| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055619 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/23/2019 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Las Colinas Post Acute | 800 East 5th Street<br>Ontario, CA 91764 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37427<br><br>Based on observation, interview and record review, the facility did not accurately complete two annual RAI-MDS assessments (The Resident Assessment Instrument - Minimum Data Set (RAI-MDS) is the standardized assessment tool for admission, quarterly, significant change in health status and annual assessments for each resident,) under neurological diagnoses for Resident 160.<br><br>This failure had the potential for inappropriate or insufficient provision of dementia-related care for one resident (Resident 160) in a universe of 35 vulnerable sampled residents.<br><br>Findings:<br><br>During an observation on May 20, 2019 at 10:16 AM, Resident 160 was observed in her wheelchair, and spoke Portuguese with little understanding of English and some understanding of Spanish.<br><br>During a review of Resident 160's clinical record on May 22, 2019 at 3:40 PM, the PASRR (Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care,) dated February 21, 2019, with admitted [DATE], indicated Resident 160 had diagnosis of dementia with psychosis (psychotic features of dementia include hallucinations (usually visual), delusions; hearing or seeing things that are not there,) under section number 13, Physical diagnosis at the time of transfer/admission to Nursing Facility.<br><br>During an interview, and concurrent record review on May 23, 2019 at 5:51 PM, with the Assistant Director of Nursing (ADON), the ADON confirmed the diagnosis listed under section 13, on Resident 160's PASRR dated February 21, 2019, indicated Resident 160 had admitting diagnoses which included dementia with psychosis.<br><br>During an interview and concurrent review of Resident 160's clinical record on May 23, 2019,<br><br>at 6:47 PM, the RAI-MDS assessments dated March 22, 2018 and March 22, 2019, under Neurological Section I, were left blank, with no indication for diagnosis of dementia for Resident 160. The MDS/ Licensed Vocational Nurse 1 (MDS/LVN 1), stated she did not know why the form was not completed accurately for the resident's last two annual RAI/MDS comprehensive assessment tools.<br><br>(continued on next page) |

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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055619 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/23/2019 |
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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on May 23, 2019 at 7:15 PM, with the ADON, MDS/LVN 1, and ADMIN, they confirmed the neurological diagnosis of dementia should have been documented on Resident 160's two annual MDS/RAI comprehensive assessment tools, dated March 22, 2018 and March 22, 2019, as indicated on Resident 160's PASRR dated February 29, 2019, with admission diagnosis of dementia with psychosis dated March 15, 2017.<br><br>A review of facility undated policy and procedure, titled Comprehensive Assessments and the Care Delivery Process, indicated the following: .Policy Interpretation and Implementation: Comprehensive assessments will be conducted to assist in developing person-centered care plans .Assessment and information: The objective of the information collection (assessment) phase is to obtain, organize and subsequently analyze information about a patient .Define current treatments and services; link problems/diagnoses .Monitoring results and adjusting interventions includes: Periodically reviewing progress and adjusting treatments . Comprehensive assessments are conducted and coordinated by a registered nurse with appropriate participation of other health professionals .Completed assessments (baseline, comprehensive, MDS, etc.) are maintained in the resident's record. These assessments are used to develop, review and revise the resident's comprehensive care plan. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39431<br><br>Based on observation, interview, and record review, the facility failed to ensure a hemodialysis (the process of removing waste products and excess fluid from the body) access site (AV shunt site - a surgical connection made between an artery and a vein for hemodialysis) dressing was removed and kept visible for the staff to observe any potential bleeding after dialysis treatment affecting one of three sampled residents (Resident 55). The facility did not follow the physician's order to remove the resident's left AV shunt dressing four hours after dialysis.<br><br>This failure had the potential to affect the resident's health and safety.<br><br>Findings:<br><br>A clinical record review of Resident 55's face sheet (demographic information) indicated Resident 55 was admitted on [DATE] with diagnosis that included end stage renal disease (a condition where the kidneys fail to function and requires the use of a hemodialysis machine to act as an artificial kidney to clean the resident's blood from toxins) and an AV shunt to the left arm for dialysis.