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	095025	A. BUILDING _____ B. WING _____	05/17/2019

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F 000	INITIAL COMMENTS	F 000		

An unannounced Long Term Care Survey was conducted at Lisner-Louise-Dickson-Hurt Home from May 13, 2019 through May 17, 2019. Survey activities consisted of a review of 26 sampled residents. The following deficiencies were based on observations, record reviews, resident and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The resident census was 54 on the first day of survey.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

Abbreviations
AD- Associate Director
AMS - Altered Mental Status
ARD - Assessment Reference Date
BID - Twice- a-day
BIMS- Brief Interview for Mental Status
B/P - Blood Pressure
cm - Centimeters
CMS - Centers for Medicare and Medicaid Services
CNA- Certified Nurse Aide
CFU Colony Forming Unit
CRF - Community Residential Facility
D.C. - District of Columbia
DCMR- District of Columbia Municipal Regulations
D/C Discontinue
Dl - Deciliter

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Hargreaves | TITLE: Administrator | (X6) DATE: 6/21/19

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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DMH - Department of Mental Health
DON - Director of Nursing
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
G-tube Gastrostomy tube
HSC Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
L - Liter
LPN- Licensed Practical Nurse
LTC- Long Term Care
Lbs. - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
Neuro - Neurological
NP - Nurse Practitioner
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO- by mouth
POS - Physician ' s order sheet
Prn - As needed
Pt - Patient
PU- Partial Upper
PL- Partial Lower
Q- Every
QIS - Quality Indicator Survey
R/P - Responsible party
RN- Registered Nurse

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F 000	Continued From page 2 SCC Special Care Center Sol- Solution SSD- Social Services Director TAR - Treatment Administration Record Trach- Tracheostomy TX- Treatment	F 000	**F584 8 Exhaust Fans without suction** **1. Immediate Response:** One rooftop exhaust fan that handled the effected 8 rooms was repaired. **2. Risk Identification:** All other exhaust fans which were linked to rooftop exhaust fan were checked. **3. Systemic Changes:** Staff in-serviced on exhaust fans preventive maintenance and repair and schedule changed from quarterly to monthly for audits. **4. Monitoring:** Audit of exhaust fans will be done by Facility Manager and reported at Quarterly QAPI meetings.	7/1/19
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §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);	F 584	**F584 Hopper Broken** **1. Immediate Response:** Identified hopper has been scheduled for repair. **2. Risk Identification**: All other hoppers were checked for proper function. **3. Systemic Changes:** Staff in-serviced on reporting broken hoppers to facilities management. **4. Monitoring:** Facilities Manager will do monthly audits on all hoppers and will report findings at the quarterly QAPI meetings.	7/1/19

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F 584	Continued From page 3 §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 comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to provide necessary housekeeping services in resident areas as evidenced by exhaust fans that were inoperative in eight (8) of 15 resident rooms, one (1) of one (1) hopper that was out of order on the Dickson Drive unit ,10 of 10 sixteen-ounce bottles of alcohol that were expired as of February 2018, and one (1) of one (1) thirty fluid ounce unopened container of Prosource protein drink with an expiration date of November 17, 2018. Findings included ... During a walk-through of the facility on May 14, 2019, between 9:48 AM and 11:00 AM the following was observed: 1. Exhaust fans located in the resident bathrooms did not provide any suction in eight (8) of 15 resident rooms including rooms #102, 104, 105, 109, 114, 116, 120 and #122. 2. One (1) of one (1) hopper located in the Soiled	F 584	**F584 10 Alcohol bottles expired** **1. Immediate Response**: Expired bottles of bulk alcohol were disposed of. **2. Risk Identification**: All other storage rooms were checked for expired bottles of bulk alcohol and none were found. **3. Systemic Changes:** Facility will no longer store bottles of bulk alcohol and staff were in-served on expiration dates. **4. Monitoring:** The Director of Nursing or her designee will conduct monthly audits to storage closets to ensure there are no bottles of alcohol being stored. Audit findings will be tracked and reported at the quarterly QAPI meetings. **F584 Prosource expired** **1. Immediate Response:** Expired container of Prosource was disposed of. **2. Risk Identification:** All other storage rooms were checked for expired bottles of Prosource and none were found. **3. Systemic Changes:** Unit Support Specialist was in-serviced as to the importance of rotating stock of Prosource in the storage room. Stock will be audited by nursing personnel. **4. Monitoring**: The Director of Nursing or her designee will conduct monthly audits of storage closets to ensure there are no expired containers of Prosource stored. Audit findings will be tracked and reported at the quarterly QAPI meetings.	7/1/19 7/1/19

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F 584 Continued From page 4

Utility room on the Dickson Drive unit was broken.

