Regency Care
of Arlington

Commonwealth of Virginia
Virginia Department of Health
Office of Licensure and Certification
9960 Maryland Drive, Suite 401 Henrico, VA 23233
Attn: Mr. Paul Wade, LTC Supervisor Davison of Long Term Care

September 21, 2015

Dear Mr. Wade,

Regency Care of Arlington, LLC is in receipt of your notice of deficiencies for our survey of August 25, 2015 through August 27, 2015. Please find the enclosed plan of correction.

Once you have reviewed the enclosed information, please call me if you have any questions or concerns. I may be reached at (703)920-5700 or admin@regencycarearlington.com

Thank you in advance.

Sincerely,

Denny G Dennis,

Administrator

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495114	A. BUILDING _____ B. WING _____	08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE OF ARLINGTON, LLC	1785 SOUTH HAYES STREET ARLINGTON, VA 22202

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 08/25/2015 through 08/27/2015. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 240 certified bed facility was 145 at the time of the inspection. The survey sample consisted of 21 current Resident reviews (Residents 1 through 21) and three closed record reviews (Residents 22 through 24).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities. Cross Reference to F-Tag 278 12VAC5-371-250 A-4 Cross Reference to F-Tag 280 12VAC5-371-250 A-4, 5; F Cross Reference to F-Tag 309 12VAC5-371-220 B Polices and Procedures 12 VAC 5-371-140(A) Hospital and Nursing Home Licensure and Inspection. COV 32.1-126.01 (A).	F 001	Cross reference 12VAC5-371-250 A-4 to F-tag 278 Cross reference 12VAC5-371-250 A-4,5;F to F-tag 280 Cross reference 12VAC5-371-220B to F-tag 309 Cross reference 12 VAC 5-371-140(A) to F-tag 371 Cross reference COV 32.1-126.01 (A) to F-tag 001	

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

Administrator | 09-21-2015

State of Virginia

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F 001	Continued From Page 1 Based on staff interview, facility document review the facility staff failed to ensure VSP (Virginia State Police) background checks were conducted and returned in a timely manner for four of 25 employee records and no reference checks were obtained for two of 25 employees prior to employment. Findings were: A review of twenty five employee records was conducted on 08/27/2015. One did not have a criminal record background check conducted through the VSP and three were not completed within 30 days of employment. A Human Resource employee was interviewed on 08/27/2015 at approximately 10:10 a.m. regarding a VSP check that had been completed 11/14/2008 on an employee with a rehire date of 01/06/2014. She stated, "I have only been doing this job since June of this year. The other company that was in charge of the facility prior to March of this year, I guess did not get another VSP background check. As for the employees with late background checks, I had to resend the requests to the State Police and that is the dates they were returned." Regarding the two employees without reference checks, the HR employee stated, "I cannot find any reference checks for these two employees. I guess they weren't done." The facility policy, "Abuse Prevention Program" contained the following information: "Our facility conducts employee background checks and will not knowingly employ any individual who has been convicted of abusing, neglecting, or mistreating individuals."	F 001	F 001 1. The criminal background check that was missing has been located. Reference checks will be obtained for two employees who did not have reference checks. 2. All residents may have been affected for this observation. 100% audit of current employees will be completed to ensure that criminal record and reference checks have been obtained. 3. The procedure for obtaining criminal record and reference checks for new hires has been refined and facility managers have been oriented in the refined procedure. 4. The QA Coordinator and/or designee will audit 25% of new hires weekly for one month to ensure that personnel records contain documentation of the criminal and reference checks. Variances will be investigated and corrected. A monthly report of the QA personnel recored audits will be provided to the QA Committee for additional oversight and recommendation.	10/2/15

State of Virginia

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F 001	Continued From Page 2 "Virginia State Law d d 32.1-126.01. Employment for compensation of persons convicted of certain offenses prohibited; criminal records check required; suspension or revocation of license: Requires that each nursing facility, home care or home health organization, and hospice obtain a criminal record background check on new hires within 30 days of employment. The law also requires that these background checks be obtained using the Central Criminal Records Exchange from the Virginia Department of State Police." No further information was obtained prior to the exit conference on 08/27/2015.	F 001		