<br><br>During an observation on May 21, 2019, at 7:51 AM, Resident 55 was in bed, awake and alert. He had a left upper arm dressing that was dry and intact. Resident 55 was Spanish speaking and a Certified Nurse Assistant (CNA 1) was at the bedside to translate for him. Resident 55 stated, the staff at the dialysis center had applied dressings on his left upper arm after his hemodialysis treatment yesterday (May 20, 2019) and he returned to the facility. CNA 1 stated, the staff at the facility did not remove Resident 55's left arm dressing and left the dressing overnight until the morning.<br><br>During a concurrent interview with CNA 1, she stated licensed nurses are responsible for checking and removing the dressing for AV shunt dialysis access sites.<br><br>During an interview with Licensed Vocational Nurse (LVN 1), on May 21, 2019, at 8:00 AM, LVN 1 verified that Resident 55 had left upper arm dressing at his AV shunt when he returned from dialysis on May 20, 2019 at 6:00 PM. LVN 1 further stated Resident 55 came back from the dialysis center after he had hemodialysis treatment on Monday, May 20, 2019, at 6:00 PM. LVN 1 stated licensed nurses are responsible for checking the AV shunt access site post dialysis treatment, by removing the dressing to ensure there is no bleeding.<br><br>A review of Resident 55's Medication Administration Record (MAR) and Order Summary Report, dated May 2019, with LVN 1, on May 21, 2019, at 8:00 AM, the records indicated Resident 55 had hemodialysis treatment ordered for three times a week (Monday, Wednesday, Friday), at 2:30 PM, at the dialysis center. Resident 55's physician order indicated, AV shunt site: Left upper arm- every shift monitor that AV shunt dressing has been removed after 4 hours of return from dialysis treatment. This order was documented as being done by the evening, night, and day shift licensed nurses on May 20, 2019 & May 21, 2019.<br><br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview with LVN 1, LVN 1 stated according to physician order, Resident 55's left upper arm AV shunt dressing should have been removed by the evening and night shift staff, or four hours when Resident 55 returned from the dialysis treatment (at 10:00 PM). She stated the shunt dressing should be removed to allow staff to check for bleeding at the site.<br><br>During an interview and concurrent record review of Resident 55's MAR and physician orders dated May 2019, with Registered Nurse 1 (RN 1), RN 1 stated licensed nurses are responsible for removing the AV shunt access site dressing, post dialysis treatment to check for bleeding, bruit (a rumbling sound caused by blood flow through the AV shunt), and thrill (a vibratory movement heard through a stethoscope). If uncontrolled bleeding were noted, staff are expected to notify the physician and call the emergency (911). RN 1 stated if the dressing was not removed four hours post dialysis, as per physician order, that meant it was not checked for bleeding, as it was documented.<br><br>During an interview with Director of Nursing (DON) on May 22, 2019, at 8:19 AM, the DON stated AV shunt access site dressing should be removed by the staffs post dialysis to check for active bleeding. She stated if active bleeding is identified at the AV shunt access site after removing the dressing, staffs were expected to notify the physician and call the emergency (911) to transfer the residents to the hospital. |

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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>34975<br><br>Based on observation, interview, and facility document review, the facility failed to ensure the competency of supervisory staff for the kitchen when the Dietary Services Supervisor (DSS) did not know the appropriate procedure for thawing meat. This failure had the potential for the contamination of meat leading to food borne illness for 167 residents who ate food from the kitchen out of a facility census of 181.<br><br>Findings:<br><br>During an observation and concurrent interviews with Cook 2 and the DSS, on May 21, 2019, at 2:30 PM, multiple, 5-pound tubes of ground meat were in a sink, with water running into the sink. Five ground meat tubes that sat on top of other ground meat tubes were not fully submerged in the water. Cook 2 stated the meat was being thawed to cook tomorrow for lunch. When the DSS was asked if the way the meat was thawed in the sink was the correct process, she stated yes. She stated it was okay if the meat was not fully submerged as long as the water was running over it. It was observed that the water did not run over all the meat that was not submerged in the water. The DSS also stated she did not know the temperature of the water that ran over the meat. She said staff did not take the temperature of the water.