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
	166197	A. BUILDING _____ B. WING _____	01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR FALLS HEALTH CARE CENTER	1728 WEST EIGHTH STREET CEDAR FALLS, IA 50613

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F 000	INITIAL COMMENTS VKC 1/27/17 Correction date 2/8/17 The following deficiencies relate to the facility's annual health survey. (See code of federal regulations (42CFR) Part 483, Subpart B-C)	F 000	This plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared solely because it is required by State and Federal Law.	
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide clean and sanitary resident equipment and a homelike resident environment. The facility census was 67 residents. Findings include: 1. During environmental tour on 1/11/17 at 1:25 p.m., with the Administrator and Environmental Supervisor the following concerns were identified: a. A Hallway had areas of missing flooring by rooms that measured approximately 4 inches long and 3/4 inches wide along the flooring seam and areas around the floor cleanout drain that measured approximately 8 inches long and 2 inches wide on all 4 sides. b. The shower room in A Hallway along the south, west and north side of the shower had a light brown substance in the corner of the wall, on floor tile and around the facet handle. The shower corners appeared dark and soiled. The brown wall vent on the west wall was rusted and the wire conduit on the south wall was rusted. The wheelchair scale was soiled and had areas of missing material in the mat.	F 253	F 253 It is the facility practice to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. #1 a. Flooring bids were obtained on 1/26/2017 and upon final approval, will be installed within two to six months. b. Facility is investigating different options to remove brown glue like substance. Bids will be obtained and facility will proceed to address this issue. All work should be completed within two months. The rusted brown wall vent will be repaired by 2/8/17. The wire conduit on the south wall will be replaced by 2/8/17. The wheel chair scale was cleaned on 1/11/17. A replacement matt for wheel chair scale was ordered on 1/26/2017. c. The ceilings and walls in rooms 8,9,10,22 & 24 were re-caulked and trim will be placed to enhance stability by 2/8/2017. d. Corner guards will be replaced on the corners in B hallway by 2/8/17. The base cove on the west side of the b hallway will be replaced by 2/8/17. e The doorways down the C hallway will be painted by 2/8/17. The triangle shape of missing plaster was patched and painted on 1/25/17. f. The dark caulking substance coming out of the corners of the shower area will have been removed by 02/8/17. Any missing areas will be repaired and regrouted by 2/8/17.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sheri Sigler	Administrator	1/26/17

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 253	Continued From page 1 c. The ceiling and wall in rooms 8, 9, 10, 22 & 24 was separated along the hallway side. Areas of caulking was pulled to approximately 1 inch deep along the length of the room. d. The corners in the B Hallway were marred and chipped. The base cove on the west side of the B hallway was soiled and marred approximately 35 feet. e. The doorways down the C Hallway had chipped paint. A triangle shape of missing plaster was approximately 4 inches long to 2 inches wide and had multiple chips around the area. f. The shower room in the C Hallway had a dark caulking like substance coming out of the corners of the shower area with missing areas on the tile being sealed and exposed to water getting under the tile. During interview on 1/12/17 at 9:50 a.m., the Administrator explained the corner guards for the B hall had not been ordered until yesterday after the environmental tour and acknowledged the above areas were in need of being taken care of, and the floor as not being sanitizable. 2. On 1/10/17 at 6:45 a.m., Staff A, Certified Nurse Aide, CNA and Staff B, CNA transferred Resident #1 into a wheel chair. Observation revealed the wheelchair had a large area of dried food dripped down the front cushion and on the seat. On 1/12/17 at 8:00 a.m., the resident propelled themselves up the hall in the wheelchair. Observation revealed the substance remained on the front of the wheel chair seat and cushion. At that time the Administrator stated staff cleaned wheel chairs on resident shower days but would expect staff to clean up food or other spills as they occur.	F 253	2. The substance from the wheelchair was removed on 1/12/17. #2 A tour of the facility was completed by the Regional Director of Operations and the Administrator on 1/26/2017. Any housekeeping or maintenance concerns were addressed. #3 The Administrator or designee will randomly audit facility for housekeeping and maintenance services to ensure sanitary, orderly, and comfortable interior on a weekly basis for three months. Any issues identified will be addressed. #4 Results of audits will be reported by the Administrator or designee to QAPI Committee monthly for a minimum of 3 months to ensure ongoing compliance.	

