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

October 25, 2019

Mr. Chad Dingman, Administrator
Pines Rehab & Health Ctr
601 Red Village Road
Lyndonville, VT 05851-9068

Dear Mr. Dingman:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **October 2, 2019**. 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

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475044	A. BUILDING _____ B. WING _____	10/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

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E 000	Initial Comments An unannounced onsite Emergency Preparedness review was completed by the Division of Licensing and Protection on 10/2/19. The facility was found to be in substantial compliance with Emergency Preparedness requirements.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification survey was conducted by the Division of Licensing and Protection on 9/30 - 10/2/19. The following regulatory deficiencies were identified.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656	F 656 1. Resident #28 now has a care plan to address needs related to elopement risk and exit seeking behavior. 2. Residents residing in the facility that have exit seeking behavior and who are at risk for elopement have the potential to be affected by the alleged deficient practice. 3. Other residents with exit seeking behavior and who are at risk for elopement have been reviewed and care plans revised as needed to ensure needs are addressed.	

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

Administrator 10/17/19

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

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F 656	Continued From page 1 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop a comprehensive care plan for 1 of 18 residents (Resident # 28). Findings include: 1. Per record review, there is no care plan to address Resident # 28's needs related to elopement and exit seeking behaviors. Resident # 28 was admitted on 8/5/19. Review of social work and nursing notes indicate resident is actively exit seeking and is an elopement risk. On 10/2/19 at 9:00 AM, the Clinical Nursing Supervisor (CNS) stated that there should be a care plan to address resident needs related to elopement or exit seeking behaviors and confirmed that there was no care plan to address these behaviors.	F 656	4. Education will be provided to licensed nurses regarding the requirement to ensure needs are addressed in the resident care plan. 5. Audits will be done weekly by the Director of Nursing or designee to monitor effectiveness of the plan. 6. Results of the audits will be reported to the QAA committee x 3 months at which time the committee will determine further action needed. 7. Corrective action to be completed by 11/1/19. F656 POC accepted 10/24/19 Karen Campos	

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F 657	Continued From page 2	F 657		
F 657 SS=F	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that all the required members of the interdisciplinary team (IDT) were involved in preparing the comprehensive care plan for 11 of 19 residents sampled (Residents # 4, 5, 6, 14, 19, 23, 27, 30, 34, 43, and 45). In addition, 3 of 19 residents sampled did not have	F 657	F 657 1. Residents #4, 27, and 30 have had their care plans revised to reflect current needs. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. The process for interdisciplinary participation in the development and revision of care plans has been reviewed and revised to ensure all necessary departments have input into the care plan. 4. Education will be provided to the interdisciplinary team regarding the requirements for input into the care plan for each resident. 5. Education has also been provided to licensed nurses regarding the requirement for the care plan to be updated with change in needs for the residents. 6. Audits will be done weekly by the Director of Nursing or designee to monitor effectiveness of the plan.	

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F 657	Continued From page 3 care plans revised to reflect their current status, (Resident #4, 27, and 30). Findings include: 1. Resident #5 had a care plan meeting held on 7/9/19. The Social Service care plan meeting documentation lists the disciplines attending, and there was no LNA, Dietary staff, or MD/NP input documented. 2. Resident #6 had a care plan meeting held on 5/14/19. The Social Services note indicated that the dietary staff and MD/NP were not present at the meeting. There was no documentation to indicate that the absent members of the team had provided input into the care plan meeting 3. Resident # 14 had a care plan meeting held on 9/30/19. The Social Services note documenting attendance does not show that activities staff, dietary staff, or an LNA were at the meeting. There was no documentation provided by social services to indicate that the absent members of the team had provided input to the care plan meeting. 4. Resident #45 had a care plan meeting on 7/3/19. Social Services note indicated that there was no LNA, MD/NP, or dietary staff who attended the care plan meeting, or documentation that indicated they had any input in development of the care plan. 5. Resident #23 had a care plan meeting on 8/1/19. Social Services documentation did not include the presence of NP/MD, dietary staff, or LNA input at this meeting,or documentation that indicated they had any input in development of the care plan.	F 657	7. Results of the audits will be reported to the QAA committee x 3 months at which time the committee will determine further action needed. 8. Corrective action will be completed by 11/1/19. F657 POC accepted 10/24/19 Karen Campos RN	