<br><br>Review of the undated facility Policy and Procedure titled Thawing of Meats read 3. Submerge [meat] under running, potable water at a temperature of 70*F or lower . |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.<br><br>34975<br><br>Based on observation, interview, and facility document review, the facility failed to ensure the competency of staff when:<br><br>1. A cook did not use appropriate procedures to ensure food was served at a safe temperature; and<br><br>2. A cook was not able to demonstrate appropriate procedures for calibrating a thermometer.<br><br>This failure had the potential for food to be served at an unsafe temperature and lead to food borne illness for 167 residents who received food from the kitchen out of a facility census of 181.<br><br>Findings:<br><br>1. An observation and concurrent interviews on 5/20/19 at 11:48 AM, with Cook 1 and the Director of Food and Nutrition Services (DFNS), showed Cook 1 measured temperatures of food on the tray-line before food service. When she took the temperature of a large pan of green beans, she placed the calibrated thermometer probe into the green beans close to the side of the pan. Her thermometer read 168.9 degrees Fahrenheit (F). She wrote down the temperature on the temperature log sheet, then moved to the next food to take a temperature. When the surveyor measured the temperature of the green beans with a calibrated thermometer in the center of the pan, the temperature read 160.2 degrees F. Then Cook 1 ripped the foil that covered a pan of mechanical soft turkey (turkey that is made into smaller pieces to make it easier to chew) at one corner and placed the thermometer probe into the mechanical soft turkey at the side of the pan near the corner. Her thermometer read 200 degrees F. She recorded the temperature in the log then moved on to take the temperature of another food. The surveyor took the temperature of the mechanical turkey in the center of the pan and the temperature read 163 degrees F. Then Cook 1 took the temperature of the pureed turkey with the thermometer probe very close to the side of the pan. The temperature read 193.4 degrees F. Then the surveyor asked Cook 1 to take the temperature of the pureed meat in the center of the pan. Her thermometer read 165.3 degrees F. When the surveyor asked the DSS the proper procedures for taking food temperatures, she stated a couple of measurements should be taken in different places in the pan including the middle and the sides.<br><br>According to the 2017 Federal Food Code, the geometric center or thickest part of a product are the points of measurement of product temperature when measuring critical limits for cooking. In addition, all parts of the food are to be heated to the critical temperature for Time Temperature Control for Safety Foods (foods that have a higher probability for bacterial growth).<br><br>(continued on next page) |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 2. An observation and concurrent interviews on 5/20/19 at 4:07 PM, with Cook 2 and the DFNS showed Cook 2 demonstrated how to calibrate a digital thermometer. First, Cook 2 filled a clear plastic cup with cubed ice and water. The ice in the cup floated over 2 inches from the bottom leaving only water at the bottom of the cup. Cook 2 placed her thermometer in the ice water with the tip of the probe resting at the bottom of the cup where there was no ice. Cook 2 watched the thermometer for over 2 minutes then stated she had to get more ice. She filled another clear cup with cubed ice and water. This time ice floated up over an inch from the bottom. Cook 2 placed her thermometer in the cup with the probe resting at the bottom where there was no ice. She waited until the temperature on her thermometer did not drop any further. The thermometer read 36 degrees F. She stated she needed to get a new thermometer because her thermometer did not drop to 32 degrees F. Then the DFNS asked Cook 2 to add more ice into the same cup. Cook 2 added more ice so it filled the cup to the bottom. Her thermometer dropped to 31.9 degrees F.<br><br>Review of the undated facility Policy and Procedure titled Thermometer Calibration stated 1. Fill a large glass with crushed ice and add clean tap water until class is full. Stir the mixture well. 2. Put the thermometer or probe stem into the ice water so that the sensing area is completely submerged . Do not let the stem touch the bottom or sides of the glass. Wait 30 seconds . |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>34975<br><br>Based on observation, interview, and facility record review, the facility failed to cook vegetables in a way to preserve the nutritional content and palatability, when frozen vegetables were left to cook in the oven 2 to 3 hours before serving.<br><br>This failure had the potential to decrease the nutritive content and palatability in the vegetables and result in a nutrition deficiency for 167 residents who consumed food from the kitchen, out of a facility census of 181 residents.