STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165562	A. BUILDING _____ B. WING _____	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE CARE CENTER	120 NORTH THIRTEENTH STREET ALBIA, IA 52531

(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 000	INITIAL COMMENTS Correction Date 5/5/17 The following deficiencies are the result of the recertification and licensure survey conducted May 1 - 4, 2017. See code 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because the provisions of federal and/ or state law require it.	
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	F 279	It is the practice of the facility to develop comprehensive care plans. 1. Care plan for resident #1 was reviewed and updated to address the prevention and development of pressure ulcers and prevent infection when caring for an open pressure ulcer on 5/5/2017 by the interdisciplinary team. 2. An audit of care plans for residents at risk for development of pressure ulcers and goals for healing if a resident obtained an ulcer was completed by the DON on 5/5/2017. 3. In-service education was provided to facility staff on 5/5/2017 by the DON on prevention and development of pressure ulcers and prevention of infection.	5/5/2017

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

[signature] | Administrator | 5/17/17

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 279	Continued From page 1 (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 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 observation, staff interviews and record review, the facility failed to develop a Care Plan with goals and interventions to prevent the development of pressure ulcers (Resident #1). The facility identified 5 of 55 residents with pressure ulcers. the sample consisted of 5	F 279	(Continue from page one) 4. DON/ designee will complete random audits/ rounds to ensure prevention of pressure ulcer development and prevention of infection is being achieved. Immediate staff education will be provided if non-compliance is noted. DON/ designeewill report findings of random audits/ rounds to the QAPI committee until compliance is achieved.	

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F 279	Continued From page 2 residents. The MDS assessment and Care Plan lacked focus for the resident to be at risk for the development of pressure ulcers and goals for healing if a resident obtained an ulcer. Although the Care Plan listed a pressure reducing device on the bed and chair, the approaches lacked multiple other interventions to prevent the development of pressure ulcers and prevent infection when caring for an open pressure ulcer. Findings include: 1. Resident #1 had an admission MDS (Minimum Data Set) assessment with a reference date of 3/1/17. The MDS identified the resident had a BIMS (Brief Interview of Mental Status) score of 8. A score of 8-12 indicated moderate cognitive impairment. The MDS indicated the resident required extensive assistance of 1 staff member for bed mobility, transfers, dressing, toilet use, person hygiene and experienced frequent episodes of bladder and bowel incontinence. The MDS identified and included diagnoses of pneumonia, diabetes, non-Alzheimer's dementia, Parkinson's disease. The MDS reported the resident at risk for the development of pressure ulcers and had no unhealed pressure ulcers or skin damage. The 3/10/17 quarterly MDS assessment indicated the resident required extensive assistance of 1 staff for bed mobility, transfers, dressing, toilet use, person hygiene and frequently incontinent of bowel and bladder. The MDS continued to identify the resident at risk for pressure ulcer development and had no unhealed pressure ulcers but had moisture associated skin damage.	F 279	Continued From Page 2	

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F 279	Continued From page 3 The Care Plan dated 3/7/17 recorded Resident #1 had a risk for skin break down related to diabetes and incontinence. Interventions included a cushion in the wheelchair and a therapeutic mattress to his/her bed and assistance with transfers and repositioning. Further interventions for incontinence required staff to assist the resident to the bathroom and provide perineal care. The Care Plan lacked a comprehensive plan to care for a pressure ulcer or skin breakdown such as a turning and repositioning program, treatments, etc. The Care Plan was updated on 3/22/17 and included a change from a therapeutic mattress to an air mattress on the resident's bed. The Nurse's Notes dated 3/17/17 at 5:10 p.m. indicated a Certified Nursing Aide (CNA) reported a reddened are at the gluteal fold on the resident's right buttock. The area measured 2 centimeters (cm) circular red, firm to touch and very tender. In the center a 1 cm superficial chafed area. The 3/17/17 Physician's Telephone Order at 5:10 p.m. recorded an order for Allevyn (dressing) 3 x3 to right gluteal fold, buttock for 10 days or healed and to check area daily and change every 7 days or as needed. The 3/22/17 Physician's Telephone Order at 6:45 a.m. recorded an order for Tegaderm (dressing) to decubitus on the right ischial tuberosity (lower buttock). The 3/22/17 weekly skin assessment at 7:30 a.m. recorded a Stage II pressure ulcer, 3-4 cm round, open area with drainage with a 6 -7 cm reddened	F 279	Continued From Page 3	