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 08/25/2015 through 08/27/2015. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The Life Safety Code survey/report will follow. The census in this 240 certified bed facility was 145 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents 1 through 21) and three closed record reviews (Residents 22 through 24).	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278	1. Resident #19 was reassessed by Speech Therapy on 8/31/15 to ensure the communication assessment is accurate. Resident #19 was found to accurately answer yes/no questions with 90% accuracy, independently and 100% accuracy with verbal cues. Resident identified pictures on communication board with field of 8 with 13% accuracy. The therapist reduced the field of the board to 4 and the resident was able to identify with 95% accuracy independently and 100% accuracy with verbal cues. The MDS for B 0600 was corrected to reflect unclear speech. 2. The facility has determined that all residents with impaired communication have the potential to be affected. 100% of residents with impaired communication will have their most current MDS assessment reviewed to ensure accurate coding of Section B 0600. 3. An inservice education program will be conducted, by the Director of Nursing, with licensed staff to address the importance of	

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[signature]	Administrator	09-21-2015

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 278	Continued From page 1 resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure a complete and accurate MDS (minimum data set) assessment for one of 24 residents, Resident #19. Section B of the MDS which addressed speech clarity and the resident's ability to make herself understood were not coded accurately. Findings were: Resident #19 was originally admitted to the facility on 06/28/2013. Her diagnoses included but were not limited to: Parkinson's disease, dysphagia, CVA (cerebral vascular accident/stroke) with speech and language deficits, hypertension and Type II Diabetes Mellitus. The most recent MDS was a quarterly assessment with an ARD (assessment reference date) of 07/29/2015. Resident #19 was coded as having a cognitive summary score of "12", indicating moderate impairment with her cognitive status. Initial tour of the facility was conducted on 08/25/2015 beginning at approximately 1:15 p.m. Resident #19 was observed lying on her bed.	F 278	F278 Continued accurate assessments related to communication. The MDS Coordinator who completed the original assessment completed MDS training for certification on 9/4/15. 4. The Director of Nursing, or designee, will conduct random audits of coding for MDS assessments at B 0600 of 5 residents per week for four consecutive weeks. These residents and their medical records will be assessed to ensure that impaired communication is identified properly and evaluated and documented in the medical record. These audits will be presented and monitored monthly at the QA Committee meeting until such time consistent substantial compliance has been met.	10/9/15

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F 278	Continued From page 2	F 278		

She was reaching out to this surveyor with her right hand. She was nonverbal. She made a guttural humming sound but did not use any words or change the pitch of her hum. A sign was observed over her bed which read, "Communication Book is to remain on top of night stand. Please use with resident as needed." There was no communication book observed on the nightstand or near Resident #19's bedside.

On 08/26/2015 at approximately 3:30 p.m., Resident #19 was observed lying flat on her bed. Again she put her right hand out to this surveyor and made a brief humming sound. There was no communication book on her nightstand.

The clinical record was then reviewed. Section B (Hearing, Speech, Vision) the quarterly MDS with an ARD of 07/29/2015 was reviewed. Section B0600 Speech Clarity coded Resident #19 as having "clear speech-distinct intelligible words". Section B0700 Makes Self Understood coded the resident as "Usually understood-difficulty communicating some words or finishing thoughts but is able if prompted or given time". Section B0800 Ability to Understand Others, coded Resident #19 as "Usually Understand-misses some part/intent of message but comprehends most conversation."

On 08/27/2015 at approximately 8:00 a.m. Resident #19 was observed on the unit being fed breakfast by the staff. The staff talked to Resident #19 but there were no verbal responses from her. She made the same humming sound that she had made with this surveyor previously.

The MDS Nurse for the Resident #19 was interviewed on 08/27/2015 at approximately 9:00

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F 278	Continued From page 3	F 278		

a.m. She was asked if she had completed the sections of the MDS regarding speech clarity and ability to understand. LPN (licensed practical nurse) #1 reviewed the electronic MDS and acknowledged that she had completed those sections for Resident #19. She was asked if Resident #19 had spoken to her during the assessment. She stated, "I can't recall...I have done so many that I really can't recall what I did with her...sometimes if the patient is asleep or in an activity I ask the staff...I don't know what I did with her."

This surveyor and LPN #1 went to speak with Resident #19. LPN #1 called the resident by name. The resident began lifting her legs. She did not answer LPN #1 and made a humming sound. LPN #1 stated, "There is no point trying to assess her, she can't communicate with me." LPN #1 was asked if this was a change since the assessment in July. She stated, "I don't know."