3. Ten (10) of ten (10) sixteen-ounce bottles of alcohol stored in the storage room on the Dickson Drive unit
were expired as of February 2018.

4. One (1) of one (1) thirty fluid ounce unopened container of Prosource protein drink stored in the storage room
on the Dickson Drive unit had an expiration date of November 17, 2018.

During a face-to-face interview on May 14, 2019, at approximately 11:00 AM, Employee #10 and /or Employee #11 acknowledged the findings.

F 645 SS=D PASARR Screening for MD & ID
CFR(s): 483.20(k)(1)-(3)

§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.

§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:
(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or

F 584

F645 Resident Records

1. Immediate Response: The Level I PASRR for resident #49 was corrected to include the diagnosis of Schizophrenia and noted exempting criteria in Section E. The corrected Level I PASRR documentation was forwarded to the District of Columbia Department of Behavioral Health for a Level II evaluation.

2. Risk Identification: All residents' charts were reviewed for documentation of serious mental illness and correctly completed Level I PLASRR forms. No additional positive screens for serious mental illness were indicated.

F 645

3. Systemic Changes: All staff that completes the Level I PASRR documentation was in-serviced on the correct use of the form and the requirements for conducting a Level II Evaluation.

4. Monitoring: The Director of Social Services or her designee will do a random audit of PASRR documentation for appropriate serious mental illness identification and report findings at the quarterly QA meetings. 7/1/19

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F 645	Continued From page 5	F 645		

(ii) Intellectual disability. as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental

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F 645	Continued From page 6	F 645		

disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview, the facility's staff failed to ensure that Resident #49 was referred to the District of Columbia Department of Behavioral Health to have a Level II Evaluation conducted for one (1) of 26 sampled residents.

Findings included ...

Resident #49 was re-admitted to the facility on July 26, 2018, with diagnoses that included Schizophrenia, Depression, Hypertension and Anemia.

A review of a document entitled, Level I Pre-Admission Screening/Resident Review for Serious Mental Illness, Intellectual Disabilities, or Related Conditions, showed the form was signed as completed by the facility's staff on January 24, 2019. Further review of the form, revealed under Section B: Evaluation Criteria for Serious Mental Illness, that Resident #49 was not coded as having a known diagnosis of a major mental disorder. However, according to the Significant Change Minimum Data Set form completed January 24, 2019, under Section I - Active Diagnoses, Resident #49 was coded as having a

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diagnosis of Schizophrenia.

Continued review of the Level I Pre-Admission Screening/Resident Review for Serious Mental Illness, Intellectual Disabilities, or Related Conditions, dated January 24, 2019, lacked documented evidence the facility's staff identified Resident #49 as having a positive screen for serious mental illness.

Subsequently, the Resident #49, who had a diagnosis of Schizophrenia was not referred to the District of Columbia Department of Behavioral Health for a Level II evaluation as stipulated by the form. Which indicates if "The beneficiary is considered to have a positive serious mental illness (SMI) if (1) questions 1 or 2 in section B are answered Yes". "With a positive screen for SMI the beneficiary must be referred to the District of Columbia Behavioral Health for a Level II Evaluation".

During a face-to-face interview with Employee #6 on May 16, 2019 at 2:00 PM, after a review of the findings, she acknowledged that the Level II evaluation screening was not conducted.

F 657 SS=D Care Plan Timing and Revision
CFR(s): 483.21(b)(2)(i)-(iii)

F 657

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-
(i) Developed within 7 days after completion of

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F 657	Continued From page 8 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, for one (1) of 26 sampled records facility staff failed to update/revise the care plan to include resident-centered goals and approaches for a resident with Dysphagia. Resident #34. Findings included... Resident #34 was admitted to the facility on 11/13/17, with diagnoses, which included Ventral Hernia without Obstruction or Gangrene.	F 657	**F657 Care Plan Timing and Revision** **1. Immediate Response:** Resident was assessed and was cleared of any complication due to dysphagia. Care plan for resident #34 was updated to reflect intermittent supervision by nursing staff during meals. **2. Risk Identification:** Care plans for all residents with dysphagia were reviewed and updated for appropriate goals and approaches. **3. Systemic Changes:** All nursing staff was in-serviced on appropriate care plan goals and interventions for residents with dysphagia. **4. Monitoring:** The Director of Nursing or her designee will conduct monthly audits of care plans of residents with dysphagia to ensure person-centered goals and approaches. Audit findings will be tracked and reported at the quarterly QAPI meetings.	7/1/19

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Dysphagia, Oral Phase, Essential (Primary) Hypertension, Unspecified Dementia without Behavioral Disturbance, and Major Depressive Disorder.