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F 657	Continued From page 4 Per interview on 10/1/19 at 3:50 PM, the Director of Social Services confirmed that not all the interdisciplinary team members were present at the care plan meetings, or that the facility had a process for documenting the input of team members who did not attend. 6. Per review of the of the social service notes for Resident #30, who had a care plan meeting dated 08/28/19 at approximately 1 PM, does not identify the presence of all members of the Interdisciplinary Team (IDT). The members who were not present are the attending physician/nurse practitioner, a nurse's aide with the responsibility for the resident and a member of the food and nutrition services. The Director of Nurse (DNS) confirmed during interview on 10/1/19 and 10/2/19 that the full IDT has not consistently attended the care plan meetings, nor does the facility have a process for documenting the input of team members who did not attend. Also, per review of the person-centered care plan, last updated on 03/04/19, identifies that Resident #30 receives Seroquel 12.5 mg (milligrams) by mouth twice a day and 25 mg at bedtime. The medication was discontinued by the physician on 09/02/19. This was confirmed by the DNS on 10/03/19 at 2 PM via telephone and identifies that the care plan does not reflect the resident's current status. 7. Per review of the person-centered care plan for Resident #4, last updated on 03/01/19 identifies that the resident receives insulin daily. The insulin is no longer ordered. The plan also identifies that the resident has pain related to kidney stones. The resident required surgical intervention to extract the stones on 03/14/19.	F 657		

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F 657	Continued From page 5	F 657		

There is no evidence in the care plan that identifies the intervention. Confirmation was made by the DNS on 10/02/19 at 8:30 AM, that the care plan does not reflect the resident's current status.

8. Per review of the of the Interdisciplinary Care Plan Meeting Record for Resident #27, who had a care plan meeting dated 08/22/19, does not identify the presence of all members of the Interdisciplinary Team (IDT). The members who were not present are the attending physician/nurse practitioner, a nurse's aide with the responsibility for the resident, a member of the food and nutrition services. The Director of Nurse (DNS) confirmed during interview on 10/1/19 and 10/2/19 that the full IDT have not consistently attended the care plan meetings, nor does the facility have a process for documenting the input of team members who did not attend.

Also, per review of the Minimum Data Set (MDS) mandated assessment dated 09/25/19, identifies that the Resident #27 is totally dependent on staff for transfer between bed/chair/standing position by 2 staff who physically assist. The resident requires support of 2 staff members for ambulation in his/her room and/or corridor. Per review of the person-centered-care plan, last updated on 06/20/18 identifies that Resident #27, is at risk for falls/injury and walks all day long. Confirmation was made by the DNS on 10/02/19 that the person-centered care plan does not reflect Resident #27's current status.

9. Per review of the of the social service notes for Resident #19, who had a care plan meeting dated 07/30/19 at approximately 1:38 PM, does not identify presence all members of the

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F 657	Continued From page 6 Interdisciplinary Team (IDT). The members who were not present are the attending physician/nurse practitioner, a nurse's aide with the responsibility for the resident and a member of the food and nutrition services. The Director of Nurse (DNS) confirmed during interview on 10/1/19 and 10/2/19 that the full IDT have not consistently attended the care plan meetings, nor does the facility have a process for documenting the input of team members who did not attend. 10. Resident #34 had a care plan meeting on 8/27/19. The Social Services note documenting attendance indicates that only social services, nursing and activities staff were present, none of the other required members of the Interdisciplinary team (IDT) contributed to or attended the meeting as required. 11. Resident #43 had a care plan meeting on 9/26/19. The Social Services note documenting attendance indicates that only social services, nursing and activities staff were present, none of the other required members of the Interdisciplinary team (IDT) contributed to or attended the meeting as required. Per interview on 10/1/19 at approximately 2:09 PM The Director of Clinical Services confirmed that not all the interdisciplinary team members were present at the care plan meetings as required, and there is no process in place to consistently get input from those team members who did not attend.	F 657		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education.	F 730		

