five pound container of egg salad, labeled by the manufacturer "use by Oct 19 2014" (8 days prior). *One closed, five pound container of egg salad, labeled by the manufacturer "use by Oct 19 2014" (8 days prior).	F 371		

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F 371	Continued From page 15 Observation of food storage areas showed the following: *One container of dry ready-to-eat cereal with its plastic cover soiled and cracked. *One plastic bin of thickener with its cover cracked and its cover and handles soiled. During an interview on 10/29/14 at 4:50 p.m., the administrative dietary staff member (#1) agreed dietary staff should change gloves between tasks, mark potentially hazardous foods with an open date and store no longer than five days, store foods to prevent cross contamination, and ensure clean and sanitary storage equipment.	F 371		
F9999	FINAL OBSERVATIONS Based on observation, record review, and staff interview, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		