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| F 756 | Continued From page 65<br>08/20/19 and a discontinued date of 01/01/20.<br><br>Lasix (Furosemide) Tablet 40 mg (milligram) give 1 tablet by mouth one time a day for edema with a start date of 08/20/19 and a discontinue date of 01/01/20.<br><br>Continued review of the January 2020 MAR showed that the facility's staff failed to administer Amlodipine Besylate (Norvasc) Tablet 10 mg (milligrams) 1 tablet by mouth one time a day for HTN (Hypertension) and Lasix (Furosemide) Tablet 40 mg (milligram) 1 tablet by mouth one time a day for edema from 01/02/20 to 01/20/20 (for a total of 19 days).<br><br>Further review of Resident #23's medical record showed no evidence of a physician's order to discontinue the Norvasc or Lasix on 01/20/20.<br><br>Continued review of Resident #23's medical record showed a document entitled, "Pharmacist's Chronological Record of Medication Regimen Review" dated 01/27/20. The review lacked documented evidence that the pharmacist captured the medication error that the facility's staff did not administer Resident #23's physician ordered Norvasc or Lasix for 19 days from 01/02/20 to 01/20/20. However, the pharmacist documented "NI" (indicating no irregularities).<br><br>During a face-to-face interview with Employee #4 at approximately 9:00 AM on February 20, 2020, the employee acknowledged that the pharmacist failed to identfy a medication error (Omission of Antihypertensive medications) during the January 2020's Drug Regimen Review. | F 756 | | |

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| F 756 | Continued From page 66 | F 756 | | |

2.The facility staff failed to ensure the pharmacist completed The Pharmacist's Chronological Record of Medication Regimen Review for 2 months (8/2019 and 1/2020) for Resident #220.

Resident #220 was admitted to the facility on May 22, 2019, with diagnoses which include Quadriplegia, Hypertension, Peripheral Vascular Disease, and Anxiety disorder.

A review of Section C400 of the Quarterly Minimum Data Set (MDS) dated December 19, 2019, showed a Brief Interview for Mental Status (BIMS) score of "15" which is an indication that the resident is cognitively intact and able to make decisions.

A review of the medical record showed The Pharmacist's Chronological Record of Medication Regimen Review was available on the record. The Medication Regimen Review was documented on the record from February 2019 through February of 2020. However, there was no documentation to show that the review was completed for August of 2019 and January 2020.

A face-to-face interview was conducted with Employee #4 on 2/18/20 at approximately 1:00 PM concerning omission of the the two-months Medication Regimen Review by the Pharmacist without a reason as to why the review was not available in the resident's record. Employee #4 stated, "I will check to see if the resident was hospitalized." The employee later reported, "The resident was in the facility. I do not know what happened. will check and let you know"

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| F 756 | Continued From page 67<br><br>Employee #4 acknowledged the finding, during the aforementioned interview. | F 756 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that—<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and | F 758 | 1. Resident #56 was seen by Psychogeriatric Services on 3/24/20 and determined that the dose reduction was not indicated at this times due to benefits out-weighing the risk. The gradual dose reduction would likely cause psychiatric and medical instability while impairing the resident's overall functional status.<br>2. An audit of the pharmacist recommendation was performed to ensure no other residents were affected.<br>3. Nurse Managers will receive a copy of the Pharmacist Recommendations each month and audit the medical record to ensure that recommendations are communicated to the attending physicians and addressed appropriately.<br>4. A summary of the Nurse Managers audits will be reported to the QAPI committee monthly for further review and recommendation. | 2/29/20 |

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| F 758 | Continued From page 68<br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and staff interview for one (1) of 75 sampled residents, the facility's staff failed to respond to the pharmacist's recommendation for dosage reduction for one resident who receives Remeron. (Antidepressant). Resident #56<br><br>Findings included ...<br><br>Resident #56 was admitted to the facility on November 30, 2016, with diagnoses that included Hypertension, Peripheral Vascular Disease, Seizure Hypercholesterolemia, Anxiety and Major Depressive Disorder.<br><br>A review of the Pharmacist's Medication Regimen Review showed that on 08/15/19 the Pharmacist documented, "RMP [Recommendation made to Physician] decrease Remeron".<br><br>Continue review of Resident #56's medical record lacked documented evidence the physician | F 758 | | |

