VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

August 24, 2018

Ms. Kim Campbell, Administrator
Maple Lane Nursing Home
60 Maple Lane
Barton, VT 05822-9494

Dear Ms. Campbell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 1, 2018**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

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
	475042	A. BUILDING _____ B. WING _____	C 08/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LANE NURSING HOME	60 MAPLE LANE BARTON, VT 05822

(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
E 000	Initial Comments The Division of Licensing and Protection conducted an unannounced onsite emergency preparedness survey on 8/1/18. There were no regulatory violations identified related to emergency planning.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification survey and an investigation of five self-reported incidents were conducted by the Division of Licensing and Protection from 7/30- 8/1/18. The following are regulatory findings.	F 000		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal	F 576	F576 483.10(g)(6)-(9) 1. No resident had a negative effect as a result of the alleged deficient practice. 2. Residents that receive mail have the potential to be affected by the alleged deficient practice 3. Facility administration has reviewed and understands the requirement for mail delivery. Residents will receive mail on all scheduled postal delivery days. 4. Audits will be done weekly by the administrator or designee to monitor effectiveness of the plan Receipt 8/23/18 KC/BL	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kim Campbell | TITLE: Administrator | (X6) DATE: 8/14/2018

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 576 Continued From page 1

service, including the right to:
(i) Privacy of such communications consistent with this section; and
(ii) Access to stationery, postage, and writing implements at the resident's own expense.

§483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.
(i) If the access is available to the facility
(ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident
(iii) Such use must comply with State and Federal law.
This REQUIREMENT is not met as evidenced by:
Based on resident and staff interviews, the facility failed to ensure that residents receive delivery of mail and other materials when there is a scheduled postal delivery. Findings include:

Per interview, during the resident council special meeting, residents reported that the facility does not deliver mail on the weekends. The residents believed that there is no staff available to deliver mail on Saturdays. The Social Worker confirmed on 7/31/18 that the facility has not delivered mail on Saturdays.

F 576

5. Results of the audits will be presented to the QAA committee x3 months at which time the committee will determine further frequency of the audits.
6. Corrective action was completed on August 31, 2018

F 623 Notice Requirements Before Transfer/Discharge
SS=C CFR(s): 483.15(c)(3)-(6)(8)

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and

F 623 F623 483.15(c)(3)-(6)(8)

1. The identified residents had no negative affect as a result of the alleged deficient practice. All identified residents remain in the facility.

DC unit 8/28/18 EC/RL

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F 623	Continued From page 2	F 623		

the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

2. Resident requiring transfer or discharge out of the facility have the potential to be affected by the alleged deficient practice
3. Facility administration has reviewed and understand the requirements for transfer notices and has revised the notice to include all required components of the notice.
4. Education will be provided to staff responsible for issuing a transfer notice.
5. Weekly audits will be done by the Administrator or designee to monitor effectiveness of the plan
6. Results of the audits will be presented to the QAA committee x3 months at which time the committee will determine further frequency of the audits
7. Corrective action to be complete by 8/31/2018

pc amt 8/23/18 KL/SD

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(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests, and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

POC amt 8/23/18 KCH

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§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to notify 4 of 4 applicable residents in the sample (Residents # 56, # 53, # 58, 47) and/or the resident's representative(s) of the transfer or discharge and the reasons for the move in writing in a language and manner they understand. Findings include:

1. Resident # 56 was discharged to an acute care facility on 7/10/18 and returned to the facility on 7/18/18. There is no evidence in the clinical record that a notice of discharge was provided to the resident or the resident's representative. This was confirmed by the Director of Nurses (DON) on 8/1/18 at 9:28 AM.

2. Per record review, Resident #47 was hospitalized for acute illness on 6/29/18 and re-admitted 7/2/18. The facility did not provide evidence that a required notice of transfer had been issued to the resident or the resident representative. On 8/1/18 at 12:50 PM, the Director of Nursing confirmed that no such notice had been sent.

3. Per record review, Resident #58 was transferred to an acute care hospital on 6/1/18

pdc amt 8/23/18 KE/SL

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F 623 Continued From page 5

after a fall and returned to the facility on 6/7/18. There is no evidence that the facility provided the required notice of transfer to the resident or the resident representative. On 8/1/18 the Social Worker (SW) confirmed that in fact no such notice had been sent.