On 5/13/19, at approximately 10:00 AM the resident was observed in her room eating breakfast. At this time, no staff were present in the resident's room.

During a resident interview on 5/13/19, at 11:00 AM, Resident states, "I don't eat in the dining room with the other residents because I don't want to choke I have to concentrate on my chewing and the noise from the resident's may cause me not to concentrate." Resident further states, "They don't supervise me when I eat, they just bring in the tray and I eat my food."

Review of a physician's order dated 04/04/19 showed the resident was ordered a "Physical, Occupational and Speech Therapy Screen."

Review of the Minimum Data Set completed on 04/08/19 showed under Section B [Hearing, Speech and Vision], Resident #34 was coded as "0", which indicated the resident's speech pattern is clear, able to make self-understood and has clear comprehension and able to understand others. Section G [Functional Status] showed the resident is coded as independent in eating (no help or staff oversight at anytime).

Review of the Speech Therapy Progress &

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Discharge Summary note dated 5/8/19 showed " goal met on 5/8/19, the patient demonstrates ability to utilize compensatory strategies to increase safe oral intake with mild impairment (25-50% impairment; risk of aspiration on liquids mild oral residue and may need meats ground or chopped; cueing and intermittent supervision for carry-over).

During a face-to-face interview with the Speech Therapist on 5/16/19, at approximately 12:30 PM, she stated, "The staff were trained on swallowing techniques, I know the staff are busy on the floor but that they need to intermittently supervise the resident when eating to be sure the resident changes from solid to liquid to be sure there is no residual food to cause choking, the staff all know to do this."

During an interview on 5/16/19 at approximately 2:00 PM, Employee #13, (Certified Nurse Aide) states I have worked with her a lot, she is not a feeder I don't supervise her or sit in the room with her I just bring in her tray and she can feed herself.

Facility staff failed to update/revise the resident's care plan to include the following speech therapist recommendations: " 25-50% impairment risk of aspiration on liquids; mild oral residue and may need meats ground or chopped cueing and intermittent superivsion for carry-over."

During a face-to-face interview on 5/17/19, at 11:00 AM, Employee #2 acknowledged the

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F 657	Continued From page 11 finding and states the care plan should be resident-centered and specific to that resident.	F 657	**F812 Soiled Food Equipment** **1. Immediate Response:** The identified grease fryer, steam table wells and ovens were cleaned. **2. Risk Identification:** All other food equipment was checked for cleanliness. **3. Systemic Changes:** Staff in-serviced on the need to clean food service equipment after use and the Dietary Supervisor will do daily inspections of food equipment. **4. Monitoring:** Dietary Manager or designee will conduct weekly audits of food equipment and findings will be reported at Quarterly QAPI meetings.	7/1/19
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that facility staff failed to prepare and store foods in sanitary condition as evidenced by soiled equipment such as one (1) of one (1) grease fryer, five (5) of five (5) steam table wells in the Nursing Facility kitchen and two (2) of two (2) ovens, and dented utensils such as nine (9) of nine (9) two-inch hotel pans, two (2) of two (2) one-third three-inch pans and four (4) of four (4) one-sixth hotel pans. Findings included ...	F 812	**F812 Dented Pans** **1. Immediate Response:** Identified dented pans were disposed of. **2. Risk Identification:** All pans were checked to ensure that they were dent free. **3. Systemic Changes:** Staff in-serviced on disposing of dented pans and reporting to Supervisor for replacement of new ones. **4. Monitoring:** Dietary Manager or designee will conduct weekly audits of pans and findings will be reported at Quarterly QAPI meetings.	7/1/19

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	095025	A. BUILDING _____ B. WING _____	05/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LISNER LOUISE DICKSON HURTHOME	5425 WESTERN AVE NW WASHINGTON, DC 20015