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F 279	Continued From page 2	F 279		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (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 rehabilitative services the nursing facility will	F 279	F 279 It is the facility practice to develop a comprehensive care plan that addresses problems and interventions to prevent development, promote healing and prevent a decline of areas of altered skin integrity. #1- Resident #3 transitioned home from the facility on 1/23/2017. No further corrective action required. #2- Similar residents were reviewed on 1/26/2017 by the Care Plan Coordinator. Any residents at risk for skin breakdown or with actual skin breakdown were evaluated and care plans reviewed/updated to ensure appropriate interventions are in place. #3- On 1/26/2017 the Care Plan Coordinator was provided education by the Director of Nursing regarding process to ensure care plans reflect prevention and healing promotion interventions as appropriate. The Director of Nursing or designee will randomly audit a minimum of 3 care plans per week for 3 months to ensure compliance. Any concerns identified will be addressed. #4 Results of audits will be reported by Director of Nursing or designee to QAPI Committee monthly for a minimum of 3 months to ensure ongoing compliance.	

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F 279	Continued From page 3 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 clinical record review and staff interview, the facility failed to develop a comprehensive care plan that included a problem or interventions to prevent, promote healing and prevent a decline of areas of altered skin integrity for one of three residents reviewed with open wounds. (Resident #3) The facility census was 67 residents. Findings include: The Minimum Data Set (MDS) assessment dated 12/26/17, documented Resident #3 had diagnoses of urinary tract infection, diabetes mellitus and cellulitis. The MDS documented the	F 279		

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F 279	Continued From page 4 resident required extensive assistance for bed mobility and dressing and was at risk of developing pressure ulcer and moisture associated skin damage. The resident was not on a turning/repositioning program. The care plan dated 12/1/16, included no problem related to alteration in skin integrity or interventions to treat or prevent such. A weekly skin report dated 1/3/17, documented the resident had a 0.8 centimeter (cm) open area not acquired in-house and first identified 11/28/16. The form documented the resident had a 0.3 cm x 0.3 cm open area on the left buttock, first identified 11/27/16. On 1/11/17 at 8:00 a.m., the Director of Nursing stated the care plan nurse add a problem for skin issues to the care plan and stated it should have already been on the care plan.	F 279		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to ensure perineal cares were provided in a manner to prevent infection for two of eight residents reviewed. (Resident #1 & #3) The facility census was 67 residents. Findings include:	F 312	F 312 It is the practice of this facility to provide necessary services to maintain good nutrition, grooming, personal and oral hygiene to residents unable to carry out activities of daily living. #1 Resident #3 transitioned to home on 1/23/2017. No further corrective action required. Staff were educated in the form of an in-service on 1-24-2017 regarding proper perineal care techniques for resident #1. #2 For all similar residents, staff were educated in the form of an in-service on 1-24-2017 regarding proper perineal care techniques.	

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F 312	Continued From page 5 1. The Minimum Data Set (MDS) assessment dated 11/18/16, documented Resident #1 had diagnoses of diabetes mellitus and psychotic disorder and required extensive assistance for transfer and toileting. During observation on 1/10/17 at 6:45 a.m., Staff A, Certified Nurse Aide, CNA and Staff B, CNA assisted the resident to the bathroom. When the resident finished, Staff A assisted the resident to stand and made multiple back to front wipes over the residents buttocks and rectal area to the center of the perineal area. 2. The MDS assessment dated 12/26/16, documented Resident #3 had diagnoses of urinary tract infection, diabetes mellitus and cellulitis and required extensive assistance for bed mobility and dressing. During observation on 1/10/17 at 8:35 a.m., the resident was incontinent of stool and laid in bed on the left side. Staff A used a cloth and made back to front wipes over the rectal area to the center of the perineal area. During interview on 1/12/17 at 8:10 a.m., the Director of Nursing stated the facility routinely did audits on incontinence care and staff were instructed to wipe from front to back.	F 312	#3 The Director of Nursing or designee will conduct random audits of perineal care a minimum of 5 times weekly for a minimum of 1 month and randomly thereafter including samples from all 3 shifts to ensure compliance. Any concerns identified will be addressed. #4 Results of audits will be reported by Director of Nursing or designee to QAPI Committee monthly for a minimum of 3 months to ensure ongoing compliance.	
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the	F 314	F314 #1 Resident #3 transitioned home on 1/23/2017. No further actions are required.	