4. Resident # 53 was discharged to an acute care facility on 7/30/2018. There was no evidence in the clinical record that a notice of discharge was given to the responsible party upon discharge to the hospital. The DON confirmed that there was no evidence of notice of discharge on 8/1/2018 at 10:16.

F 638 Qrtly Assessment at Least Every 3 Months
SS=C CFR(s): 483.20(c)

§483.20(c) Quarterly Review Assessment
A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to assess 2 of 21 applicable residents (#38, #56) using the quarterly instrument specified by the State and approved by CMS (Centers for Medicare and Medicaid Services) not less frequently than once every 3 months. Findings include:

Per record review, the facility failed to complete quarterly assessments in a timely manner for the following residents:
38 - Assessment due 6/19/18 and not completed until 7/11/18;
56 - Assessment due 7/3/18 and not completed

F 623

F 638 F638 483.20(c)

1. No identified residents had any negative effect related to the alleged deficient practice
2. Residents requiring scheduled MDS assessments have the potential to be affected
3. An initial audit was completed and any identified late or missing assessments were completed
4. An MDS coordinator has been hired for the facility
5. Facility administration is aware of the requirements and schedules of MDS assessments to be completed

ac mgt 8/23/18 tc/bl

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F 638 Continued From page 6
until 7/23/18
The above was confirmed by the MDS (Minimum Data Set) consultant on 8/1/18 at 12:11 PM.

F 640 SS=C Encoding/Transmitting Resident Assessments
CFR(s): 483.20(f)(1)-(4)

§483.20(f) Automated data processing requirement-
§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment
(iii) Significant change in status assessment.

F 638

6. Audits will be done weekly by the administrator or designee x3 months to monitor effectiveness of the plan
7. Results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the audits.
8. Corrective action will be complete by 8/31/2018

F640 483.20(f)(1)-(4)

1. No identified residents had any negative effect related to the alleged deficient practice
2. Residents with MDS assessments requiring submission have the potential to be affected by the alleged deficient practice
3. All MDS assessments have been submitted at this point
4. An MDS coordinator has been hired for the facility
5. Facility administration is aware of the requirement to submit MDS assessments within 14 days of completion

Recvd 8/23/18 ec/hl

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F 640 Continued From page 7

(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to electronically transmit encoded, accurate, and complete Minimum Data Set (MDS) data to the Centers for Medicare & Medicaid (CMS) System in a timely manner for 9 of 21 applicable residents (Residents #1, #2, #14, #56, #30, #161, #210, #211, #310). Findings include:

1. Per record review, Resident # 56 had an Quarterly MDS completed 6/20/18. The Assessment was not submitted to CMS until 7/12/18.

2. Per record review, Resident # 30 had a quarterly MDS completed 6/8/18. The Assessment was not submitted to CMS until 7/12/18.
3. Per record review, the admission MDS (3/16/18) for Resident #210 was never transmitted to the CMS system.

F 640

6. Audits will be completed weekly by the Administrator or designee to monitor effectiveness of the plan
7. Results of the audits will be presented to the QAA committee x3 months at which time the committee will determine further frequency of the audits.
8. Corrective action will be completed by 8/31/2018

POC cmpt 8/23/18 kel

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F 640	Continued From page 8 4. Per record review, the MDS for Resident #211 with target date 12/29/17 was submitted to CMS more than 14 days after the assessment. 5. Per record review, Resident #310 had an Quarterly MDS completed 1/10/18. The Assessment was submitted to CMS on 2/26/18, more than 14 days after completion. 6. Per record review, Resident #14 had a Significant Change MDS completed 4/16/18 The Assessment was submitted to CMS on 6/14/18, more than 14 days after completion. 7. Per record review and staff interviews, the admission MDS for Resident #1 with a target date of 3/23/18 was submitted to CMS on 4/9/18, more than 14 days after the assessment. 8. Per record review and staff interviews, the admission MDS for Resident #2 with a target date of [illegible]/18 was submitted to CMS on 4/9/18, more than 14 days after the assessment. 9. Per record review and staff interviews, the quarterly MDS for Resident #161 with a target date of 1/5/18 was submitted to CMS on 3/26/18, more than 14 days after the assessment. Per interview on the morning of 8/1/18, the MDS Consultant at the facility confirmed with multiple surveyors that the above listed MDS assessments were not electronically submitted to CMS within the required timeframe.	F 640		
F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for	F 645		

pvc mgt 8/23/18 KC/W

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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
(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