(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 812	Continued From page 12 The following observations were made during a walkthrough of dietary services on May 13, 2019: 1. Food equipment such as one (1) of one (1) grease fryer, five (5) of five (5) steam table wells in the Nursing Facility kitchen and two (2) of two (2) ovens were soiled. 2. Nine (9) of nine (9) two-inch hotel pans, two (2) of two (2) one-third three-inch pans and four (4) of four (4) one-sixth hotel pans were dented throughout. During a face-to-face interview on May 13, 2019, at approximately 11:00 AM, Employee #9 acknowledged these findings.	F 812	**F842 Resident Records – Identifiable Information** **1. Immediate Response:** Resident's personal inventory sheet was completed and placed in the medical record. **2. Risk Identification:** All medical records for admission personal inventory sheets were audited for signatures and dates. **3. Systemic Changes:** All nursing staff were in-serviced regarding proper admission protocol for dates and signatures on personal inventory sheets. **4. Monitoring:** The Director of Nursing or her designee will conduct monthly audits of all newly admitted residents to ensure personal inventory sheets have been properly dated and signed. Audit findings will be tracked and reported at the quarterly QAPI meetings.	7/1/19
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		

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(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services

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F 842	Continued From page 14	F 842		

provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:

Based on policy review, record review and staff interview for one (1) of 26 sampled records, the facility failed to complete the personal inventory sheet with the date and signature for Resident # 255.

Findings included...

Record review of facility's policy titled "Policy and Procedures for Resident Belongings" the facility will encourage each resident or resident representative to complete an initial inventory ...list should be completed upon admission and updated periodically ...the inventory [sic] will be stored in the medical record.

Resident #255 was admitted to the facility on 4/17/19 with diagnoses to include Pneumothorax, Unspecified, Emphysema Unspecified, Lobar Pneumonia and Non-ST Elevation Myocardial Infarction. Admission Minimum Data Set [MDS] Section C [Cognitive Patterns] showed a Brief Interview for Mental Status score of "15" which indicates cognitively intact.

Review of the medical record on 5/1519 at 12:30 PM showed Resident # 225's Personal Inventory List without a date or signature of the resident.

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F 842	Continued From page 15 Further review of the form showed a staff signature recorded on the form. During a face-to-face interview on 5/15/19 at 12:20 PM, Employee #4 stated, "I am working on the personal inventory form; the corrected form is in my office." At the time of the medical record review Employee #4 acknowledged the finding.	F 842	**F908 Ice Machine Cover missing** **1. Immediate Response:** Identified ice machine cover was reinstalled. **2. Risk Identification:** All ice machines were checked to ensure a cover was in place. **3. Systemic Changes**: Staff in-serviced on reporting any missing ice covers to Supervisor for replacement/installation. **4. Monitoring:** Dietary Manager or designee will conduct weekly audits of ice machine covers and findings will be reported at Quarterly QAPI meetings.	7/1/19
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain mechanical and electrical equipment in safe operating condition as evidenced by one (1) of one (1) ice machine in the main kitchen that lacked a protective grill cover, one (1) of one (1) Robot Coupe machine with a broken 'OFF' switch and a missing slat from the air curtain in one (1) of one (1) walk-in refrigerator. Findings included ... During observations in Dietary Services on May 13, 2019, at approximately 9:20 AM: 1. One (1) of one (1) ice machine lacked a cover/grill to prevent access to its internal parts. 2. One (1) of one (1) Robot Coupe machine used to puree foods had a broken 'OFF' switch. 3. The air curtain in the walk-in refrigerator was	F 908	**F908 Puree Machine Off switch broken** **1. Immediate Response:** Identified Robot Coupe machine off switch was repaired. **2. Risk Identification:** This is the only Robot Coupe machine in the Home. **3. Systemic Changes**: Staff in-serviced on reporting to Supervisor any malfunctions of the Robot Coupe machine so that it may be repaired. Weekly audits of the Robot Coupe machine will be conducted by the Dietary Director or designee. **4. Monitoring:** Dietary Manager or designee will conduct weekly audits and findings will be reported at Quarterly QAPI meetings.	7/1/19

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F 908	Continued From page 16 missing a slat. During a face-to-face interview on May 13, 2019, at approximately 11:00 AM, Employee #9 acknowledged these findings.	F 908	**F908 Air Curtain missing a slat** **1. Immediate Response:** Missing slat was replaced on the air curtain for the walk in refrigerator. **2. Risk Identification:** No other walk in refrigerator in the Home. **3. Systemic Changes**: Staff in-serviced on reporting any missing slats to Supervisor for replacement of new ones. Weekly audits of walk in refrigerator curtains will be conducted by the Dietary Manager or her designee. **4. Monitoring:** Dietary Manager or her designee will conduct weekly audits and findings will be reported at Quarterly QAPI meetings.	7/1/19