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F 314	Continued From page 6 facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interviews, the facility failed to prevent the development, promote healing and prevent infection of pressure ulcers (Resident #3). The facility identified a census of 67 residents and the sample consisted of 3 residents. Resident #3 had a coccyx pressure ulcer upon admission and a blister on the abdominal fold. The resident developed additional open areas on the buttocks and the coccyx area increased in size due to lack of timely repositioning and thigh wound areas due to pressure from the tubing of the bladder indwelling catheter. Observation identified the resident not repositioned in order to promote healing and prevent further development of pressure ulcers. Observation during cares identified a staff member performing incontinency care and contaminated the wound by moving the soiled cloth over the open area. Findings include: Resident #3 had a 14 day assessment with a	F 314	#2 Similar residents were reviewed by the Director of Nursing and Assistant Director of Nursing on 1/25/2017. In-service education was completed on 1/24/2017 with staff regarding pressure ulcer prevention, proper perineal care for infection prevention and promotion of healing. Staff C was educated on 01/25/2017 by the Director of Nursing regarding proper treatment technique to prevent infection, interventions to promote healing and interventions for pressure ulcer prevention. #3 The Director of Nursing and Assistant Director of Nursing will personally oversee the skin program effective 1/25/2017 for a minimum of 3 months to ensure pressure areas are prevented unless clinically unavoidable, promotion of healing and prevention of infection. Audits of infection prevention and pressure ulcer prevention interventions will be conducted a minimum of 5 times per week to include samples from all 3 shifts for a minimum of 3 months. Any problems identified will be immediately addressed. #4 Results of audits will be reported by Director of Nursing or designee to QAPI Committee monthly for a minimum of 3 months to ensure ongoing compliance.	

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reference date of 12/5/16. The MDS identified Resident #3 had no cognitive problems and required extensive assistance from staff for bed mobility and transfers. The resident experienced incontinent episodes and had a Foley indwelling bladder catheter to drain urine into a bag. The MDS identified the resident at risk for the development of pressure ulcers and did not have any pressure ulcers present. The MDS indicated the resident had moisture associated skin damage (MASD) and had pressure reducing devices on the bed and in the chair. The MDS identified the resident had diagnoses including urinary tract infection, diabetes mellitus and cellulitis.

Resident #3 had a MDS (Minimum Data Set) assessment with a reference date of 12/26/16. The MDS documented the resident required extensive assistance of 1 staff person for bed mobility and dressing. The MDS identified the resident to be at risk for the development of pressure ulcers. The MDS identified a risk for developing pressure ulcers, had moisture associated skin damage and no unhealed pressure ulcers. The MDS documented the resident had no turning/repositioning program. The resident experienced bowel incontinence frequently and had a bladder indwelling catheter.

A Nursing Admission Data Collection assessment dated 11/28/16, documented the resident had an open area, located on the coccyx which measured 4.0 cm x [by] 0.1 cm, and superficial. The form identified no other open areas on admission, and a blister on the abdominal fold.

The care plan dated 12/1/16 included no problem related to alteration in skin integrity or