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F 279	Continued From page 4 firm area surrounding the open area. The 3/24/17 skin assessment recorded a Stage II pressure ulcer 4 cm x [by] 3 cm. On 5/2/17 at 11:20 a.m. observation of a treatment by Staff D, Registered Nurse (RN) and in the presence of Staff C RN. Staff D pushed Resident #1's brief out of the way to remove the dressing. Once the nurse moved her hand, the brief fell over the wound. Staff D continued with cleansing the wound and again the brief fell back over the wound once she moved her hand. Staff D next took the medication cup with gauze soaked in Gentamycin holding the cup in close proximity to the brief and packed the wound with the gauze. Once again the brief fell back over the wound and Staff D moved her hand. Staff D continued to move the brief over and placed folded 4 x 4 gauze over the wound and covered with Tegaderm (clear adhesive dressing). A second piece was required of the Tegaderm in order to protect the wound. The physician Operative Report, dated 4/6/17, indicated the resident had an infected right buttock wound. The resident received anesthesia and the physician made an excision and debrided the area with a sharp dissection. The wound measured 4 cm by 2 cm. During an interview on 5/3/17 at 1:45 p.m. with The Director of Nursing (DON) and Staff C RN acknowledged that Staff C had observed the dressing change with this surveyor on 5/2/17 at 11:20 a.m. Staff C acknowledged she observed Resident #1's brief being moved out of the of the dressing change and the brief falling back over the wound several times during the dressing change.	F 279	Continued from Page 4	

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F 279	Continued From page 5 During an interview on 5/3/17 at 2:00 p.m. with Staff B RN acknowledged she did the skin assessments weekly. Staff B explained that Resident #1's gluteal fold area had just been red at the beginning with a small chaffed area. Staff B further explained that Resident #1 was always incontinent and laying on his/her side that the urine could pool in the affected area. Staff B acknowledged that shortly after the open area to the right gluteal fold (ischial area) the staff changed the mattress to an air mattress on the resident's bed.	F 279	Continued From Page 5	
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 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, staff interviews and record review, the facility failed to implement interventions to prevent the development of an	F 314	It is the practice of the facility to implement interventions to prevent development of avoidable pressure sore and perform a t reatment without contamination of the wound. 1. Care plan for resident #1 was revlewed to address interventions to prevent development of pressure sore on 5/5/2017 by the interdisciplinary team. Turn/repositioning report was implemented on 5/5/2017. 2. An audit of care plan interventions to prevent development of avoidable pressure sore was completed on 5/5/2017 by the DON to ensure interventions to prevent development of avoidable pressure sore.	5/5/2017

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F 314	Continued From page 6 avoidable pressure sore, located on the ischial tuberosity (lower buttock area) and failed to perform a treatment without contamination of the wound by the soiled brief (Resident #1). The facility identified 5 of the 55 residents had pressure ulcers. The sample consisted of 5 residents with pressure ulcers. Findings include: 1. Resident #1 had an admission MDS (Minimum Data Set) assessment with a reference date of 3/1/17. The MDS identified the resident had a BIMS (Brief Interview of Mental Status) score of 8. A score of 8-12 indicated moderate cognitive impairment. The MDS indicated the resident required extensive assistance of 1 staff member for bed mobility, transfers, dressing, toilet use, person hygiene and experienced frequent episodes of bladder and bowel incontinence. The MDS identified and included diagnoses of pneumonia, diabetes, non-Alzheimer's dementia, Parkinson's disease. The MDS reported the resident at risk for the development of pressure ulcers and had no unhealed pressure ulcers or skin damage. The 3/10/17 quarterly MDS assessment indicated the resident required extensive assistance of 1 staff for bed mobility, transfers, dressing, toilet use, person hygiene and frequently incontinent of bowel and bladder. The MDS continued to identify the resident at risk for pressure ulcer development and had no unhealed pressure ulcers but had moisture associated skin damage. The Care Plan dated 3/7/17recorded Resident #1 had a risk for skin break down related to diabetes	F 314	Continued From Page 6 3. In-service education was provided to facility staff on 5/5/2017 by DON on interventions to prevent development of avoidable pressure sore and perform treatment without contamination of the wound. 4. DON/ designee will make random rounds/ audits to ensure residents are provided interventions to prevent development of avoidable pressure sore and perform a treatment without contamination of the wound. Immediate staff education will be provided if non-compliance is noted. DON/designee will report finding of random rounds/ audits to QAPI committee until compliance is achieved.	

