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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095021	A. BUILDING ______ B. WING ______	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH & REHABILITATION CENTER AT THOMAS CIRCLE	1330 MASSACHUSETTS AVENUE NW WASHINGTON, DC 20005

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F 000	INITIAL COMMENTS An unannounced Quality Indicator Survey was conducted at Health & Rehabilitation Center At Thomas Circle September 20, 2016 through September 22, 2016. Survey activities consisted of a review of 30 resident clinical records during Stage 1; and review of 16 sampled residents during Stage 2. The following deficiencies are based on observation, record review 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 following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue Dl - deciliter DMH - Department of Mental Health	F 000	This Plan of Correction is submitted Without denying or acknowledging that the Cited deficiencies exist. This plan of Correction is a requirement of the Department of Health.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maria Allen (signature) TITLE: Executive Director, NHA (X6) DATE: 11/2/16

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 000	Continued From page 1 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 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 Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive	F 246		

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F 246	Continued From page 2 services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews for one (1) of 16 Stage 2 sampled residents, it was determined that facility staff failed to ensure one (1) resident reasonable accommodation of individual needs as evidenced by a nonfunctioning clock in the resident ' s room. Resident #20 The findings include: A resident interview was conducted on September 20, 2016 at approximately 3:20 PM in Resident #20 ' s room. A query was made "Do you have any problems with the temperature, lighting, noise or anything else in the building that affects your comfort?" , the resident stated " my clock is broken. " An observation of the clock was made on September 20, 2016 at approximately 4:20 PM. The clock was showing 9:40, the second hand was not moving. The observation was made in the presence of Employee #2 who acknowledged the finding.	F 246	I.The battery for Resident #20's clock was immediately replaced. II. Environmental Services Director or designee will conduct an inspection of clocks in the to ensure clocks are working. III. Monthly Environmental rounds will be conducted by Director of Environmental Services and Director of Plant Operations or designees. IV. Environmental Round findings will be documented monthly and reported to the Quality Assurance Committee for review, Evaluation, and recommendations.	11/7/16
F 256 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and	F 256		

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F 256	Continued From page 3 comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview for one (1) of 16 Stage 2 sampled residents, it was determined that facility staff failed to ensure adequate lighting for one (1) resident. Resident #10. The findings include: A resident interview was conducted on September 20, 2016 at approximately 2:56 PM, In the resident ' s room. In response to a query, "Do you have any problems with the temperature, lighting, noise or anything else in the building that affects your comfort? " Resident #10 stated, " the lighting is bad in my room, it is difficult to read or write." An attempt to was made to turn on the resident ' s over-the-bed light. The light failed to illuminate. A face-to-face interview and observation was made with Employee #2 on September 20, 2016 at approximately 4:10 PM. After review of the aforementioned Employee #2 acknowledged the finding. The observation was made on September 20, 2016.	F 256	I.The over-the-bed light in Resident #10's Room was repaired immediately. II.Environmental Services Director, Plant Operations Director, or designees will conduct an Environmental round to ensure light fixtures are working in resident rooms. III. Environmental rounds will be conducted monthly by Director of Environmental Services, Director of Plant Operations, or designees. IV. Environmental round findings will be documented and presented to the Quality Assurance Committee for review, evaluation and recommendations.	11/7/16
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	F 309		