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| F 758 | Continued From page 69<br>responded in writing to the Pharmacist reccommendations.<br><br>A face-to-face interview was conducted on 02/14/20 at 2:00 PM with Employee#4 concerning the physician response to the Pharmacist Recommendation dated 08/15/19. She stated,"I will look for it."<br><br>A face-to-face interview was conducted on 02/18/20 at approximately 1:00 PM with Employee #4, she acknowledged the findings.<br><br>The phyisican failed to responded to the pharmacist's recommendation for a dosage reduction of Remeron (Antidepressant) on 08/15/19 for Resident #56. | F 758 | | |
| F 760 SS=E | Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and interview, the facility staff failed to ensure a resident was free from a significant medication error for one (1) of 75 sampled residents (Resident #23).<br><br>Findings included...<br><br>During an interview on 02/10/20 at 11:00 AM, Resident #23 stated that the nursing staff failed to administer his antihypertensive medications for January 2020.<br><br>Continued interview revealed that the nurses take | F 760 | 1. Resident #23's medications were reviewed and audited to ensure that all of his medications were current and available. His care plan was updated to reflect his hypertensive and diuretic medications as well.<br>2. A full-house audit was performed of resident medications to ensure that medications were accurate, available, and current. Any issues identified were corrected. | 2/18-3/8/20 |

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| F 760 | Continued From page 70<br>his blood pressure daily, and he always requests his readings. Resident #23 said once his blood pressure reached "189/111," he asked to see the nurse practitioner, who informed him that his blood pressure medication had been "left off the list." The resident also stated, "The last time my blood pressure was that high (189/111). I had a stroke."<br><br>Review of Resident #23's current medical record on 02/13/20 starting at 2:00 PM showed that the resident had an initial admission date of 07/30/19 with multiple diagnoses including Essential Hypertension, Cerebral Infarction, and Acute Kidney Failure.<br><br>Continued review of Resident #23's medical record revealed a Quarterly Minimum Data Set (MDS) dated 11/06/19. The MDS data showed the following:<br><br>Section C (Cognitive Pattern) the resident had a score of 15 (cognitive response intact); and<br><br>Section I (Active Diagnoses) - the resident had several active diagnoses, including Hypertension and Cerebrovascular Accident.<br><br>Further review of Resident #23's medical record showed a Care Plan with an initiation date of 07/31/19 with the following focus area and interventions:<br><br>Focus area- Hypertension related to lifestyle, Intervention- antihypertensive medications as ordered ...Amlodipine Besylate tablet 10 milligrams by mouth one time a day; and<br><br>Focus area- Acute renal failure superimposed on | F 760 | 3. Licensed staff was in-serviced on proper medication administration, storage, and documentation by the Chief Operating Officer of Clinical Services for the company and the Director of Nursing.<br>4. Unit Managers will select 5 random resident charts from their respective nursing units every thirty (30) days to ensure resident medications are administered and accounted for. Results of these audits will be reported to the QAPI Committee monthly for further review and recommendations. | 2/12 – 3/8/20 |

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| F 760 | Continued From page 71<br>chronic kidney disease, Intervention - give medications as ordered by a physician.<br><br>Further review of the resident's record revealed a January 2020 Medication Administration Record (MAR) that showed the following:<br><br>Amlodipine Besylate (Norvasc) Tablet 10 mg (milligrams) give 1 tablet by mouth one time a day for HTN (Hypertension) with a start date of 08/20/19 and a discontinue date of 01/01/20.<br><br>Lasix (Furosemide) Tablet 40 mg (milligram) give 1 tablet by mouth one time a day for edema with a start date of 08/20/19 and a discontinue date of 01/01/20.<br><br>Continued review of the January 2020 MAR showed that the facility's staff failed to administer Amlodipine Besylate (Norvasc) Tablet 10 mg (milligrams) 1 tablet by mouth one time a day for HTN (Hypertension) and Lasix (Furosemide) Tablet 40 mg (milligram) 1 tablet by mouth one time a day for edema from 01/02/20 to 01/20/20 (for a total of 19 days).<br><br>Further review of Resident #23's medical record showed that there was no evidence of a physician's order to discontinue the Norvasc or Lasix on 01/20/20.<br><br>Continued review of Resident #23's medical record showed a nurse practitioner's note dated 01/20/20 that documented "Was asked to see pt (patient) for elevated BP (Blood pressure) ... Meds (medications) reviewed. No antihypertensive noted on profile-pt (patient) was previously on Norvasc". | F 760 | | |