<br><br>Findings:<br><br>During an observation and concurrent interview with Cook 1, on May 20, 2019, at 9:03 AM, pans covered with foil were observed in the oven. Cook 1 stated she had carrots and green beans cooking. She stated they were frozen vegetables and she would cook them for about 2 hours.<br><br>During an observation and concurrent interview with Cook 1, on May 22, 2019, at 9:30 AM, pans covered with foil were observed in the oven. Cook 1 stated the only thing she had in the oven was frozen spinach, and she placed it in the oven before her break at about 8:20 AM. She stated she would cook the spinach for 2 to 3 hours, and take it out just before tray-line food service started.<br><br>During an interview with the Registered Dietitian (RD), on May 22, 2019, at 10:28 AM, she stated cooking frozen vegetables for 2 to 3 hours seemed like a long time. She stated the nutrients could possibly leach (drain away from) out if cooked for that long.<br><br>During an interview with the Director of Food and Nutrition Services (DFNS), on May 22, 2019, at 11:03 AM, the DFNS stated that cooking frozen vegetables for 2 to 3 hours was the process and that was how long it took to cook frozen vegetables. She stated that cooks took the temperatures during the cooking process and took the vegetables out of the oven when they reached 155 degrees Fahrenheit (F). She stated cooks did not cook spinach for 2 to 3 hours because that was too long to cook spinach, and it would be overdone and will fall apart if it was cooked for that long.<br><br>During an interview with Cook 1, on May 22, 2019, at 11:20 AM, Cook 1 confirmed the only temperature she took of vegetables was when she took them out of the oven just before trayline. She stated she only took the temperature of the spinach after it was in the oven for 2 to 3 hours, just before trayline. On May 20, 2019, she stated when she cooked the green beans, the only temperature she took occurred after the green beans had been in the oven for 2 to 3 hours, before putting the vegetables on trayline.<br><br>During a concurrent interview with the Administrator, on May 22, 2019, she stated she looked at the recipe for Spinach Au Gratin, the spinach recipe cooked that day, and stated Cook 1 did not follow the recipe pertaining to the amount of time the spinach should be cooked. She stated vegetables did not need to be cooked so far in advance, and they could be cooked right before or closer to the start of the tray-line.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Review of the recipe titled, Spinach Au Gratin dated Week 3 Wednesday, indicated the amount of time to prepare the recipe was 15 minutes. The directions indicated to first cook the spinach in water, then mix with cheese and place in the oven for 10 - 15 minutes.<br><br>A review of the cooking instructions for the spinach, that the DFNS confirmed were located on the box of the frozen spinach used for lunch on May 22, 2019, showed the time for cooking the spinach in boiling water was 6 minutes, and in a steamer oven for 25 minutes. |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34975<br><br>Based on observation, interview, and facility record review, the facility failed to provide food options of similar nutritive value for residents who chose an alternate food to what was served on the menu when:<br><br>1. Residents who chose an alternate entree were not served vegetables with similar nutritive value; and<br><br>2. Grilled cheese alternates served did not contain the protein content shown in the recipe.<br><br>These failures had the potential for over 22 residents who requested alternate entrees from the kitchen, out of a facility census of 181 residents, to receive an inadequate amount of nutrients as calculated for the menu.<br><br>3. The facility did not ensure a food allergen was not served to Resident 179.<br><br>This failure had the potential to result in an allergic response for Resident 179, and further compromise the medical condition of one of 35 vulnerable sampled residents.<br><br>Findings:<br><br>1. During a review of the Cooks' Spread sheet menu titled, Spring Cycle Menus dated Week 3 Monday, May 20, 2019, the items on the menu for lunch on May 20, 2019 included Roast Turkey with [NAME] Sauce for the main entree, and Green Beans with Dill for the vegetable.