The administrator and the DON (director of nursing) were made aware of the above information during an end of the day meeting on 08/27/2015.

No further information was obtained prior to the exit conference on 08/27/2015.

F 280 SS=D — 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP — F 280

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

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F 280	Continued From page 4 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to review and revise a comprehensive care plan for one of 24 residents, Resident #19. Resident #19's care plan for the nursing staff and the CNA (certified nursing assistant staff) did not contain interventions for eating safety or for communication. Findings were: Resident #19 was originally admitted to the facility on 06/28/2013. Her diagnoses included but were not limited to: Parkinson's disease, dysphagia, CVA (cerebral vascular accident/stroke) with speech and language deficits, hypertension and Type II Diabetes Mellitus. The most recent MDS was a quarterly assessment with an ARD (assessment reference	F 280	1. On 9/10/15 the Unit Manager and Social Worker updated care plans on resident #19 for communication and eating precautions. 2. Residents with impaired communication may be at risk and their care plans will be reviewed to ensure heir communication needs are addressed. Residents with precautions may be at risk and their care plans will be reviewed to ensure meal safety is addressed. 3. The facility's licensed staff responsible for for care plans will be inserviced by the Director of Nursing. In addition, the leadership team will participate in a care planning webinar facilitated by an independent consultant on person centered care plans. Unit managers and/or designated staff will review and update care plans weekly, as necessary, for residents with impaired communication and/or eating precautions to ensure accurate interventions are in place. 4. The Director of Nursing or designee will review a random sample of 10% of resident care plans once a week for one month and every other week for one month to assure review and revision of care plans. Results of audits will be presented monthly to the QA Committee until such time as substantial compliance has been achieved as determined by the committee.	10/9/15

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F 280	Continued From page 5	F 280		

date) of 07/29/2015. Resident #19 was coded as having a cognitive summary score of "12", indicating moderate impairment with her cognitive status.

Initial tour of the facility was conducted on 08/25/2015 beginning at approximately 1:15 p.m. Resident #19 was observed lying on her bed. She was reaching out to this surveyor with her right hand. She was nonverbal. She made a guttural humming sound but did not use any words or change the pitch of her hum. A sign was observed over her bed which read, "Communication Book is to remain on top of night stand. Please use with resident as needed." Other signs included the following information: SAFE SWALLOWING GUIDELINES sit upright, remain sitting 30-45 minutes after meals, NO STRAWS, small sips and bites, cut food into small pieces, alternate solid and liquids, frequent sips of liquids during meals, if coughing take a rest break, allow time to chew each bite. Caregivers check ,South for residue throughout and following meals and snacks." An additional sign contained the following: :Nectar liquids, dysphagia advanced diet texture, chopped meat only (cut in small pieces), puree vegetables only".

The clinical record was reviewed on 08/26/2015. The care plan did not contain any of the interventions listed on the signage above Resident #19's bed.

On 08/27/2015 at approximately 8:00 a.m. Resident #19 was observed in the dining room being fed breakfast by CNA (certified nursing assistant) #1. Resident #19 was fed toast with jelly, a hard boiled egg and a glass of nectar think liquid. CNA #1 did not alternate solids with liquids

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F 280	Continued From page 6	F 280		

or check her mouth for residue during the meal as the signage over Resident #19's bed directed. There was no communication book available in the dining room for CNA #1 to communicate with Resident #19. Resident #19 remained nonverbal and making humming sounds throughout the meal.

CNA #1 was interviewed after Resident #19 completed breakfast. CNA #1 was asked how she knew what to do for Resident #19. She stated, "I am not taking care of her today, I am helping (name of CNA caring for Resident #19)...we work as a team." CNA #1 was asked if there was a care plan that she followed for Resident #19. She stated, "We have an ADL (activities of daily living) plan." CNA #1 was asked if she was aware of the feeding directions over Resident #19's bed. She stated, "I have not been to her room. I am just helping out."

The ADL plan was requested from the unit manager, LPN (licensed practical nurse) #2. The directions for feeding that were on the signage above Resident #19's bed were not on the ADL plan for the CNAs. The directions for eating were: "Arrange meals in patient visual field; House supplements as ordered."