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F 314	Continued From page 7 and incontinence. Interventions included a cushion in the wheelchair and a therapeutic mattress to his/her bed and assistance with transfers and repositioning. Further interventions for incontinence required staff to assist the resident to the bathroom and provide perineal care. The Care Plan lacked a comprehensive plan to care for a pressure ulcer or skin breakdown such as turning and repositioning, treatments, etc. The Care Plan was updated on 3/22/17 and included a change from a therapeutic mattress to an air mattress on the resident's bed. A form titled Nurses Admission Record and dated 2/22/17 at 10:30 a.m. indicated the resident had only 2 bruised areas on the resident's skin. The Skilled Daily Nurses Note, dated 3/2/17, recorded a new telephone order for Calmoseptine (for moisture related areas) to the groin area twice a day for 14 days or healed. The 3/9/17 Skilled Daily Nurses Note recorded Resident #1 has very excoriated skin to his/her groin, genitals and rectum and a fax sent to request Nystatin (medication for fungal infection) due to the yeasty smell noted. The 3/10/ 17 Physician's Telephone Orders recorded a new order for Nystatin powder to groin and rectum three times a day for 14 days or healed. The Nurse's Notes dated 3/17/17 at 5:10 p.m. indicated a Certified Nursing Aide (CNA) reported a reddened are at the gluteal fold on the resident's right buttock. The area measured 2 centimeters (cm) circular red, firm to touch and very tender. In the center a 1 cm superficial	F 314	Continued From Page 7	

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F 314	Continued From page 8 chafed area. The 3/17/17 Physician's Telephone Order at 5:10 p.m. recorded an order for Allevyn (dressing) 3 x3 to right gluteal fold, buttock for 10 days or healed and to check area daily and change every 7 days or as needed. The 3/22/17 Physician's Telephone Order at 6:45 a.m. recorded an order for Tegaderm (dressing) to decubitus on the right ischial tuberosity (lower buttock). The 3/22/17 weekly skin assessment at 7:30 a.m. recorded a Stage II pressure ulcer, 3-4 cm round, open area with drainage with a 6 -7 cm reddened firm area surrounding the open area. The 3/24/17 skin assessment recorded a Stage II pressure ulcer 4 cm x [by] 3 cm. On 5/2/17 at 11:20 a.m. observation of a treatment by Staff D, Registered Nurse (RN) and in the presence of Staff C RN. Staff D pushed Resident #1's brief out of the way to remove the dressing. Once the nurse moved her hand, the brief fell over the wound. Staff D continued with cleansing the wound and again the brief fell back over the wound once she moved her hand. Staff D next took the medication cup with gauze soaked in gentamycin holding the cup in close proximity to the brief and packed the wound with the gauze. Once again the brief fell back over the wound and Staff D moved her hand. Staff D continued to move the brief over and placed folded 4 x 4 gauze over the wound and covered with Tegaderm (clear adhesive dressing). A second piece was required of the Tegaderm in order to protect the wound.	F 314	Continued From page 8	