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F 730	Continued From page 7 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 record review and confirmed by staff interview the facility failed to ensure that 1 of 5 Licensed Nurse Aides (LNA's), received no less than (12) twelve hours of in-service education per year based on his/her individual performance review, (Employee 4). the findings include the following: Per review of Employee #4's file on 10/02/19 at approximately 9:30 AM in the presence of the Director of Clinical Services, identifies that the employee has completed a total of 7.5 hours of education since 09/28/18. The employee was hired on 04/04/17. A performance evaluation was completed on 04/08/19 and does not identify any weaknesses. However, the employee has not completed the educational requirements of 12 hours per year. The list of completed educational programs by Employee #4, does not include Abuse/Neglect/Exploitation training or Universal Precautions/Infection Control practices. This was confirmed by the Director at the time of the review.	F 730	F 730 1. Employee #4 will receive the required mandatory in-services. 2. Other employees of the facility will be reviewed to ensure the requirement for in-service hours are met. 3. Facility administration has reviewed and is aware of the required education to be provided to employees each year. 4. The tracking logs for employee in-servicing have been revised and are now current. 5. The Director of Nursing or designee will review the tracking logs monthly to ensure compliance with required in-servicing. 6. The Director of Nursing will review the findings with the QAA committee x 3 months at which time the committee will determine further action needed. 7. Corrective action to be completed by 11/1/19. F730 POC accepted 10/24/19 Karen Campos RN	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5	F 759		

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F 759	Continued From page 8 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that it's medication error rate was no greater than 5% during a medication administration observation, for Resident #10. The error rate was calculated at 10.34%. The findings include the following: 1. During a medication administration observation on 10/01/19 at 7:46 AM with a Licenses Practical Nurse (LPN), s/he was observed to administer (13) thirteen oral medications to Resident #10. Fibercon was ordered to be administered before meals and Lactaid was to be administered with meals. The resident confirmed at the time the medication was administered, that s/he had already eaten breakfast. The LPN confirmed at 8 AM that the medications were not administered as directed. 2. During a medication administration observation on 10/01/19 at 7:46 AM with a Licenses Practical Nurse (LPN), s/he was observed to administer (13) thirteen oral medications to Resident #10. The nurse surveyor reconciled the Medication Administration Record (MAR) with the physician's orders and identified that the resident was to receive Fluticasone nasal spray (a topical anti-inflammatory), at 8 AM. At the conclusion of the reconciliation, Resident #10 confirmed that s/he had not received the nasal spray. The LPN confirmed at 9:11 AM that the nasal spray has not been administered to Resident #10 as ordered.	F 759	F 759 1. Resident #10 had no negative affects as a result of the alleged deficient practice. 2. Residents with physician orders for medications have the potential to be affected by the alleged deficient practice. 3. In-servicing and medication pass audits will be done for licensed nurses to ensure orders are followed as written. 4. On-going medication pass audits will be completed by the Director of Nursing or designee monthly x 3 months to monitor effectiveness of the plan. 5. Reports of the audits will be reported to the QAA committee x 3 months at which time the committee will determine further action needed. 6. Corrective action will be completed by 11/1/19. F 759 POC accepted 10/24/19 Karen Campbell RN	
F 800 SS=C	Provided Diet Meets Needs of Each Resident CFR(s): 483.60	F 800		

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F 800	Continued From page 9 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview and record review, the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Findings include: During a 3 week period in August 2019, residents were served cold meals on 26 occasions between 8/7/19 - 8/25/19. Per interview on 9/30/19 at 3:49 PM, Resident # 1 stated that h/she was served only cold food in August. Per interview on 10/2/19 at 9:25 AM, Resident # 44 stated that h/she recalls a period in August where only cold meals were served. The resident stated "that's not all right". Two family members in the room during the interview also stated that they recalled the cold meals. Per review of facility menus with food temperatures confirm that cold meals were served on 26 occasions as described above. On 10/2/19 at 9:13 AM, the Head Cook confirmed there was a 3 week period in August 2019 that residents were served cold food at most meals. The Head Cook stated that the steam table had broken and was that staff were unaware how to provide hot meals without the steam table.	F 800	F 800 1. No residents were negatively affected by the alleged deficient practice. 2. Residents receiving meals in the facility have the potential to be affected by the alleged deficient practice. 3. The steam table has been repaired and hot meals are being served at the facility. F 880 POC accepted 10/24/19 Karen Lampson RN	
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2)	F 801		

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F 801	Continued From page 10 §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.	F 801	F 801 1. No residents were negatively affected by the alleged deficient practice. 2. Residents receiving meals in the facility have the potential to be affected by the alleged deficient practice. 3. The dietary services in the building now has oversight by a Certified Dietary Manager and there is a second manager that is in training to become certified. 4. The facility contracts with a Registered Dietician that is at the facility one day per week. F801 POC accepted 10/24/19 Karen Campo RN	