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F 309	Continued From page 4 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: Based on observations record review, and staff interview for one (1) of 16 sampled residents, it was determined that the facility staff failed to ensure that each resident received the necessary care and services to attain or maintain the highest practicable well-being, as evidenced by, failure to assess and implement interventions to maintain proper body alignment for one (1) resident observed with his/her neck flexed forward. Resident #5. The findings include: Facility staff failed to properly position Resident #5 in a Geriatric chair (recliner) to maintain proper body alignment of his/her head and neck. A first observation was made on September 20, 2016 at approximately 3:00 PM. The resident was seated in the common area, resting in a semi-fowler [45-degree angle] position with his/her head flexed forward (with head touching chest position). A second observation was made on September 21, 2016 at approximately 10:30 AM. The resident was seated in the common area, resting in a recliner chair in a semi-fowler [45-degree angle] position observed with his/her head flexed forward (with head touching chest position).	F 309	I. Resident #5 will be provided with neck support device as recommended by therapy. II. ADON or designee will assess residents to identify the need for any positioning/support device. III. Charge nurses will conduct physical Assessments to identify the need for positioning/support devices and refer to therapy for assessment and recommendation. DON or designee will re-in-service nursing Staff as to this requirement. IV. DON or designee will audit physical Assessments monthly, document findings and report to the Quality Assurance Committee for review, evaluation, and recommendations.	11/7/16

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F 309	Continued From page 5 A third observation was made on September 22, 2016. The resident was in the common area, resting in a semi-fowler [45-degree angle] position observed with his/her head flexed forward (with head touching chest position), at appropriately 11:30 AM. The observation was made in the presence of Employee # 8 who acknowledged Resident # 5's head to chest position was not proper positioning. There was no evidence that facility staff implemented head positioning measures or adaptive devices to provide support and alignment of the resident ' s head and neck. A review of Resident # 5 ' s June 3, 2016 quarterly Minimum Data Set [MDS] revealed: In Section C, "Cognitive Patterns" , the resident was coded as moderately cognitively impaired, decisions poor; cues/supervision required. Section G, "Functional Status" was coded to reflect the resident was totally dependent requiring the assistance of one (1) person for bed mobility, total dependence of two (2) persons for transfer, total dependence of one (1) person for locomotion, extensive assistance for eating and total dependence for toilet use. Section H, "Bowel and Bladder" always incontinent of bowels and bladder. Section I, "Active Diagnoses" Alzheimer ' s Disease, Dementia, and Cerebrovascular disease. Through observation, it was determined that	F 309		

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F 309	Continued From page 6 facility staff failed to consistently maintain proper body alignment as it relates to positioning; Resident #5 was observed multiple on occasions with his/her head and neck flexed forward. On September 22, 2016 at approximately 1:00 PM, a face-to-face interview was conducted with Employee #8 who acknowledged the findings. The Medical record was reviewed on September 22, 2016.	F 309		
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 observations made on September 20, 2016 at approximately 9:00 AM and 11:00 AM, and on September 21, 2016 at approximately 9:30 AM, it was determined that the facility failed to store, prepare and serve foods under sanitary conditions as evidenced by two (2) of two (2) convection ovens, four (4) of four (4) fire suppression covers, five (5) of eight (8) stainless steel filters, the kitchen floor and one (1) of one (1) flat grill that was soiled, food items such as salmon, chicken, fish, cheese, one (1) of one (1)	F 371	I. 1. Convection ovens have been cleaned. 2. Contractor will be scheduled to have the suppression system cleaned. 3. Contractor will be scheduled to have the hood system cleaned. 4. The kitchen floor has been cleaned. 5. The flat grill has been cleaned. 6. The meat items not dated and labeled were thrown out immediately. 7. Yellow cheese not labeled and dated was thrown out. 8. Creamy dressing not dated and labeled was thrown out immediately. 9. Bread not dated was thrown out.	