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F 314	Continued From page 8 interventions to identify prevent, promote healing, etc. A weekly skin report all "other" skin problems worksheet dated 1/3/17, documented the resident had a 0.8 centimeter (cm) x 0.2 cm open area on the coccyx (not facility acquired) and first identified on 11/28/16. The form also documented the resident had a 0.3 cm x 0.3 cm open area on the left buttock, first identified 11/27/16. During the initial facility tour on 1/9/17 at 10:15 a.m., the facility Director of Nursing (DON) identified the resident as being a reliable interview. During an observation on 1/10/17 at 8:40 a.m., the resident laid in bed on back (supine position). Staff A (Certified Nurse Aide, CNA) and Staff B CNA assisted the resident with morning cares. Staff A and Staff B (CNA) assisted the resident to turn to the left. Observation identified bright red blood on a soaker [thick incontinence pad) pad under the resident. The resident had stool incontinence. The resident had visible open areas on the coccyx and right and left inner buttock. Staff A used a cloth and wiped stool over the open areas, as well as over an open area on the resident ' s right inner thigh. At that time Staff B exited the room and returned with Staff C (Licensed Practical Nurse, LPN). Observation identified at that time, the resident had a deep red linear discolored area of skin which ran across the anterior upper thigh and visible when the catheter tube had been moved from the area. Staff A assisted the resident to turn to the right so Staff C could assess the open areas. Observation again identified open areas to the right inner thigh, coccyx and right and left buttock. At that	F 314		

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F 314	Continued From page 9 time Staff C directed Staff B to make sure they cleaned the resident well and stated they would return to complete a treatment to the areas. Staff A and Staff B continued to assist the resident to complete morning cares and at 9:00 a.m., assisted the resident to transfer to a wheelchair. At that time the resident stated they normally got up at 7:30-8:00 a.m. Staff C returned to the room and the resident stated since they were already up and dressed, she/he wanted to eat breakfast before the treatment. At that time Staff A verified they and Staff B had been the aides assigned to the wing and this had been the first time they had been in the room to provide any care to the resident, which would have last been done prior to 6:00 a.m. by the night shift and they did not know what time. Observation at 11:00 a.m. (same day-1/10/17), the resident sat in their room in the wheel chair. At 1:00 p.m., the resident sat in their room in the wheelchair. At 1:30 p.m., the resident sat in their room in the wheelchair. At that time, Staff C verified they had not provided a treatment to the resident but would let the surveyor know when they completed it. Staff C stated they had asked the resident a few times already and the resident did not want to lie down so they could do the treatment. Staff C stated they had asked the resident at breakfast time and again when the resident had gotten their lunch. Staff C then entered the resident ' s room with the surveyor. Staff C asked the resident if they could do the treatment to their bottom and the resident stated they had been scheduled to go to therapy then. At that time the resident stated no staff had been in the room to reposition him/her since they had been transferred to the	F 314		

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wheelchair that morning. The resident stated their bottom hurt but staff did not believe that. Staff C stated they would send someone in to reposition the resident.

At 3:00 p.m., the resident sat in their room in the wheelchair. The resident verified a staff person had just been in to help him/her reposition in the wheel chair.

At 3:05 p.m., the surveyor informed the facility DON the resident had been sitting in the wheel chair with open areas identified that morning which had not yet been treated. Staff C then stated the resident had been in the therapy room at that time. The surveyor informed Staff C the resident had been observed sitting in the wheelchair in their room. Staff C stated they could then do the treatment.

Observation at 3:15 p.m. (same day-1/10/17), identified Staff D (CNA) and Staff E (CNA) transfer the resident from the wheelchair to the bed and removed the resident ' s pants. Staff C noticed the linear dark red line which remained on the resident ' s right anterior and inner thigh and stated "Oh what is that". Staff C then stated it looked like the catheter tube on the leg to be tight. Staff C measured the area to be 10.0 cm x 0.4 cm. Staff C asked the resident to turn and the resident stated they needed help to roll in bed. Staff C assisted the resident to turn to the left. Observation identified a visible open area on the right inner thigh with a small amount of bleeding. The resident complained of pain to the bottom area. Staff C informed the resident their skin had broken down more. Staff C told the resident they needed to be repositioned more. Staff C then measured the following superficially open areas:

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(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 314	Continued From page 11 a. coccyx, 2.3 cm x .3 cm b. left gluteal cleft, 1.0 cm x 1.0 cm c. left gluteal cleft, 0.6 cm x 0.2 cm d. right gluteal cleft, 1.5 cm x 0.4 cm e. right gluteal cleft, 0.7 cm x 0.4 cm f. right gluteal cleft, 1.5 cm x 1.0 cm g. right inner thigh, 1.2 cm x 0.5 cm h. right posterior thigh, 0.5 cm x 0.2 cm Staff C also measured a red area on the left inner thigh 1.0 cm x 0.3 cm. Staff C then applied Silvadene (anti-bacterial cream) cream to all areas with no cleansing of the areas prior to the application. A Progress Note dated 1/10/17 at 4:03 p.m., documented the measurements obtained and did not include the open area measured on the right inner thigh, 1.2 cm x 0.5 cm., or the red area on the left inner thigh 1.0 cm x 0.3 cm.. The note documented the Impact Team had been called. Review of skin grid for all "other" skin impairment forms revealed no sheet for the open area to the coccyx or the left gluteal cleft 0.6 x 0.2 cm or right inner thigh 1.2 cm x 0.5 cm A physician order summary dated 1/10/17 at 5:17 p.m., documented a treatment change made due to new areas.	F 314		

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	165197	A. BUILDING _____ B. WING _____	01/12/2017

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F 314	Continued From page 12 A physician order dated 1/10/17 included a directive for Calazime skin protectant paste to the right and left buttocks twice a day for skin breakdown. On 1/11/17 at 8:00 a.m., the facility DON stated they had panicked the previous day when the discussed of the resident ' s open areas. The DON stated they had added a low-air loss mattress to the resident ' s bed and another cushion to the resident ' s wheelchair. The DON stated they now felt they had just panicked and should not have added the interventions because the areas were not pressure related. The DON stated they had also had the care plan nurse add a problem for skin to the care plan and it should have been on it already. At 9:15 a.m., the facility DON stated they were not sure how Staff C documented all of the wound measurements but they had been unable to find anything more than had been provided. The DON verified they had added a gel cushion to the resident ' s wheel chair because it would reduce pressure to the areas more than the one that had already been in the chair.	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based	F 315	F 315 It is the practice of the facility to ensure that appropriate catheter care is provided to residents. #1 Resident #3 transitioned home 1/23/2017. No further action required. #2 For similar residents, staff were educated in the form of an in-service on 1-24-2017 regarding proper catheter care.	

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F 315	Continued From page 13 on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to ensure staff completed appropriate catheter cares after an incontinent episode for one of two residents reviewed with an indwelling urinary catheter. (Resident #3). The facility census was 67 residents. Findings include: The Minimum Data Set (MDS) assessment dated	F 315	#3 The Director of Nursing or designee will perform catheter care audits 3 times per week for a minimum of 1 month and randomly thereafter to ensure compliance. Any concerns identified will be addressed. #4 Results of audits will be reported by Director of Nursing or designee to QAPI Committee monthly for a minimum of 3 months to ensure ongoing compliance.	

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F 315	Continued From page 14 12/26/16, documented Resident #3 had diagnoses of urinary tract infection, diabetes mellitus and cellulitis and required extensive assistance for bed mobility and dressing. The care plan dated 12/1/16, included a diagnoses of urinary tract infection with an intervention for catheter care every shift and as needed. During observation on 1/10/17 at 8:40 a.m., the resident laid in bed on their back after being incontinent of stool. Staff A, Certified Nurse Aide, CNA cleansed the stool from the residents left groin and right groin. Staff A cleansed a small portion, approximately one inch of the residents Foley catheter with the same cloth used to cleanse stool from the residents groin. Staff A failed to use a clean cloth to complete any further cleansing of the Foley catheter tube or around the insertion site. During interview on 1/12/17 at 8:10 a.m., the Director of Nursing stated staff were educated to cleanse the catheter tubing as part of catheter care and the facility did audits periodically. A review of the facility nursing procedure manual for catheter care dated 1/13, revealed a directive to gently cleanse the urethral/catheter junction and about three inches of the catheter from the urethra outward avoiding traction.	F 315		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 371	F 371 It is the practice of the facility to date and label resident food items, ensure kitchen equipment is stabilizable and staff handle food items in a sanitary manner.	