<br><br>During an observation and concurrent interviews with Cook 1 and the Director of Food and Nutrition Services (DFNS), on May 20, 2019, at 1:10 PM, lunch trays were prepared for residents on the trayline. Over 15 trays had two enchiladas instead of the turkey entree, over five trays had a grilled cheese sandwich in place of the entree, and over two trays had quesadillas in place of the entree. The plates with the enchiladas also included a starch, a dessert, and drinks that were listed on the menu. The plates with the grilled cheese and quesadilla included dessert and drinks. There were no vegetables on any of the plates that had an alternate entree. When the surveyor asked Cook 1 why vegetables were not served with the entrees, she stated she did not know and it was just like that. The DFNS explained that residents received a paper menu on their tray the day before, and they circled foods they preferred to eat the next day. She stated if the resident did not circle the item, they did not get it. The surveyor asked, if the resident did not circle the vegetable, then the resident did not receive a vegetable? The DFNS confirmed and stated they did not receive a vegetable if they did not circle the vegetable. She explained the kitchen received all the meal menus from the residents, and if the resident preferred an alternate, the information was transferred to an alternate entree tray ticket that the cooks followed on trayline. It was noted that the alternate tray tickets included alternate entrees, but did not indicate not to serve vegetables.<br><br>(continued on next page) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the menu titled, Your menu for tomorrow dated Monday, May 20, 2019, was the paper menu the DFNS confirmed was the menu residents received to choose their food preferences for the next day. It showed the planned menu written on one side, and on the reverse side, there were alternate foods listed. At the top of the reverse side, the menu read, Special Meal for the day Lunch and Dinner 'Cheese Enchilada'. Below that it read, Always available - fresh fruit salad (side) -Salad (side) -Sandwiches (Tuna, Meat, PB&J) -Grilled cheese -Quesadillas . *Circle your alternate choice and cross out the entree you do not want.* It was noted that all of the food listed as alternates were entree type foods, with exception to the side salads, and there was not an alternate vegetable listed (except for salad).<br><br>During an interview with Resident 179, on May 20, 2019, at 1:40 PM, she stated she received the enchilada alternate for her lunch, but she did not receive vegetables. She stated she did not like green beans, but she would eat an alternate vegetable such as carrots, because she needed fiber.<br><br>During an interview with Resident 138, on May 20, 2019, at 1:43 PM, she stated she received enchiladas as an alternate entree. She confirmed she did not receive a vegetable. She said she would have eaten green beans, if she had them on her plate. She stated the alternate food did not include vegetable choices.<br><br>During an interview with Resident 43, on May 20, 2019, at 1:46 PM, he confirmed he received enchiladas as an alternate entree. He stated the alternates did not come with vegetables. He then stated he would have eaten green beans or other vegetables, if he received them on his tray. He said the only vegetable he did not like was spinach, and that was listed under dislikes on his tray ticket.<br><br>During an interview with the RD, on May 22, 2019, at 10:28 AM, the RD stated when a resident picked an alternate entree, a vegetable should still be provided. The RD stated since she was new to the facility, she did not know the facility's process.<br><br>During an interview with the DFNS, on May 22, 2019, at 3:03 PM, the DFNS stated her expectation was that the menu was followed, and if the resident requested an alternate entree, they should also receive a vegetable.<br><br>During a review of the undated facility Policy titled, Food Preferences, it indicated, . Substitutions for all foods disliked will be given from the appropriate food group .<br><br>2. During an observation on May 20, 2019, at 1:10 PM, over 8 grilled cheese sandwiches were prepared to be cooked for trayline. Each sandwich had 2 slices of cheese. Over 5 residents were served grilled cheese sandwiches as an alternate to the entree for lunch.<br><br>During an interview with the DFNS, on May 22, 2019, at 8:30 AM, the DFNS confirmed the grilled cheese sandwiches had 2 slices of cheese each. She stated that was what the recipe said to use. An observation of the sliced cheese package the DFNS confirmed was the cheese used for the sandwiches showed there were 3 grams of protein per slice.<br><br>Review of the undated recipe titled, Grilled Cheese Sandwich indicated the portion size was 1 sandwich, and each sandwich had 2 ounces of protein. The directions stated to make the sandwiches with 2 ounces of cheese per sandwich.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 800 East 5th Street Ontario, CA 91764 | |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | It is a standard that 7 grams of protein is equivalent to 1 ounce of meat protein. The facility recipe required 2 ounces of protein. The two slices of cheese that were in the grilled cheese sandwiches equaled 6 grams of protein which was less than 1-ounce portion of protein or less than half the amount of protein the recipe called for.<br><br>During an interview with the DFNS and the RD, on May 22, 2019, at 11:03 AM, the surveyor asked the DFNS to show where the recipe stated to use 2 slices of cheese. The DSS looked at the recipe and confirmed the recipe did not state to use 2 slices of cheese. The RD confirmed the grilled cheese served at the facility with 2 slices of cheese did not equal 2 ounces of protein, and was less protein than what the recipe called for.