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| F 760 | Continued From page 72<br>During a face to face interview on 02/13/20 at 3:00 PM, Employee #2 (D'ON) and Employee #7 (Unit Manager) acknowledged the findings.<br><br>The facility's nursing staff failed to administer Resident #23's ordered medications Norvasc and Lasix for 19 days from 01/02/20 to 01/20/20. | F 760 | | |
| F 804 SS=D | Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation resident and staff interview for one (1) of 75 sampled residents, the facility's staff failed to ensure the food prepared for the resident was attractive" refers to the appearance of the food when served to residents." (Resident #246).<br><br>Findings included ...<br><br>During a face-to-face interview with Resident #246 on 02/12/20 at 10:38 AM, she stated, "I don't like the food here... I get food from the grocery store...I need food to take my meds (medication)."<br><br>During dining on 02/12/20 at approximately 1:30 | F 804 | 1. The resident's meal with the "wilted" salad/lettuce was immediately replaced with other food items that resident desired. No other residents were affected by the above deficiency.<br>2. A new resident visiting log was devised to ask residents about their satisfaction with food services on a daily basis.<br>3. Residents will also be queried to resolve any issues with food presentation and/or taste on a regular basis with the dietary staff.<br>4. Food Service Director will monitor all food concerns and will be reported to the QAPI Committee monthly for further review and recommendations. | 3/10/20 |

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| F 804 | Continued From page 73<br>PM (the lunch meal), the resident came to the writer upset about the salad that was served for her to eat. Resident #246 stated, "I can't eat this food, look at it [pointing to the plate of food]." The writer observed the resident with a plate of salad that appeared to have withered lettuce. The resident stated, "She asked for an alternate meal a half smoke, and was told she could only have chicken or a cold cut sandwich." The resident siad, "I'm tired of eating chicken and cold cuts. I asked for a half smoke" The resident became tearful and said she could not eat the food.<br><br>The writer informed Employee #1, Administrator, of the concern at the time of the occurrence, and he acknowledged the findings on 02/12/20 at 1:45 PM. | F 804 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional | F 812 | 1. The freezer was charged with Freon and temperatures were corrected immediately and outside refrigerator temperature gauge was replaced. New air curtains (slats) were ordered on 2/24/2020 and replaced on March 3/4/2020. The temperature gauge for refrigerator #5 was replaced immediately during survey.<br>2. Temperatures will be checked 3x daily and logged on temperature checklist by shift supervisors.<br>3. Director of Food Services will check temperature log sheets weekly to | 2/4-3/4/25 |

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| F 812 | Continued From page 74<br>standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations and staff interview, facility staff failed to store and prepare foods under sanitary conditions as evidenced by inadequate internal temperatures in one (1) of one (1) walk-in freezer, four (4) of four (4) soiled convection ovens, one (1) of five (5) missing slat in one (1) of one (1) walk-in refrigerator and a broken outer temperature gauge in one (1) of three (3) reach-in refrigerator.<br><br>Findings included ...<br><br>During a walkthrough of dietary services on February 9, 2020, at approximately 7:20 AM, the following were observed:<br><br>1. Internal temperatures in one (1) of one (1) walk-in freezer fluctuated between 30 degrees Fahrenheit (F) and 38 degrees F between 7:22 AM and 9:30 AM. Food items such as mixed vegetables and French fries were still frozen but approximately 15 of 15 one-serving containers of ice cream were melted and discarded. No other foods were affected as the walk-in freezer was repaired soon thereafter.<br><br>2. Four (4) of four (4) convection ovens were soiled throughout with burnt food deposits.<br><br>3. One (1) of five (5) slats was torn off in one (1) of one (1) walk-in refrigerator.<br><br>4. The outer temperature gauge to reach-in refrigerator #5 was broken, one (1) of three (3) | F 812 | ensure that there are no fluctuating temperatures.<br>4. Director of Food Services will inform the results of these audits to the QAPI Committee monthly.<br><br>1. All convection ovens were cleaned and put on cleaning schedules (3xweek).<br>2. All convection ovens will be checked and cleaned daily by dietary supervisors and logged on cleaning checklist.<br>3. Food Services Director will audit cleaning checklist weekly.<br>4. Director of Food Services will inform the results of these audits to the QAPI Committee monthly. | 3/18/20 |