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F 314	Continued From page 9 The physician Operative Report, dated 4/6/17, indicated the resident had an infected right buttock wound. The resident received anesthesia and the physician made an excision and debrided the area with a sharp dissection. The wound measured 4 cm by 2 cm. The physician consultation note dated 4/25/17 identified the buttock wound much improved. The physician indicated the plan to continue dressing changes twice a day with antibiotic, Gentamycin-soaked with NuGauze (thin gauze strips used for packing wounds) and follow up in 2 to 3 weeks. During an interview on 5/3/17 at 1:45 p.m. with The Director of Nursing (DON) and Staff C RN they acknowledged that Staff C had observed the dressing change with this surveyor on 5/2/17 at 11:20 a.m. Staff C acknowledged she observed Resident #1's brief being moved out of the of the dressing change and the brief falling back over the wound several times during the dressing change. During an interview on 5/3/17 at 2:00 p.m. with Staff B RN acknowledged she did the skin assessments weekly. Staff B explained that Resident #1's gluteal fold area had just been red at the beginning with a small chaffed area. Staff B further explained that Resident #1 was always incontinent and laying on his/her side that the urine could pool in the affected area. Staff B acknowledged that shortly after the open area to the right gluteal fold (ischial area) the staff changed the mattress to an air mattress on the resident's bed.	F 314	Continued From page 9	
F 323	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT	F 323		

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F 323 SS=E	Continued From page 10 HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to properly secure chemicals for 9 cognitively impaired, independently mobile residents. The facility reported a census of 55 residents. Findings: During the environmental tour on 5/2/17 at 9:22 a.m., the Blue Hall shower room was not locked.	F 323	Continued From Page 10 It is the facility practice to keep the environment free of accident/ hazard/ supervision/devices. 1. Blue shower room chemicals were immediately locked up on 5/2/2017 by the housekeeping supervisor after discovering the cabinet was unlocked. 2. An audit of the shower rooms was completed on 5/2/2017 by the housekeeping supervisor, to ensure, chemicals were locked to keep the resident environment free of accident hazards. 3. In-service education was provided to facility staff on 5/5//2017 by the administrator. 4. Housekeeping supervisor/ designee will complete random rounds to ensure chemicals are locked for the residents to have an environment free of accident hazards. Immediate staff education will be provided if non-compliance is noted. Housekeeping supervisor will report findings of random rounds to QAPI committee until compliance is achieved.	5/5/2017

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F 323	Continued From page 11 The room contained an unlocked cabinet containing the following chemicals with precautionary labels: a. 2 bottles of Claire Disinfectant Spray. The product's SDS(Safety Data Sheet) stated it caused skin corrosion/irritation and serious eye damage and directed staff to seek medical attention if contact occurred. b. 1 bottle of Lemon Hi-Con 64 Disinfectant. The product's information sheet stated it caused irreversible eye damage and skin burns, was harmful if swallowed, and directed staff to seek medical attention if contact occurred. c. 2 bottles of Claire Red Delicious Apple Dry Air Freshener. The product's SDS stated it caused serious eye damage and directed staff to seek medical attention if contact occurred. A facility document listed 9 cognitively impaired, independently mobile residents. During an interview on the environmental tour, the Administrator stated the cabinet should be locked.	F 323	Continued From Page 11	
F 363 SS=E	483.60(c)(1)-(7) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED (c) Menus and nutritional adequacy. Menus must- (c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; (c)(2) Be prepared in advance; (c)(3) Be followed;	F 363	It is the facility practice to have menus meet resident needs/ prepared in advance/followed. 1. Residents will continue to receive correct serving amounts. 2. Dietary staff A was re-educated on 5/2/2017 by dietary supervisor on weight versus volume. 3. Facility staff was re-educated on 5/5/2017 by dietary supervisor on weight versus volume.	5/5/2017

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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 363	Continued From page 12 (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; (c)(5) Be updated periodically; (c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide the correct serving amounts for 3 of 3 residents on a pureed diet and 10 of 10 residents on a ground diet. The facility reported a census of 55 residents. Findings: 1. During an observation on 5/2/17 at 10:46 a.m., Staff A Cook began the ground/puree process. a. Staff A stated she would make 10 servings of ground chicken. Staff A placed 10, 2 ounce scoops of ground chicken into the food processor and processed it to a ground consistency. Staff A then emptied a portion the ground meat into a measuring cup to measure 20 ounces and placed this in a metal pan. She stated each person received 2 ounces so the total would equal 20 ounces for the 10 servings. The surveyor requested Staff A measure the left-over chicken and Staff A measured this at 20 ounces.	F 363	Continued From Page 12 4. Dietary supervisor/ designee will complete random audits to ensure residents receive correct serving amounts. Immediate staff education will be provided if non-compliance is noted. Dietary supervisor will report findings to QAPI until compliance is achieved.	