<br><br>37427<br><br>3. During an observation and concurrent interview, on May 20, 2019 at 3:53 PM, with Resident 179, a plastic covered container of pineapple dated 5/20, and a second plastic covered, manufactured mixed fruit cup containing pineapple, was on Resident 179's over-bed table. Resident 179 stated she required assistance to eat, as she was not able to open the snack containers. Resident 179 further stated she could not eat the fruit cup snacks provided by the staff (the resident did not recall the name of the staff who placed the pineapple cup), as she identified pineapple in both cups, and was allergic to pineapple.<br><br>During an observation and concurrent interview, on May 20, 2019 at 4:04 PM, with the Certified Nurse Assistant/Restorative Nurse Aide 1 (CNA/RNA 1,) she confirmed the mixed fruit cup on Resident 179's over-bed table contained pineapple and removed it from the resident's table. CNA/ RNA 1 further stated Resident 179 should not have the mixed fruit cup, as it contained pineapple and Resident 179 was allergic to pineapple.<br><br>During an interview and concurrent record review, on May 20, 2019 at 4:15 PM, at Nursing Station 3, LVN 2 stated afternoon nourishments were distributed by CNAs daily, and the food should have been verified with diet restrictions before they were distributed to residents. A review of Resident 179's clinical record with LVN 2 indicated Resident 179's allergies included pineapple. LVN 2 confirmed Resident 179 should not have been served pineapple due to her allergy indicated on the resident's Admission Face sheet (current demographic information).<br><br>During an interview on May 20, 2019 at 4:25 PM, the Director of Nursing (DON) confirmed Resident 179 should not have been served pineapple, and the nursing staff must always check to ensure food served to residents is accordance with allergens listed on the resident's clinical record.<br><br>During an interview on May 21, 2019 at 7:56 AM, the facility administrator (ADMIN) stated the nursing staff should check the special needs binder before distributing snacks to residents, to ensure food allergens are not served to those with allergy considerations.<br><br>During a review of Resident 179's Admission Face Sheet, it was indicated Resident 179 was admitted to the facility on [DATE], with diagnoses which included Dysphagia (difficulty in swallowing), Gastro-esophageal reflux disease (GERD: when stomach acid frequently flows back into the tube connecting your mouth and stomach). Under Other Information; Allergies, it was indicated Resident 179 was allergic to pineapple.<br><br>(continued on next page) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of facility policy and procedure dated May 21, 2019, titled Food Allergies and Intolerances indicated the following: .Policy Interpretation and Implementation, Assessment and Interventions, 1. Residents are assessed for a history of food allergies and intolerances as part of the comprehensive assessment.; 2. All resident reported food allergies and intolerances are documented in medical records.; 3. Residents with food intolerances and allergies are offered appropriate substitutions for foods that they cannot eat.; 4. The dietician will determine whether food allergies or intolerances are interfering with the resident's overall nutrition status and make recommendations regarding appropriate food substitutions and/or dietary supplements if needed.<br><br>During a review of facility policy and procedure dated May 21, 2019, titled Tray Identification indicated the following: Policy Statement: Appropriate identification/coding shall be used to identify various diets. Policy Interpretation and Implementation: 1. To assist in setting up and serving the correct food trays/diets to residents, the Food Services Department will use appropriate identification (e.g. computer generated diet cards) to identify the various diets. 2. The Nursing Staff will check trays for correct diets before the food carts are transported to their designated areas to be served to the residents . |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>34975<br><br>Based on observation, interview, and facility record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service to follow safe food handling and sanitation when:<br><br>1. The inside of the ice machine was not clean;<br><br>2. Staff personal clothing was stored in an area with single use food service items;<br><br>3. Cooking equipment was stacked and stored wet;<br><br>4. A food storage cabinet was not clean; and<br><br>5. Food preparation tools were not clean and stored in a wooden box that was not clean.<br><br>These findings had the potential to cause contamination of food leading to food borne illness for 167 residents who received food from the kitchen out of a facility census of 181 residents.