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| F 812 | Continued From page 75<br>reach-in refrigerators in the kitchen.<br><br>These observations were acknowledged by Employee #13 during a face-to-face interview on February 9, 2020, at approximately 9:30 AM. | F 812 | | |
| F 867 SS=D | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(g)(2)(ii)<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee must:<br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations, record review, resident and staff interview, the facility failed to maintain and implement an effective, comprehensive quality assurance and performance improvement (QAPI) program inclusive of all systems; as evidenced by failing to ensure that they developed plans of action to identify quality deficiencies. The resident census during the survey was 346.<br><br>Findings included . . .<br><br>A review of the facility's previous survey dated December 18, 2018 showed that the facility was cited for the following deficiencies:<br><br>F558 Reasonable Accommodations | F 867 | 1. The QAPI process was reviewed with the facility Department Heads and the Medical Director. While there were repeat deficiencies from last year's survey, the team recognizes that some areas of care and the environment required a more thorough review, investigation, and corrective actions. Plans of Correction will now be followed for an entire year, regardless of the level of compliance, to ensure more scrutiny is applied to achieve better outcomes and investigative activity to formulate decisive conclusions as well as corrections when appropriate.<br>2. The facility recognizes that all residents have the potential to be affected by this citation. An audit of the QAPI Performance Improvement plans was performed to ensure that all survey issues were accounted for and plans are in place.<br><br>3. All survey deficiencies and other facility issues identified will be thoroughly monitored monthly by the QAPI Committee, with targeted dates | 4/8/20 |

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| F 867 | Continued From page 76<br>Needs/Preferences<br>F584 Safe/Clean/Comfortable/Homelike Environment<br>F656 Develop/Implement Comprehensive Care Plan<br>F600 Free from Abuse and Neglect<br>F607 Develop/Implement Abuse/Neglect Policies<br>F610 Investigate/Prevent/Correct Alleged Violation<br>F656 Develop/Implement Comprehensive Care Plan<br>F657 Care Plan Timing and Revision<br>F684 Quality of Care<br>F689 Free of Accident Hazards/Supervisions/Devices<br>F812 Food Procurement, Store/Prepare/Serve-Sanitary<br>F865 QAPI/QAA Improvement Activities<br>F880 Infection Control Program<br>F908 Essential Equipment, Safe Operating Condition<br>F919 Resident Call System<br><br>The aforementioned deficiencies were again cited in this current survey of February 20, 2020.<br><br>Based on the repeated deficiencies, there is no evidence that the facility staff continuously monitored their deficient practices from the prior survey and implemented the corrective actions as they indicated in their Plan of Correction from the recertification survey of 12/14/2018 with a compliance date of 2/7/2019.<br><br>In addition, the facility failed to:<br>Develop and implement appropriate plans of | F 867 | of compliance, appropriate goals and thresholds, and validation of compliance. The Company Regional Nurse will in-service the QAPI process and attend all QAPI meetings to ensure that this process is followed. The Regional Nurse will also communicate any issues of non-compliance to the Chief Operating Officer of Transitions Healthcare, LLC, for appropriate administrative follow-up.<br>4. The QAPI Committee will meet monthly, attended by the Regional Nurse for Governing Body oversight purposes, and all focused areas will be reviewed for achieving and maintaining compliance. The facility administrator will ensure that this process is followed. | |

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| F 867 | Continued From page 77<br>action to correct identified quality deficiencies<br>Failed to develop and implement a policy for providing 1:1 care to residents and<br>Failed to thoroughly investigate and provide corrective action for one male resident who was accused of abusing several female residents.<br><br>A face-to-face interview was conducted with Employee #1 at approximately 2/20/2020 at 4:20 PM. The employee acknowledged the findings: | F 867 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and | F 880 | 1. All dust was immediately cleaned from the heater blower in the laundry room during the annual survey and completed on February 19, 2020.<br>2. Environmental services staff will use a Dryer/Vent/ & Heater audit tool and monitored daily.<br>3. Environmental Services Director will check Dryer/Vent/& Heater audit tool weekly.<br>4. Director of Environmental will inform the results of these audits to the QAPI Committee monthly. | 2/19/20 |