The DON (director of nursing) was interviewed on 08/27/2015 at approximately 10:00 a.m. She was asked if she would expect the information above the bed to be located on Resident #19's care plan. She stated, "Yes."

The administrator and the DON (director of nursing) were made aware of the above information during an end of the day meeting on 08/27/2015.

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F 280	Continued From page 7 No further information was obtained prior to the exit conference on 08/27/2015.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide care and services to ensure the highest well being for one of 24 residents, Resident #19. Resident #19 did not have a communication book at her bedside to facilitate communication, nor were physician orders for yogurt at every meal communicated with the main kitchen. Findings were: Resident #19 was originally admitted to the facility on 06/28/2013. Her diagnoses included but were not limited to: Parkinson's disease, dysphagia, CVA (cerebral vascular accident/stroke) with speech and language deficits, hypertension and Type II Diabetes Mellitus. The most recent MDS was a quarterly assessment with an ARD (assessment reference	F 309	1. 8/31/15 to 9/4/15 resident #19 was evaluated and treated by Speech Therapy. Resident noted to need communication communication board for most accurate communication. Updated communication book placed at resident's bedside. Resident's order fro yogurt at every meal communicated to the kitchen on 8/27/15. Resident's diet order and dietary communication slip are accurate. 2. Residents with impaired communication may be at risk and will be screened for need for communication books. Residents with special dietary orders may be at risk. A 100% review of current physician orders will be completed and communicated to the dietary department. 3. The Director of Nursing will inservice all staff on importance of communication devices, their accessibility and care planning. Licensed staff will also be inserviced on ensuring accuracy of diet orders with dietary meal tickets. 4. The Director of Nursing or designee will review a random sample of 10% of resident physician orders weekly for one month and every other week for one month to assure accuracy with communication between dietary and nursing. An observational audit of residents with plans for communication books/ devices will be completed weekly for one month, cont'd	

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F 309	Continued From page 8	F 309	F 309 Cont'd	

date) of 07/29/2015. Resident #19 was coded as having a cognitive summary score of "12", indicating moderate impairment with her cognitive status.

Initial tour of the facility was conducted on 08/25/2015 beginning at approximately 1:15 p.m. Resident #19 was observed lying on her bed. She was reaching out to this surveyor with her right hand. She was nonverbal. She made a guttural humming sound but did not use any words or change the pitch of her hum. A sign was observed over her bed which read, "Communication Book is to remain on top of night stand. Please use with resident as needed."

The clinical record was reviewed on 08/26/2015. Observed on the physician order sheet was: "Yogurt (sp) with meals..."

On 08/27/2015 at approximately 8:00 a.m. Resident #19 was observed in the dining room being fed breakfast by CNA (certified nursing assistant) #1. Resident #19 was fed toast with jelly, a hard boiled egg and a glass of nectar think liquid. CNA #1 did not alternate solids with liquids or check her mouth for residue during the meal as the signage over Resident #19's bed directed. There was no communication book available in the dining room for CNA #1 to communicate with Resident #19. Resident #19 remained nonverbal and making humming sounds throughout the meal. After Resident #19 was fed breakfast, CNA #1 wiped her face and moved her to another table in the dining area. CNA #1 was asked if Resident #19 was through with breakfast. She stated, "Yes." CNA #1 was asked if Resident #19 had eaten her yogurt. She stated, "She is on soft diet...she has nectar thick liquids." CNA #1 was

and every other week for one month by DON and/or designee to ensure that the device/book accessible to the resident and staff for use; variances will be investigated and corrected. Results will be reviewed by the QA Committee until such time consistent with substantial compliance has been achieved as determined by the committee. 10/9/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495114	A. BUILDING _____ B. WING _____	C 08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE OF ARLINGTON, LLC	1785 SOUTH HAYES STREET ARLINGTON, VA 22202

(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 309	Continued From page 9	F 309		

again asked about the yogurt. She stated, "She did not have any meat for breakfast...we cut her meat into small bites." The CNA was asked if she knew what yogurt was. She stated, "Yes, I have called the kitchen and asked for them to send it."