<br><br>Findings:<br><br>1. During an observation and concurrent interview with the Property Services Director (PSD) and the Director of Food and Nutrition Services (DFNS), on May 20, 2019, at 11:20 AM, the PSD opened the ice machine for the surveyors to view inside. The plastic cover that covered the top opening of the ice machine had black dotted residue on the inside surface, facing the inside over the evaporator plates (the part of the ice machine where water flows over and ice formed), and the exposed ice in the ice bin. There was also a significant amount of condensation on the inside surface of the plastic cover that came into contact with the black residue, and had the potential to drip onto the evaporator plate, or into the exposed ice. PSD confirmed there was black residue on the plastic cover, but he stated it was not a concern. There was also black, dotted residue on the plastic surface that separated the evaporator plates. PSD wiped the residue with a paper towel and he confirmed the residue wiped off easily. The surveyor also wiped the residue with a paper towel and the DFNS confirmed the residue wiped off onto the paper towel. PSD stated, in addition to a deep cleaning every 6 months that involved following the manufacturers cleaning guidelines, he wiped the inside of the ice machine with only a towel and warm water every 3 weeks. He also stated he ran a product through the machine to remove any mineral build-up in the machine every 3 weeks. He confirmed he did not use any other product, such as a sanitizer, after he wiped the inside surfaces with warm water.<br><br>Review of the facility's undated manufacturer's manual for the ice machine, it showed cleaning procedures, followed by sanitizing procedures, but it did not describe a process where inside components were wiped solely with warm water.<br><br>Review of the undated facility policy and procedure titled, Sanitation, read, Ice which is used in connection with food or drink shall be from a sanitary source .<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | According to the 2017 Federal Food Code, equipment food-contact surfaces are to be clean to sight and touch. In addition, equipment food-contact surfaces are to be sanitized before use and after cleaning.<br><br>2. During an observation and concurrent interview with the DFNS on May 20, 2019, at 9:50 AM, multiple sweaters and light jackets were hanging from the corner of a rack in a room that stored single-use food service items such as Styrofoam cups and small plastic cups. Single-use food service items were on a rack adjacent to the rack where the sweaters and jackets hung. The clothing was less than 3 inches away from uncovered Styrofoam cups and uncovered small plastic cups. The DFNS stated the clothing on the rack was staffs' personal clothing from home, and the clothing should not be stored close to the single service items. She confirmed the single service items were used to serve resident food and drinks.<br><br>Review of the facility document titled, Employee Personal Items dated 2015, indicated personal items brought in by staff from outside would not be kept in the kitchen and would be kept in the Registered Dietitian's office across from the kitchen.<br><br>According to the 2017 Federal Food Code, street clothing can contaminate food, food equipment, and food contact surfaces. Proper storage facilities are required for the storage of clothing and personal items.<br><br>3. During an observation and concurrent interviews with the DFNS and Dietary Aide 1 (DA 1), on May 20, 2019, at 9:16 AM, 19 metal hotel pans (pans used for cooking and serving food) of various sizes were stacked inside one another and were wet. One large mixing bowl and a colander were also wet and stacked together. DA 1, who was observed putting away dishes that were cleaned in the dish machine, confirmed the hotel pans, metal bowl, and colander were wet. She stated they should all be air dried. The DFNS stated all of the cookware and food preparation equipment were to be air dried on racks. She confirmed the pans, bowl, and colander were not air dried before being stacked and stored.<br><br>According to the 2017 Federal Food Code, after cleaning and sanitizing, equipment and utensils are to be air-dried before contact with food and are to be stored in a way that allows for air drying.<br><br>4. During an observation and concurrent interview with the DFNS, on May 20, 2019, at 9:03 AM, a cabinet that contained opened containers of Teriyaki sauce, vinegar and soy sauce was observed. The bottom surface of the cabinet was covered with a significant amount of a sticky reside, and there were particles that resembled food particles stuck to the crevice where the bottom surface of the cabinet met the side of the cabinet. The DFNS confirmed the surface of the cabinet was sticky, and stated it was not clean.