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| F 880 | Continued From page 78<br>procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its | F 880 | 1. The Legionella risk assessment was completed but located in a different section of the manual.<br>2. A flow diagram of all potable and non-potable water was created by an outside contractor and completed on March 26, 2020.<br>3. Risk assessment will be reviewed annually to stay in compliance.<br>4. Director of Maintenance will inform QAPI of any changes made to the water system. | 3/26/20 |

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| F 880 | Continued From page 79<br>IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and interview, facility staff failed to provide a safe, sanitary environment to help prevent the expansion and transmission of communicable diseases and infections as evidenced by one (1) of one (1) heater blower in use, that was soiled with dust in the laundry room and the lack of a water management program with a risk assessment to identify where Legionella and other waterborne pathogens could grow in the facility's water system.<br><br>Findings included ...<br><br>1. During a walkthrough of the facility's laundry area on February 19, 2020, at approximately 11:07 AM, one (1) of<br>one (1) heater blower, hanging down from the ceiling in the washing machine room, was soiled with dust.<br>This deficient practice consistently exposes resident clean, personal clothing and linen to dust contamination.<br><br>2. A comprehensive water management plan to include a complete description of all potable and non-potable water<br>systems in the building and a facility risk assessment to identify where Legionella and other water borne pathogens<br>could grow and spread in the facility's water system was not available for review on February 14, 2020, at<br>approximately 9:15 A.M.<br><br>These findings were acknowledged by Employee #15 on February 18, 2020, at approximately 1:00 | F 880 | | |

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| F 880 | Continued From page 80<br>PM. | F 880 | | |
| F 908 SS=E | Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2)<br><br>§483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations, record review and staff interview, facility staff failed to: (I) maintain essential equipment in a safe condition as evidenced by a high internal temperature in one (1) of one (1) walk-in freezer, a broken temperature gauge in one (1) of five (5) reach-in refrigerators and one (1) of five (5) slats from one (1) of one (1) walk-in refrigerator that was completely torn off; and (II) ensure a New Life Intensity Oxygen Concentrator was operating in a safe condition for one (1) of 75 sampled residents (Resident #215).<br><br>Findings included ...<br><br>(I). The facility's staff failed to maintain essential equipment in a safe condition as evidenced by a high internal temperature in one (1) of one (1) walk-in freezer, a broken temperature gauge in one (1) of five (5) reach-in refrigerators and one (1) of five (5) slats from one (1) of one (1) walk-in refrigerator that was completely torn off.<br><br>a. Internal temperatures in one (1) of one (1) walk-in freezer fluctuated between 30 degrees Fahrenheit (F) and 38<br>degrees F between 7:22 AM and 9:30 AM and food items were not frozen solid as required. | F 908 | 1. The freezer was charged with Freon and temperatures were corrected immediately and outside refrigerator temperature gauge was replaced. New air curtains (slats) were ordered on 2/24/2020 and replaced on March 3/4/2020. The temperature gauge for refrigerator #5 was replaced immediately during survey. Resident #215's concentrator was changed out to a new concentrator with clean filter and maintenance check.<br>2. Temperatures will be checked 3x daily and logged on temperature checklist by shift supervisors.<br>3. Director of Food Services will check temperature log sheets weekly to ensure that there are no fluctuating temperatures.<br>4. Director of Food Services will inform the results of these audits to the QAPI Committee monthly. | |