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F 371	Continued From page 7 open bottle of salad dressing, one (1) of one (1) open bag with three (3) bagels, one (1) of one (1) opened bag with six (6) potato rolls, two (2) of two (2) open bags of white bread, five (5) of five (5) plastic containers of prepared salads, and six (6) of six plastic containers with sandwiches that were stored in the walk-in refrigerator and were not labeled or dated and expired foods such as three (3) of three (3) five (5) - pound containers of cottage cheese and seven (7) of seven (7) five (5) - pound bags of Shredded Low moisture Mozzarella Cheese that were stored in the walk-in refrigerator. The findings include: 1. Two (2) of two (2) convection ovens were soiled with leftover food deposits and grease. 2. Four (4) of four (4) fire suppression covers from the Ansul fire suppression system were soiled with dust particles and debris. 3. Five (5) of eight (8) stainless steel filters from the hood system were soiled and rusted. 4. The entire kitchen floor was soiled. 5. One (1) of one (1) flat grill was soiled with burnt food particles. 6. Food items such as salmon, chicken, and fish were stored in the walk-in refrigerator and were not labeled or dated. 7. Approximately 100 slices of yellow cheese	F 371	10. Prepared salads and sandwiches not labeled and dated were thrown out. 11. Expired cottage cheese was thrown out. 12. Expired Mozzarella Cheese was thrown out. 13. Dented cans were thrown out. 14. Water bottles were thrown out. 15. Soiled rag was thrown out. II. F&B Director conducted an environmental round to identify and correct any other issues. III. F&B Director or designee will conduct monthly environmental rounds. F&B Director will schedule contractor to clean fire suppression systems more frequently. F&B Director will re-in-service F&B staff to address sanitation and food handling procedures. IV. F&B Director or designee will document environmental rounds findings and report monthly to the Quality Assurance Committee for review, evaluation, and recommendations.	11/7/16

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F 371	Continued From page 8 stored partially wrapped in the walk-in refrigerator was not labeled or dated. 8. A partially filled one-gallon container of Liberty Creamy dressing stored in the walk-in refrigerator was not dated. 9. One (1) of one (1) open bag with three (3) bagels, one (1) of one open bag with six (6) potato rolls and two (2) of two (2) open bags of white bread were not dated. 10. Five (5) of five (5) plastic containers of prepared salads, and six (6) of six plastic containers with sandwiches were stored in the walk-in and were not labeled or dated. 11. One (1) of one (1) five-pound container of cottage cheese was expired as of August 14, 2016 and two (2) of two (2) five-pound containers of cottage cheese were expired as of September 14, 2014. 12. Seven (7) of seven (7) five (5) - pound bags of Shredded Low moisture Mozzarella Cheese were expired as of August 19, 2016. 13. Two (2) of two (2) blue colored eight-pound containers of Sea Scallops were dented. 14. Two (2) of two (2) sixteen-ounce bottles of water were stored open, on the first and second shelf of the walk-in	F 371		

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F 371	Continued From page 9 refrigerator. 15. A soiled rag was observed on the second shelf of the walk-in refrigerator. These observations were made in the presence of Employee #10 and Employee #4 who acknowledged the findings.	F 371		
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that facility staff failed to properly dispose of garbage, grease and refuse which could potentially contribute to the harborage of vermin. The findings include: An observation of the facility ' s garbage, grease and refuse disposal practices was conducted on September 21, 2016 at approximately 10:00 AM with Employee #10. Two (2) of two (2) outdoor refuse containers were overfilled and uncovered; one (1) of one (1) grease receptacle stored outdoors was uncovered with large sediments of grease spillage and one (1) of 1 trash compactor was observed overfilled. These improper disposal practices could potentially contribute to the harborage of vermin. Employee #10 acknowledged the findings.	F 372	I.Refuse containers were covered, boxes were broken down, and grease receptacle was cleaned. II.F&B Director, Environmental Services Director, Plant Operations Director, or designees will conduct an environmental round to address any other refuse & garbage concern. III. F&B Director will re-in-service his staff on the need to maintain refuse containers covered and clean. Monthly environmental rounds will be conducted by F&B Director, Environmental Services Director, and Plant Operations Director, or designees.	