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PINES REHAB & HEALTH CTR	601 RED VILLAGE ROAD LYNDONVILLE, VT 05851

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 801	Continued From page 11	F 801		

(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service. this has the potential to affect all residents of the

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F 801	Continued From page 12 facility. Findings include: Per interview on 9/30/19 at 10:45 AM, the Head Cook (HC) stated that there is no full time Registered Dietician or Food Service Director. The HC stated that h/she was an LNA (Licensed Nursing Assistant) and had been the HC for approximately 2 months. The Head cook also confirmed that h/she had no formal training in the role of Dietary/kitchen manager. On 10/01/19 at 11:01 AM, the facility Administrator confirmed there is not a full time Registered Dietician and that there is not a Dietary Director in place that meets regulatory requirements.	F 801		
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by:	F 802	F 802 1. No residents were negatively affected related to the alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. The dietary services in the facility now has oversight by a Certified Dietary Manager and a second manager is in training to become certified. 4. Training and education will be provided to dietary staff regarding proper food storage and temperature of food.	

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F 802	Continued From page 13 Based on observation, staff and resident interview and record review, the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service. This has the potential to affect all residents of the facility. Findings include: Per interview on 9/30/19 at 10:45 AM, the Head Cook (HC) stated that there is no full time Registered Dietician or Food Service Director. The HC stated that h/she was an LNA (Licensed Nursing Assistant) and had been the HC for approximately 2 months. The Head cook also confirmed that h/she had no formal training in the role of Dietary/kitchen manager. The HC stated that food storage and food temperatures were not being properly recorded due to lack of training and qualified staff. On 10/1/19, a dietary aide stated during interview that h/she did not have enough training to do the job properly. During the 3 survey days, staff from other nursing facilities were observed assisting in the kitchen. Review of the kitchen schedule showed only 1 dietary staff on duty on several occasions. On 10/2/19, the Maintenance Director was observed doing dishes. On 10/2/19 at 11:30 AM, the Administrator and Director of Operations confirmed during interview the lack of qualified staff is due to non-qualified management overseeing the dietary department.	F 802	5. Facility administration will continue to review daily staffing in the dietary department to ensure enough staff to meet the needs of the residents. 6. Weekly audits will be completed by the administrator or designee to monitor compliance. 7. Results of the audits will be reported to the QAA committee x 3 months at which time the committee will determine further action needed. 8. Corrective action to be completed by 11/1/19 F802 POC accepted 10/24/19 Karen Campos RD	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		

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F 812	Continued From page 14 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 observation and staff interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. This has the potential to affect all residents of the facility. Findings include: During the initial kitchen tour with the Head Cook (HC) on 09/30/19 at 10:45 AM., the following observations were made: 1. There were no dishwasher temperatures recorded in September 2019. 2. There are no recorded 3 bay sink sanitizer levels despite being observed in use. 3. Two wall mounted air conditioning units were soiled with dust and grease. 4. A wall mounted knife storage unit containing knives that are used daily was soiled with dust	F 812	F 812 1. No residents were negatively affected by the alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. All identified areas that required cleaning have been cleaned. 4. Policies have been developed to address food storage and requirements to record temperatures of refrigerators, freezers, and food, and requirements to monitor levels of sanitizers. 5. Education will be provided to dietary staff regarding the above policies. 6. Audits will be completed weekly by the administrator or designee to monitor effectiveness of the plan. 7. Results of the audits will be reported to the QAA committee x 3 months at which time the committee will determine further action needed. 8. Corrective action to be completed by 11/1/19.	