F 645 F645 483.20(k)(1)-(3)

1. Resident #20, 35, and 310 have had no negative effect as a result of the alleged deficient practice. All 3 residents have now had a PASARR completed as required
2. Residents admitted to the facility have a potential to be affected by the alleged deficient practice
3. The Social Service Director has reviewed and understands the requirements for PASARR screening and timeframes
4. An audit will be completed weekly by the administrator or designee to monitor effectiveness of the plan
5. Results of the audits will be presented to the QAA committee x3 months at which time the committee will determine further frequency of the audits.
6. Corrective action will be completed by 8/31/2018

pc amt 8/23/18 kc/sl

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F 645	Continued From page 10	F 645		

(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 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 interviews, the facility failed to complete a Preadmission Screening and Resident Review (PASARR) for Mental Illness or Intellectual Disability for 3 of 21 residents in the applicable sample (Resident #20, #35 & #310). Finding Include:

1. Record review indicated that Resident #20 was admitted to the Nursing Facility (NF) on 1/24/17. The list of diagnoses includes a Psychiatric Disorder which would potentially entitle the resident to additional specialized services

pc emailed 8/23/18 kcp

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	475042	A. BUILDING _____ B. WING _____	C 08/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LANE NURSING HOME	60 MAPLE LANE BARTON, VT 05822

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F 645	Continued From page 11	F 645		

provided by the state.

"Specialized Services" are those services the State is required to provide or arrange, that raise the intensity of services to the level needed by the resident. That is, specialized services are an "add-on" to NF services-they are of a higher intensity and frequency than specialized rehabilitation services, which are provided by the NF.

During an interview on 7/31/18, the Social Worker (SW) confirmed that the facility did not complete the PASARR screening. She provided the surveyor with a copy of the PASARR that was completed while the resident was at the hospital, as part of the discharge process and the form accompanies the resident on admission to the NF. However, the form she provided indicated a short stay of 30 days or less. She confirmed that the facility failed to re-screen the resident as required when it was determined the stay would exceed 30 days

2. Per record review, Resident #310 was admitted to the facility on 6/29/17 with a PASSAR screening that was completed by the hospital before discharge to the NF. The physician checked the box on the form that indicated the Nursing Home placement was expected to be less than 30 days. The resident remained at this facility for long term placement, and there was no evidence that the resident was re-screened when the stay exceeded the 30 day timeframe. Per interview on 8/1/18 at 9.40 AM, the Social Worker confirmed that the re-screening was not completed as required

3. Per record review, Resident # 35 was admitted

We amf 8/23/18 kc/kl

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F 645 Continued From page 12

on 7/18/2011. There was no evidence of a PASSAR found in the clinical record. The Social Worker confirmed that a PASSAR screening was not available in the clinical record.

F 695 SS=D Respiratory/Tracheostomy Care and Suctioning
CFR(s): 483.25(i)

§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews, and record review, the facility failed to provide respiratory care consistent with professional standards of practice regarding infection control, for 2 out of 3 applicable residents in the sample (Residents #31 and #48). Findings include:

1. Per observation on 7/30/2018 at 2:34 PM, Resident # 31's oxygen tubing on the oxygen concentrator that was in use was not dated and the oxygen tubing on the portable oxygen concentrator that was not in use was also not dated. The Licensed Practical Nurse Unit Coordinator, (LPN) (UC), confirmed that the tubing should be dated and that it was not on 7/31/2018 at 1:55 PM. The UC also stated that the change of tubing should be documented in the treatment record, (TAR). There was no evidence in the TAR that the tubing had been changed. On 8/1/18 at 12:18 PM, the LPN staff

F 645

F 695 F695 483.25(i)