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F 371	Continued From page 15 (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. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to date and label resident food items, failed to ensure kitchen equipment was properly sanitizable and failed to ensure staff handled resident food items in a sanitary manner. The facility census was 67 residents. Findings include: 1. During the initial tour of the kitchen on 1/9/17 at 9:35 a.m., observation of a two door refrigerator revealed and opened box of bacon with no date or label, a ham with no date or label uncovered and a clear plastic bag with two cooked meat patties with no date or label. The unlabeled hamburger patties were identified	F 371	#1. On 1/09/2017, box of bacon was labeled and dated, ham was covered and dated and the clear plastic bag with two cooked meat patties was removed. The three Teflon frying pans and three cutting boards were thrown away and three new Teflon frying pans and cutting boards were purchased on 1/11/2017. Staff H and Staff G were educated immediately on 1/10/2017 on the Cleaning and Sanitizing policy. Kitchen staff will be educated during Dietary In-Service on 2/01/2017. Staff H was educated immediately on 1/10/2017 on the Personal Hygiene policy. Kitchen staff will be educated during Dietary In-Service on 2/01/2017. #2 Dietary Services Manager and Administrator toured the kitchen on 1/11/17 to ensure food items were labeled and dated, kitchen items were sanitizable and staff were handling food items in a sanitary manner. Any issues were corrected. #3 The Administrator and Dietary Services Manager will monitor labeling, dating, kitchen equipment sanitation, and proper food handling techniques 3 times weekly for one month and randomly thereafter to ensure compliance. #4 Results of audits will be reported to QAPI Committee monthly for a minimum of 3 months to ensure ongoing compliance. **Date of Compliance: 02/08/2017**	

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F 371	Continued From page 16 by Staff H, cook at the time and disposed of in the trash can. Staff H stated the items should have been dated and labeled. 2. During observation of food preparation 1/10/17 at 11:05 a.m., three Teflon frying pans had scratched and bubbled surfaces. The pans were used at 11:40 a.m. to make grilled cheese and fried eggs. Observation revealed three cutting boards, red, green and blue with a white fuzzy surface. During interview on 1/11/17 at 12:55 p.m., the dietary manager stated that pans and cutting boards would be replaced. 3. Observation of lunch preparation on 1/10/17 at 11:15 a.m., revealed Staff H, cook fill a green bucket with plain water from the faucet and utilized it to wipe down the food preparation area between the stove and microwave and areas between the stove and refrigerator. During lunch observation Staff G, cook picked up a marker off the floor and put it on the prep surface area. Staff H continued to butter bread in this area and make grilled cheese. Staff G used the food preparation area to make pureed green bean casserole and turkey for the noon meal adding bread and butter to turkey that was prepped on an unsanitized surface. During interview on 1/11/17 at 12:55 p.m., Staff G with dietary manager present stated green works cleanser should be utilized to clean the preparation areas and wiped the surface with sanitizer prior to making food. Review of the facility policy provided by the facility titled Cleaning and Sanitizing dated 6/2015,	F 371		

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F 371	Continued From page 17 stated counters and tabletops are cleaned before and after food preparation. Wipe with a clean cloth soaked in clear, hot water. Spray counter with sanitizing solution and wipe with clean dampened cloth. 4. During the lunch observation on 1/10/17 at 11:05 a.m., Staff H, cook washed hands and used gloves to assemble grilled cheese sandwiches. Staff H went to the refrigerator and touched door handles to retrieve cheese and without changing gloves opened saran wrap and touched the cheese. Staff H covered grilled cheese and placed it in the refrigerator. During meal service when residents ordered grilled cheese or fried egg sandwich Staff H removed grilled cheese or eggs from refrigerator with gloved hands touching contaminated surfaces and place them in the fry pan to cook without washing hands or changing gloves between tasks. During interview on 1/11/17 at 12:55 p.m., Staff G with dietary manager present stated hands should be washed and clean gloves applied after touching contaminated surfaces. Review of the facility policy provided by the facility titled Personal Hygiene dated 6/2015, stated all staff involved in handling food follows proper personal hygiene practices to prevent contamination of food. The policy directed staff to wash hands after touching anything that may contaminate hands, such as unsanitized equipment, work surfaces or wash cloths.	F 371		