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F 372	Continued From page 10	F 372	IV. Environmental Rounds findings will be documented and presented monthly to the Quality Assurance Committee for review, evaluation, and recommendations.	11/7/16
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	A. I. Employees will get annual screening. II. New employees have been receiving the two-step PPD since this deficiency was identified. III. Administrator or designee will revise existing policy to reflect the two-step PPD for new hires. Human Resources will audit new employee files to ensure compliance with this new requirement. IV. Human Resources will document audit findings and present monthly to the Quality Assurance Committee for review, evaluation, and recommendations. B. 1. I. Staff members have been re-in-services as to proper hand washing techniques and ice scooper was removed.	11/7/16

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F 441	Continued From page 11 infection. This REQUIREMENT is not met as evidenced by: A. Based on a review of employee records for (seven) 7 of (seven) 7 newly hired employees and through staff interview, it was determined that facility staff failed to maintain an infection control program designed to help prevent the development and transmission of disease and infection as evidenced by a failure to ensure that seven (7) of seven (7) newly hired employees received the 2nd step PPD screening for communicable disease such as Mycobacterium Tuberculosis (TB) upon and/or after hire, within the recommended time period . Employee ' s # 11, #12, #14, #15, #16, #17, and #18. The findings include: " Centers for Disease Control (CDC's) Prevention Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis (TB) in Health Care Setting: Testing for health care workers indicates: TB testing programs should include anyone working or volunteering in health-care settings. Persons (health care workers and non- health care workers) who have face- to- face contact or potential exposure to TB through shared air or space with infectious patient(s) should be part of a TB testing program. There are two types of testing for TB in health care workers. · Initial baseline testing upon hire: Two-step testing with a TB skin test or a TB blood test · Annual or serial screening: determined by	F 441	II. Nursing and F&B staff have been re-in-serviced as to proper hand washing techniques and the proper storage of ice scooper. III. Director of Nursing or designee will conduct infection control rounds with emphasis on hand washing technique observations. F&B Director or designee will conduct monthly sanitation rounds including checking on ice scooper storage. IV. DON and F&B Director will document findings report monthly to the Quality Assurance Committee for review, evaluation, and recommendations.	11/7/16

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state regulations or risk assessment outcomes. "

<http://www.cdc.gov/tb/topic/testing/healthcareworkers.htm>

1. The facility failed to ensure that Employee # 11 was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines.

A review of Employee #11's personnel file revealed the following:

Job title: Food and Beverage Aide

Date of hire: September 8, 2016

A review of the mandatory tuberculosis screening form revealed: " A two-step tuberculin skin test (TST) should be given to each new employee, ideally the 2nd step TST should be given within 3 weeks from the 1st step when the employee has not received a test within the past 12 months ...). "

1st Step - Employee #11 received step #1 of the TST skin test on August 30, 2016 and the results were read on September 1, 2016 as being negative.

2nd Step- area was blank indicating step # 2 was not done.

There was no evidence that Employee #11 was offered or received a tuberculin skin test [a test that determines if you suffer from tuberculosis], for step #2 after he/she was employed within the

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three-week time frame.

A face- to- face interview was done with Employee #14 on September 22, 2016 at approximately 3:00 PM. He/she acknowledged the aforementioned findings.

2. The facility failed to ensure that Employee # 12 was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines.

A review of Employee #12's personnel file revealed the following:

Job title: Food and Beverage Aide

Date of hire: August 11, 2016

A review of the mandatory tuberculosis screening form revealed: " A two-step tuberculin skin test (TST) should be given to each new employee, ideally the 2nd step TST should be given within 3 weeks from the 1st step when the employee has not received a test within the past 12 months ...). "

1st Step - Employee #12 received step #1 of the TST skin test on August 9, 2016 and the results were read on August 11, 2016 as being negative.

2nd Step- area was blank indicating step # 2 was not done.

There was no evidence that Employee #12 was offered or received a tuberculin skin test [a test that determines if you suffer from tuberculosis],

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for step #2 after he/she was employed within the three-week time frame.

A face- to- face interview was done with Employee #14 on September 22, 2016 at approximately 3:00 PM. He/she acknowledged the aforementioned findings.

3. The facility failed to ensure that Employee # 14 was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines.

A review of Employee #14's personnel file revealed the following:

Job title: HR [Human Resource] Assistant

Date of hire: May 2, 2016

A review of the mandatory tuberculosis screening form revealed: " A two-step tuberculin skin test (TST) should be given to each new employee, ideally the 2nd step TST should be given within 3 weeks from the 1st step when the employee has not received a test within the past 12 months ...) " .