1. Resident #31 and 48 had no negative effects related to the alleged deficient practice and the oxygen tubing was replaced
2. Residents requiring respiratory care have the potential to be affected by the alleged deficient practice
3. Education to be provided to licensed nurses regarding the standards of practice for infection control as it relates to respiratory care
4. Audits will be completed weekly by the Director of Nurses or designee to monitor effectiveness of the plan
5. Results of the audits will be presented to the QAA committee x3 months at which time the committee will determine further frequency of the audits
6. Corrective action will be completed by 8/31/2018

RDC cmt 8/23/18 ICC/SL

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F 695 Continued From page 13

nurse confirmed that it was policy to document when the tubing was changed in the TAR and that it was not documented in the TAR.

2. Per observation on 7/31/2018 at 11.50 AM, Resident # 48's oxygen tubing that was in use was not dated. On 7/31/18 at 1:50 PM, the LPN, UC, confirmed that it should be labeled with a date and that it was not.

F 730 SS=C Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7)

§483.35(d)(7) Regular in-service education.
The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure that Licensed Nursing Assistants (LNAs) received annual performance evaluations and at least 12 hours of training as required. Findings include:

Per review of the training records, 24 LNAs did not receive the 12 hours of annual training as required by regulation. This was confirmed by the Director of Nurses (DON) on 7/31/18 at 11:00 AM. Additionally, the DON confirmed that no staff in the facility have had annual performance evaluations for several years.

F 812 SS=F Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)

F 695

F 730 F730 483.35(d)(7)

1. No residents were negatively affected by the alleged deficient practice
2. Residents in our care have the potential to be affected by the alleged deficient practice
3. Facility administration has reviewed and is aware of the requirements for LNA training and performance evaluations annually
4. LNA staff will receive the required hours of training by the corrective action date
5. LNA staff will receive performance evaluations by the corrective action date

F 812

ove ampd 8/23/18 kc/sl

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 695	Continued From page 13 nurse confirmed that it was policy to document when the tubing was changed in the TAR and that it was not documented in the TAR. 2. Per observation on 7/31/2018 at 11:50 AM, Resident # 48's oxygen tubing that was in use was not dated. On 7/31/18 at 1:50 PM, the LPN, UC, confirmed that it should be labeled with a date and that it was not.	F 695		
F 730 SS=C	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that Licensed Nursing Assistants (LNAs) received annual performance evaluations and at least 12 hours of training as required. Findings include: Per review of the training records, 24 LNAs did not receive the 12 hours of annual training as required by regulation. This was confirmed by the Director of Nurses (DON) on 7/31/18 at 11:00 AM. Additionally, the DON confirmed that no staff in the facility have had annual performance evaluations for several years.	F 730	6. Ongoing tracking and audits will be done monthly to review required training hours and performance evaluations due 7. The tracking and audits will be presented to the QAA committee x3 months at which time the committee will determine further frequency of audits 8. Corrective action will be complete by 8/31/2018	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

POC cmt 8/23/18 KC/8

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F 812 Continued From page 14

§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 staff interview and record review, the facility failed to prepare, distribute and serve food in accordance with professional standards for food service safety regarding monitoring the temperatures of served food items. Findings include:

Per review of the food temperature logs for the past 4 months (April, May , June, July 2018), there is no indication that hot or cold beverages' temperatures were monitored. Additionally, there are 13 meals labeled "cold plate" with no temperatures for the food. There are 31 meals that have only one food item with a temperature. There are also 11 meals that no food temperatures were taken.

The above was confirmed by the Dietary Manager

F 812 F812 483.60(i)(1)(2)

1. No residents had any negative effect related to the alleged deficient practice
2. Residents receiving food and beverages in the facility have the potential to be affected by the alleged deficient practice
3. Education will be provided to dietary staff regarding the requirements for monitoring temperature of food and beverages to include cold plates
4. Audits will be done weekly to monitor effectiveness of the plan
5. Results of the audits will be presented to the QAA commit x3 months at which time the committee will determine further frequency of the audits
6. Corrective action will be completed by 8/31/2018

QC cmpl 8/23/18 KC/8

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 812	Continued From page 15 on 7/30/18 at 1:20 PM	F 812		

pc cmt 8/23/18 kc