<br><br>On May 22, 2019, at 3 PM, the Dietary Weekly Cleaning Schedule for the dates of May 20, 2019 through May 22, 2019 was reviewed during a concurrent interview with the DFNS. The DFNS stated this was the cleaning schedule that was followed, and per the schedule, the cleaning of the cabinet fell under the cleaning of working area for cook. She further stated a staff deep-cleaned the kitchen 3 days per week. Review of the cleaning schedule did not indicate the cleaning of cabinets specifically, but it did indicate the cook working area was cleaned daily by the AM and the PM cooks. The DFNS stated the staff that did the deep-cleaning 3 days per week did not have a cleaning schedule. The DFNS stated the cabinet with the sauces did not look like it was cleaned daily or deep-cleaned.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | According to the 2017 Federal Food Code, equipment food-contact surfaces are to be clean to sight and touch. Also, nonfood-contact surfaces of equipment are to be kept free of an accumulation of residue and cleaned at a frequency necessary to prevent accumulation of residue.<br><br>5. During an observation and concurrent interviews with the DFNS and Cook 1, on May 20, 2019, at 9:23 AM, a wooden box inside a drawer that held food preparation utensils such as vegetable peelers and measuring spoons was observed. The inside of the box had a significant amount of crumbs and particles that resembled food particles. The particles were also on the surface of the measuring spoons. A peeler stored in the box had a dried residue that resembled food residue on the blade surface. The inside surface of the box had a rough texture, and had grooves and crevices. Cook 1 stated she used the food preparation tools stored in the box, and that the peeler and measuring spoons were dirty. The DFNS confirmed the box had crumbs and was not clean.<br><br>According to the 2017 Federal Food Code, equipment food-contact surfaces are to be clean to sight and touch. Also, nonfood-contact surfaces of equipment are to be kept free of an accumulation of residue and cleaned at a frequency necessary to prevent accumulation of residue and debris. In addition, nonfood-contact surfaces are to be designed and constructed to allow easy cleaning. |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>34975<br><br>Based on interview and facility document review, the facility failed to have a policy for storing food safely that was brought in by family and visitors. This failure did not allow residents to have food brought in by family and visitors stored safely for them to eat at a later time for 167 residents that consumed food by mouth out of a facility census of 181.<br><br>Findings:<br><br>Review of the undated facility policy titled Food Receiving and Storage read 3. Residents must consume foods from sources not procured by the facility within the same day of receiving to prevent food borne illness. Any unused food should be disposed of immediately thereafter.<br><br>In an interview on 5/21/19 at 4:21 p.m., Certified Nursing Assistant 2 (CNA 2) stated family members brought in food but it was not kept and that the residents had to eat it right away.<br><br>In an interview on 5/21/19 at 4:23 p.m., CNA 3 stated food brought in by family members was not stored. If the residents did not eat it right away it was thrown away.<br><br>In an interview on 05/21/19 4:31 p.m., the DON stated the facility staff encouraged residents to eat food brought in by family members the same day it was brought in to prevent food poisoning. |

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| F 0912<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37427<br><br>Based on observation, interview, and record review the facility failed to meet the required 80 square (sq.) footage (ft.) for five of 77 resident rooms.<br><br>This failure had the potential to limit the freedom of movement of the residents that occupied the rooms, which may place them at risk for injury.<br><br>Findings:<br><br>During the environmental tour with the Property Services Director (PSD) on May 23, 2019 at 9:35 AM the MSD stated the facility had rooms less than minimum square footage required per resident. The following rooms and the measurement were noted as follows:<br><br>a. room [ROOM NUMBER] (3 beds) measured 226.92 sq. ft. (75.64 ft. per resident).<br><br>b. room [ROOM NUMBER] (3 beds) measured 224.4 sq. ft. (74.8 ft. per resident).<br><br>c. room [ROOM NUMBER] (3 beds) measured 224.4 sq. ft. (74.8 ft. per resident).<br><br>d. room [ROOM NUMBER] (3 beds) measured 224.4 sq. ft. (74.8 ft. per resident).<br><br>e. room [ROOM NUMBER] (3 beds) measured 224.4 sq. ft. (74.8 ft. per resident).<br><br>During the survey, the residents occupying the rooms 106, 108, 110, 118, and 120 were observed and interviewed with no complaints with regard to the size and space of their rooms.<br><br>During the survey, observations of rooms 106, 108, 110, 118, and 120 were conducted. The rooms were not crowded, and did not impose any safety hazards to the residents who occupied those rooms.<br><br>The survey team recommends the approval of the room waiver request for the rooms listed in this deficiency. |