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	165562	A. BUILDING _____ B. WING _____	05/04/2017

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F 363	Continued From page 13 b. Staff A then stated she would make 3 servings of pureed chicken. Staff A placed 3 2 ounce scoops of ground chicken into the food processor, added an unmeasured amount of whole milk and 3 slices of bread and processed to a pureed consistency. Staff A then emptied a portion of the pureed chicken into a measuring cup to measure 6 ounces and placed this into a metal pan. The surveyor requested Staff A measure the left-over pureed chicken and Staff A measured this at 4 ounces. c. Staff A then stated she would make 3 servings of pureed beets. Staff A added 3, 4 ounce scoops of beets into the blender and processed it to a pureed consistency. Staff A measured this at 10 ounces and then added it to a metal pan. After completing the pureed and ground preparations, Staff A placed the metal pans in the oven and left the left-over 20 ounces of ground chicken and 4 ounces of pureed chicken on the counter. The noon meal service on 5/2/17 revealed the following observations: a. Staff A served 10 servings of ground chicken with a 2 ounce scoop and 2 ounces of ground chicken remained. b. Staff A served 3 servings of pureed chicken with a 2 ounce scoop with no chicken remaining. c. Staff A served 2 servings of pureed beets with a 2 ounce scoop. For the last resident on a pureed diet, only a quarter of a scoop of beets remained for Staff A to serve. The Week 4 Day 2 Menu stated residents on a	F 363	Continued From Page 13	

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F 363	Continued From page 14 ground diet should receive 2 ounces of ground chicken and residents on a pureed diet should receive 1 serving of pureed chicken and 1 serving of pureed beets. The facility procedure for preparing ground chicken directed staff to: 1. Measure desired number of servings into food processor(2 ounces/serving). 2. Grind to appropriate consistency. 3. If needed, add milk to moisten. 4. Divide resulting amount by the number of ground portions to determine portion amount to serve. The facility procedure for preparing pureed chicken directed staff to: 1. Prepare according to regular recipe instructions. 2. Measure desired number of servings into food processor. 3. Blend until smooth. 4. Add just enough milk(or other appropriate liquid/condiment) to thin product. 5. Add commercial thickener if product needs thickening. 6. Divide resulting amount by the number of portions pureed to determine portion amount to serve. During an interview on 5/2/17 at 11:50 a.m., Staff A stated she discarded the 20 ounces of left-over ground chicken and the 4 ounces of left-over pureed chicken and this was not included in what she would serve the residents. During an interview on 5/2/17 at 12:30 p.m., the	F 363	Continued From page 14	

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F 363	Continued From page 15 Dietary Manager stated staff should divide the total volume of the pureed and ground food in order to reach the correct serving sizes. During an interview on 5/3/17 at 10:54 a.m., the facility dietician consultant stated staff should either utilize the entire chicken breast for 1 serving or they should weigh the meat to ensure each resident on a ground or pureed diet received the correct amount. She stated the menu serving sizes referred to weight measurements, not volume. She stated after staff ground or pureed the food, they should measure the total volume and divide the portions equally. She stated no portion of the food should be discarded in the process and stated she would conduct an in-service to discuss weight versus volume.	F 363	Continued From page 15	
F 371 SS=E	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. (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	F 371	It is the facility practice to store/prepare/ serve under sanitary conditions. 1. Facility will continue to store/ prepare/ serve under sanitary conditions. 2. Dietary staff immediately removed ice machine cover and ran through the dish machine, ice cream cups in clean utility freezer were thrown away, "Magic cups" frozen desserts in med room refrigerator were thrown away, cupboards containing coffee cups and bowls were cleaned, microwave ceiling was cleaned, mixer was cleaned, pitchers rewashed and shelf cleaned, maximum refrigerator bottom was cleaned, ice machine crevices cleaned, hanging metal rack cleaned, outside of sugar and flour containers cleaned.	5/5/2017