1st Step - Employee #14 received step #1 of the TST skin test on March 23, 2016 and the results were read on March 25, 2016 as being negative.

2nd Step- area was blank indicating step # 2 was not done.

There was no evidence that Employee #14 was offered or received a tuberculin skin test [a test

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F 441	Continued From page 15 that determines if you suffer from tuberculosis], for step #2 after he/she was employed within the three-week time frame. A face- to- face interview was done with Employee #14 on September 22, 2016 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. 4. The facility failed to ensure that Employee # 15 was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines. A review of Employee #15's personnel file revealed the following: Job title: Activities Assistant Date of hire: September 2, 2016 A review of the mandatory tuberculosis screening form revealed: " A two-step tuberculin skin test (TST) should be given to each new employee, ideally the 2nd step TST should be given within 3 weeks from the 1st step when the employee has not received a test within the past 12 months ...) " . 1st Step - Employee #15 received step #1 of the TST skin test on September 2, 2016 and the results were read on September 5, 2016 as being negative. 2nd Step- area was blank indicating step # 2 was not done. There was no evidence that Employee #15 was	F 441		

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F 441	Continued From page 16 offered or received a tuberculin skin test [a test that determines if you suffer from tuberculosis], for step #2 after he/she was employed within the three-week time frame. A face- to- face interview was done with Employee #14 on September 22, 2016 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. 5. The facility failed to ensure that Employee # 16 was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines. A review of Employee #16's personnel file revealed the following: Job title: Activities Manager Date of hire: June 21, 2016 A review of the mandatory tuberculosis screening form revealed: " A two-step tuberculin skin test (TST) should be given to each new employee, ideally the 2nd step TST should be given within 3 weeks from the 1st step when the employee has not received a test within the past 12 months ...) " . 1st Step - Employee #16 received step #1 of the TST skin test on May 19, 2016 and the results were read on May 21, 2016 as being negative. 2nd Step- area was blank indicating step # 2 was not done. There was no evidence that Employee #16 was	F 441		

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offered or received a tuberculin skin test [a test that determines if you suffer from tuberculosis], for step #2 after he/she was employed within the three-week time frame.

A face- to- face interview was done with Employee #14 on September 22, 2016 at approximately 3:00 PM. He/she acknowledged the aforementioned findings.

6. The facility failed to ensure that Employee # 17 was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines.

A review of Employee #17's personnel file revealed the following:

Job title: Certified Nurse Assistant

Date of hire: May 12, 2016

A review of the mandatory tuberculosis screening form revealed: " A two-step tuberculin skin test (TST) should be given to each new employee, ideally the 2nd step TST should be given within 3 weeks from the 1st step when the employee has not received a test within the past 12 months ...) " .

1st Step - Employee #17 received step #1 of the TST skin test on May 3, 2016 and the results were read on May 5, 2016 as being negative.

2nd Step- area was blank indicating step # 2 was not done.

There was no evidence that Employee #17 was offered or received a tuberculin skin test [a test

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F 441	Continued From page 18 that determines if you suffer from tuberculosis], for step #2 after he/she was employed within the three-week time frame. A face- to- face interview was done with Employee #14 on September 22, 2016 at approximately 3:00 PM. He/she acknowledged the aforementioned findings. 7. The facility failed to ensure that Employee # 18 was pre- screened for communicable disease prior to employment in accordance with regulations and guidelines. A review of Employee #18's personnel file revealed the following: Job title: Social Worker Date of hire: August 11, 2016 A review of the mandatory tuberculosis screening form revealed: " A two-step tuberculin skin test (TST) should be given to each new employee, ideally the 2nd step TST should be given within 3 weeks from the 1st step when the employee has not received a test within the past 12 months ...) " . 1st Step - Employee #18 received step #1 of the TST skin test on March 28, 2016 and the results were read on March 30, 2016 as being negative. 2nd Step- area was blank indicating step # 2 was not done. There was no evidence that Employee #18 was offered or received a tuberculin skin test [a test	F 441		

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that determines if you suffer from tuberculosis], for step #2 after he/she was employed within the three-week time frame.