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| F 908 | Continued From page 81<br><br>b. The outer temperature gauge to reach-in refrigerator #5 was broken, one (1) of five (5) reach-in refrigerators.<br><br>c. One (1) of five (5) slats was torn off in one (1) of one (1) walk-in refrigerator.<br><br>d. The top, protective plastic cover to remote bed controller cords were torn throughout in resident's rooms #104,<br>#141 and #325, three (3) of 60 resident's rooms.<br><br>These observations were acknowledged by Employee #13 during a face-to-face interview on February 9, 2020, at approximately 9:30 AM.<br><br>(II). The facility's staff failed to ensure a New Life Intensity Oxygen Concentrator was operating in a safe condition for one (1) of 67 sampled residents (Resident #215).<br><br>According to the New Life Intensity Oxygen Concentrator Service Manual under Section 4.1.1 Air Intake Gross Particle Filter/GPF - The external air intake gross particle filter is located on the back of the unit. You can easily remove it by hand. Instruct the patient to clean this filter weekly.<br><br>Observation on 02/09/20 at 8:00 AM of Resident #215's room showed that the resident was sitting in bed, receiving oxygen at a flow rate of 7 liters per nasal cannula being delivered by an oxygen concentrator. | F 908 | 1. Protective plastic covers to remote bed controller cords in rooms #104, #141, and #325 were replaced and completed on February 20, 2020.<br>2. A sample size of 5 bed controller cords will be inspected daily Maintenance staff and replaced or repaired as needed.<br>3. Director of Maintenance will review audit tool weekly.<br>4. The results of these audits will be submitted to the QAPI Committee monthly x 3 months. | 2/20/20 |

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| F 908 | Continued From page 82<br>Continued observation of the back of the oxygen concentrator revealed that the concentrator had a serial number of CBB0117250050 and an inspection sticker dated 06/17/17. Further observation showed that the concentrator did not have an Air Intake Gross Particle Filter, and dust particles were collected in the filter area. It should be noted that Resident #215 did not appear to have any respiratory distress, and her oxygen saturation was 95% on oxygen at 7 liters per nasal cannula.<br><br>Review of the facility's Preventive Maintenance Log revealed preventive maintenance service for equipment was conducted on 08/07/19. Continued review of the log lacked documented evidence that Resident #215 oxygen concentrator #CBB0117250050 was inspected on 08/07/19.<br><br>During a face to face interview on 02/10/20 at 10:00 AM, Employee #16, Director of Environmental Services and Supplies, acknowledged the finding. Employee #16 stated that he was not aware that Resident #215's oxygen concentrator #CBB0117250050 had not been inspected during the preventive maintenance services on 08/07/19. He also said that he was not aware that oxygen concentrator #CBB0117250050 did not have a filter.<br><br>Continued interview with Employee #16 revealed that oxygen concentrators are inspected by "a company" every six (6) months. However, he did not have documented evidence on when oxygen concentrators were inspected before 08/07/19. When asked if he knew what residents were assigned to each oxygen concentrator, Employee #16 stated, "No, I'm new to the job. I would have to go to the floors and look at the serial numbers | F 908 | | |

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| F 908 | Continued From page 83<br>on each resident's concentrator."<br><br>The facility failed to ensure Resident #215's oxygen concentrator was maintained in a safe operating condition. | F 908 | | |
| F 919 SS=E | Resident Call System<br>CFR(s): 483.90(g)(2)<br><br>§483.90(g) Resident Call System<br>The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area.<br><br>§483.90(g)(2) Toilet and bathing facilities.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observations and staff interview, facility staff failed to maintain the call bell system in good working condition as evidenced by call bells in two (2) of 60 resident's rooms that failed to alarm when tested, torn protective call bells cord cover in five (5) of 60 observations and a broken reset button from one (1) of 60 resident call bell housing.<br><br>Findings included...<br><br>During an environmental walkthrough of the facility on February 10, 2020, between 10:35 AM and 3:30 PM:<br><br>1. Call bells in resident's rooms #332 and #355 did not alarm when tested, two (2) of 60 resident's rooms. This breakdown could prevent or delay care to residents in an emergency. | F 919 | 1. All call bell issues identified in room #124A, #205A, #214A, #235 and #332 were repaired immediately during annual survey.<br>2. Call bell system was checked throughout the facility and repaired as needed.<br>3. Maintenance staff was in-serviced on the importance of working call bells. The maintenance staff will continue to monitor rooms during daily rounds.<br>4. Director of maintenance will report results of findings to QAPI committee will determine compliance. | 3/17/20 |

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| F 919 | Continued From page 84<br><br>2. The top, protective plastic cover to call bell cords in resident's room's #124A, #205A, #214A, #235 and #332<br>was torn, five (5) of 60 resident's rooms.<br><br>3. The reset push-button to the call bell housing, attached to the wall in resident room #336 was broken, one (1)<br>of 60 resident's rooms.<br><br>These findings were acknowledged by Employee #14 on February 10, 2020, at approximately 3:30 PM. | F 919 | | |