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F 371	Continued From page 16 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, record review, and interview, the facility failed to maintain proper kitchen sanitation and food handling/preparation practices and failed to maintain proper refrigerator/freezer minimum temperatures to prevent foodborne illness. The facility reported a census of 55 residents. Findings: The initial kitchen tour on 5/1/17 at 9:45 a.m. revealed the following concerns: a. A layer of thick dust on the underside of the ice machine cover located directly above the stored ice b. A thick red substance, multiple crumbs, and cheese shreds on the bottom of the Maximum refrigerator During the environmental tour on 5/2/17 at 9:15 a.m., the Green Hall clean utility room freezer thermometer stated 45 degrees Fahrenheit. The freezer contained multiple individual ice cream cups. The cups were soft to the touch. During an observation on 5/2/17 at 10:10 a.m., the medication room refrigerator thermometer stated 44 degrees Fahrenheit. The refrigerator contained 2 "Magic Cup" frozen desserts.	F 371	Continued From page 16 3. In-service education was provided to facility staff on 5/5/2017 by dietary supervisor on store/prepare/ serve under sanitary conditions. 4. Dietary supervisor/ designee will complete random audits to ensure store/prepare/serve under sanitary conditions is achieved. Immediate staff education will be provided if non-compliance is noted. Dietary supervisor/ designee will report random audits to QAPI committee until compliance achieved.	

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F 371	Continued From page 17 Kitchen observations on 5/2/17 at 11:10 a.m. revealed the following concerns: a. Multiple crumbs and coffee grounds on a shelf containing coffee cups b. Multiple crumbs in the bottom of a cupboard containing trays of bowls c. Brown splatters on the ceiling of the microwave d. White splatters on the base of the Hamilton Beach mixer e. Multiple crumbs under a mesh shelf liner. The shelf contained upside down pitchers with the pitcher rims in contact with he shelf liner/crumbs f. The outside of the Globe Chefmate slicer's plastic cover was covered with red and brown splatters e. The plastic cover covering the Kitchenaide mixer was sticky to the touch. The underside of the mixer was covered with white and yellow splatters f. A thick red substance, multiple crumbs, and cheese shreds remained on the bottom of the Maximum refrigerator g. Dust in the crevices of the door hinge on the inside of the ice machine. Kitchen observations on 5/2/17 at 11:50 a.m. revealed the following concerns: a. Staff A Cook touched the lid to a garbage can in order to throw away a piece of foil. Without washing her hands, Staff A touched metal lids she then placed on top of pans of food on the steam table. b. Dust particles hung from hanging metal racks holding spoons and ladles. The racks were directly above a preparation area containing a cookie sheet containing cookie dough.	F 371	Continued From Page 17	

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F 371	Continued From page 18 c. The outside of the flour and sugar containers were sticky to the touch. Red spatters covered the outside of the flour container. Review of the medication room refrigerator temperature log during the period of 3/18/17-5/2/17 listed daily temperatures ranging from 36-52 degrees Fahrenheit. The facility kitchen monthly cleaning assignments directed staff to: a. Clean cabinets b. Wash blender base c. Wipe off big mixer d. Wipe flour and sugar bins e. Clean microwave Facility in-service documentation entitled "Heating, Holding, and Cooling Foods Correctly" stated the danger zone for food temperatures was between 41 degrees Fahrenheit and 135 degrees Fahrenheit and stated food kept in the danger zone for too long could allow bacteria to grow, causing foodborne illness. During the environmental tour on 5/2/17 at 9:15 a.m., the Administrator acknowledged the Green Hall clean utility room freezer thermometer stated 45 degrees Fahrenheit. She stated the freezer was going through a defrost cycle and she would discard all of the ice cream. During an interview on 5/2/17 at 12:30 p.m., the Dietary Supervisor stated staff should clean up messes as they go and it was difficult to keep up with the cleaning due to having multiple staff members.	F 371	Continued from page 18	

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F 371	Continued From page 19 During an interview on 5/2/17 at approximately 2:30 p.m., the Director of Nursing stated if staff obtained high refrigerator temperatures, they should close the door and obtain another reading a few minutes later. She stated she suspected the door was open for a period of time prior to the temperature measurements and stated the thermometer possibly needed moved toward the center of the refrigerator.	F 371	Continued from Page 19	