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F 812	Continued From page 15 and grease. 5. An upright freezer in the kitchen had no recorded temperatures since 9/4/19. 6. A freezer used for ice cream had no recorded temperatures. 7. In the walk-in refrigerator, there were 2 plastic bags identified as cooked chicken that were unlabeled. The chicken was being thawed on the top shelf. There was food on shelves underneath the chicken. The HC was unable to identify when the chicken was thawed, placed in the refrigerator or expires. 8. There were 3 freezers in the basement. The vegetable freezer had no recorded temperatures in September 2019. The meat freezer and freezer in the dry storage area had no recorded temperatures. 9. The wire shelving in the reach-in refrigerator were rusted and soiled. 10. A refrigerator used for milk in the kitchen had no recorded temperatures. 11. There are no recorded food temperatures for September 2019. In August 2019, there were 8 meal occasions with no recorded temperatures. The Head cook confirmed the above observations during the initial tour. Additionally, the Head Cook was unsure if there are related kitchen policies.	F 812	F 812 PoC accepted 10/24/19 Karen Campo RN	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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	F 880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 880	Continued From page 16 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880	F 880 1. No residents were negatively affected by the alleged deficient practice. 2. Residents requiring blood glucose monitoring have the potential to be affected by the alleged deficient practice. 3. The policy for cleaning and disinfecting of blood glucose monitors has been reviewed and revised to follow manufacture guidelines. 4. Education has been provided regarding the above policy. 5. Audits will be completed weekly by the Director of Nursing or designee to monitor effectiveness of the plan. 6. Results of the audits will be reported to the QAA committee x 3 months at which time the committee will determine further action needed. 7. Corrective action to be completed by 11/1/19. F880 PoC accepted 10/24/19 Karen Campos RN	

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F 880	Continued From page 17 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 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview, the facility failed to ensure that all staff carried out infection control practices to prevent the development and transmission of communicable diseases and infection related to the management of resident equipment. Finding include: During observation on 10/1/19 at approximately 8:28 AM the Licensed Practical Nurse (LPN) was observed wiping down a shared glucometer (a medical device for determining the approximate concentration of glucose in the blood) using an alcohol swab. Per interview at the time of the observation, the LPN confirmed that the glucometer was used for more than one resident and that it was his/her practice to wipe it down after use with an alcohol swab.	F 880		

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F 880	Continued From page 18 In reviewing the manufacturer's user instruction manual, it indicates that cleaning and disinfecting guidelines were to use a commercially available disinfectant or germicide wipe. In interview on 10/1/19 at approximately 10:00 AM, The Director of Clinical Services confirmed the protocol for cleaning and disinfecting the glucometer had not been followed.	F 880		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Notice Requirements Before Transfer/Discharge 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 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: (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

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

The above isolated deficiencies pose no actual harm to the residents

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F 623	Continued From Page 1 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. §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 record review and staff interview, the facility failed to issue a written notice of transfer/discharge to the resident and/or legal representative for 2 of 4 residents (Residents #5, 19). Findings include: 1. Per record review, Resident # 5 had a fall on 9/29/19, and was sent to the Emergency Department for evaluation. There was no notice of transfer provided to the resident's legal representative as required. Per interview on 10/1/19 at 3:15 PM, the Social Services Director confirmed that this transfer happened on a weekend and that the notice was not issued. 2. Per record review, Resident #19, with diagnoses to include, but not limited to Parkinson's Disease, Personality Disorder and Anxiety, had an unwitnessed fall on 07/06/19 at approximately 11 AM. The resident sustained a facial laceration and was sent to the Emergency Room for evaluation. There is no evidence in the medical record that a written notice of transfer was provided to the resident/resident's legal representative as required. Per interview with the Social Service Director on 10/01/19 at approximately 3 PM, confirmation is made that a written notice was not provided as required. Confirmation was also made that the transfer occurred on a weekend and there is no process in place ensuring that notices are provided on weekends, holidays and/or at time of leave.
F 625	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;

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(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to issue a written notice of bed-hold policy to the resident and/or legal representative upon transfer to the hospital for 2 of 4 residents (Residents #5, 19). Findings include:

1. Per record review, Resident # 5 had a fall on 9/29/19, and was sent to the Emergency Department for evaluation. There was no notice of bed-hold policy provided to the resident or resident's legal representative as required. Per interview on 10/1/19 at 3:15 PM, the Social Services Director confirmed that this transfer happened on a weekend and that the bed-hold notice was not issued.

2. Per record review, Resident #19 had an unwitnessed fall on 07/06/19 at approximately 11 AM. The resident sustained a facial laceration and was sent to the Emergency Room for evaluation. There is no evidence in the medical record that a written notice of bed-hold was provided to the resident/resident's legal representative as required. Per interview with the Social Service Director on 10/01/19 at approximately 3 PM, confirmation is made that a written notice was not provided as required. Confirmation was also made that the transfer occurred on a weekend and there is no process in place ensuring that notices are provided on weekends, holidays and/or at time of leave.