A face- to- face interview was done with Employee #14 on September 22, 2016 at approximately 3:00 PM. He/she acknowledged the aforementioned findings.

B. Based on an observation of the lunch dining service and through staff interview, it was determined that facility staff failed to practice hand hygiene in accordance with accepted standards of practice and an ice scooper was observed stored uncovered inside the ice machine in the main kitchen.

The findings include:

According to Centers for Disease Control and Prevention handwashing guidelines are as follows:

" Wet your hands with clean, running water ...Lather your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails. Scrub your hands for at least 20 seconds ...Rinse your hands well under clean, running water. Dry your hands using a clean towel or air dry them. "
http://www.cdc.gov/handwashing/when-how-handwashing.html

1. Facility staff failed to practice hand hygiene in

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F 441	Continued From page 20 accordance with accepted standards during a dining observation. A dining observation was conducted on September 20, 2016 at approximately 11:30 AM. the following was observed: Employee #9 turned on the kitchen faucet, applied hand soap, scrubbed hands less than 5 seconds, obtained towel to dry hands and turned off the faucet using the towel. A face-to-face interview was conducted on September 20, 2016 at approximately 11:30 AM with Employee #9 who acknowledged the finding and was not able to articulate the minimum amount time to sanitize hands. the observation was made on September 20, 2016. 2. An ice scooper was observed stored uncovered amongst the ice inside of the ice machine in the main kitchen on September 20, 2016 at approximately 9:00 AM. These observations were made in the presence of Employee #4 who acknowledged the findings.	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by:	F 456	I. 1. Fire control knobs will be replaced. 2. Stainless steel filter from the hood filter will be mounted. 3. Stainless steel filter will be tightenend.	

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F 456	Continued From page 21 Based on observations made on September 21, 2016 at approximately 9:30 AM, it was determined that the facility failed to maintain essential equipment in safe working condition as evidenced by two (2) of eight (8) fire control knobs from the gas stove that needed to be replaced, one (1) of nine (9) baffle filters from the hood filter system that was not mounted and one (1) of eight (8) baffle filters from the hood filter system that was loose. The findings include: 1. Two (2) of eight (8) fire control knobs from one (1) of one (1) gas stove were missing. 2. One (1) of nine (9) stainless steel filter from the hood filter system was not mounted. 3. One (1) of eight (8) stainless steel filter from the hood filter system was loose. These observations were made in the presence of Employee #4 who acknowledged the findings	F 456	II. F&B Director, Plant Operations Director, or designees will conduct an environmental round to identify equipment needing maintenance. III. F&B Director, Plant Operations Director, or designees will conduct monthly rounds. IV. F&B Director or designee will document findings and report to the Quality Assurance Committee monthly for review, evaluation, and recommendations.	11/7/16
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview of the facility's kitchens, it was determined that facility staff failed to keep the kitchen area free of flying	F 469		

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F 469	Continued From page 22 pest. The findings include: 1. Facility staff failed to keep the second floor kitchen free of flying pests. During the dining (lunch) observation conducted on September 20, 2016 at approximately 12:27 PM flying pests were observed flying in the kitchen and dining area on the 2nd floor. The observation was made in the presence of Employee #9 who acknowledged the observation.	F 469	I. Pest Control Company has addressed the flying insect concern. II. Director of Environmental Services, Plant Operations Director, or designees will conduct an environmental round to identify any pest control issues. III. Director of Environmental Services, Plant Operations Director, or designees will conduct monthly environmental rounds . IV. Director of Environmental Services will document findings and report to the Quality Assurance Committee monthly for review, evaluation, and recommendations.	11/7/16