The unit manager, LPN (licensed practical nurse) #2 was interviewed regarding the yogurt and the communication book for Resident #19. He stated, "We get her the yogurt every day...that is something she likes and the family has requested it." The physician order was shown to LPN #2. He stated, "Yes, we get that for her." The communication book was then discussed. LPN #2 and this surveyor went to Resident #19's room. A communication paper was found across from Resident #19's bed, beside her television. The paper was inside of a plastic sleeve and had pictures of common phrases/objects, such as "I'm sad (picture of face with a teardrop), I'm hungry (a figure with a knife and fork), Glasses (a picture of glasses). There were a total of 16 phrases/objects. LPN #2 stated, "These are everywhere...if you show her this it just confuses her...she can tell you what she needs." This surveyor and LPN #2 went to the nurse's station where Resident #19 was sitting. She was unable to point to anything on the communication paper. She continued to make humming sounds in response to his questions. She did not nod her head yes or no. LPN #2 was asked how staff communicated with the resident. He stated, "She says words when she wants to...everyday at 1:30 or 2:00 she says "Bed", it is very plain." LPN #2 stated, "All those signs over her bed are from speech therapy." LPN #2 was asked who the speech therapist was that had worked with Resident #19. He stated, "That was with the old company, they are no longer here."

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	495114	A. BUILDING _____ B. WING _____	C 08/27/2015

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F 309	Continued From page 10 The dietary manager was interviewed at approximately 9:15 a.m. on 08/27/2015 The tray ticket for Resident #19 was shown to him. Information on the ticket included: "Mech (mechanical) soft, Pu (puree) Veg (vegetables), Nectar thick." There was nothing on the ticket regarding the physician ordered yogurt for each meal. The dietary manager stated, "If we had gotten that order it would be on the ticket." The administrator and the DON (director of nursing) were made aware of the above information during an end of the day meeting on 08/27/2015. No further information was obtained prior to the exit conference on 08/27/2015.	F 309		
F 371 SS=C	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, facility staff failed to procure, store/prepare/serve food in a sanitary manner in the main kitchen.	F 371	1. No residents reported any adverse outcomes from this observation. 2. All residents may have been affected. No resident reported and adverse outcomes from this observation. 3. The dietary manager will re-educate staff on facility policy and the form to log sanitizer testing. The dietary staff will be educated on logging the sanitizer testing each shift. 4. The dietary manager will audit the sanitizer log two times per week for one month then weekly for one month and then monthly to ensure test results are logged each shift. Any variances will be investigated and staff will be re-educated as appropriate. Findings from the weekly audits will be provided to the administrator and a summary report will be made to the QA committee for additional oversight, recommendation and continued monitoring.	10/2/15

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F 371	Continued From page 11	F 371		

Facility staff failed to document sanitizer testing for the three compartment sink on seven shifts in July and four shifts in August 2015.

Findings included:

Initial tour of the kitchen was performed on 08/25/2015 at approximately 1:45 p.m. The Dietary Manager accompanied this surveyor on tour.

During observation of the three compartment sink, the "Manual Warewashing Sanitizing Log" for the month of July was noted to have seven shifts without documentation for sanitizer testing and the month of August had four shifts without documentation. The days were July 24, 25, 26, 27, 28, 29, 30 during the noon check and August 18, 19, 20, 21 during the evening check.

The Dietary Manager was interviewed regarding the missing documentation. He stated, "The cook didn't record on the log. It is the cooks responsibility to record the three compartment sink testing."

At approximately 2:15 p.m. the Dietary Manager brought a copy of the policy used for sink sanitation guidelines to the conference room. He stated, "This is the only policy we have. It doesn't state how often to check the three compartment sink. We go by the guidelines written on the sanitizing log."

Policy: "Washing Pots and Pans...4. Place in sanitizer (per sanitation protocol)..." Sanitation protocol per the "Manual Warewashing Sanitizing Log" stated, "Standards: Chemical Sanitizing

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F 371	Continued From page 12	F 371		

150ppm (parts per million) - 400ppm (unless a different range is indicated by the manufacturer)...Instructions: For chemical sanitizing, record the ppm level..." The log was noted to have three columns labeled as "Morning, Noon, Evening; ppm/temp (temperature), Initials." The logs were consistently completed in all three columns, except for the blanks mentioned above.

The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 08/26/2015 at approximately 4:00 p.m.

No further information was received by the survey team prior to the exit conference on 08/27/2015.