The Facility will adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness.

B. There were no residents harmed by these practices.

B. All residents had the potential for harm due to these practices, but none have been found at this time.

C. 1. Refrigerators and Freezers will have all food appropriately stored and they will be cleaned and outdated food removed weekly and PRN. To be monitored by CDM/Designee.
   (a) The sour cream was removed on 4/28/13.
   (b) The mustard was removed on 4/28/13.
   (c) The butter and rolls were removed and disposed of on 4/28/13.

2. Hair coverings will be worn by all persons entering dietary and around food preparation and serving areas.
   (a) A permanent container for hair nets has been placed outside the entrance to the kitchen and the CDM and dietary staff will monitor daily for compliance and for refill of container.

3. All employees are required to wash hands before serving residents, after collecting soiled plates, PRN.

4. All vents and fans in dietary will be maintained in a sanitary condition. Maintenance has added this to the monthly preventive maintenance program and will be additionally monitored by the Administrator, CDM and/or Designee on a weekly basis and added to the maintenance work order as a PRN situation.

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Freezers' policy documented, "...All food shall be appropriately dated to ensure proper rotation by expiration dates. "Use by" dates will be completed with expiration dates on all prepared on all prepared food in refrigerators... and "use by" dates indicated once food is opened. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates."

a. Observations in the walk in refrigerator on 4/28/13 at 11:30 AM revealed the following:
   a. A 5 pound tub of sour cream with an opened date of 2/20 with approximately 3/4 of the item gone with a best by date of 4/1/13, the date was smeared and unable to see the expiration date due to a smear over the date.
   b. A gallon container of mustard with an opened dated of 4/11 with a furry black substance with the appearance of mold scattered on the top and around the sides of the container.

During an interview in the walk in refrigerator on 4/28/13 at 11:50 AM, the Certified Dietary Manager (CDM) was asked how long items are good after opened. The CDM stated, "...3 days..."

During an interview in the walk in refrigerator on 4/28/13 at 11:50 AM, the CDM was asked what the substance might be. The CDM replied, "I'm like you, I honestly don't know..." and removed the containers of the sour cream and the mustard.

b. Observations in the walk in freezer on 4/28/13 at 11:40 AM, revealed 1 box of butter and egg dinner rolls opened with the plastic opened exposing the rolls to the air.

During an interview in the kitchen on 4/28/13 at 11:40 AM revealed:...
11:50 AM, the CDM was asked if this was acceptable for the food item to be open to the air while stored. The CDM stated, "No."

2. Review of the facility’s "Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices" policy documented, "...Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils..."

Observations in the kitchen on 4/28/13 revealed the following:

a. At 11:50 AM - the CDM was in the kitchen with no hair cover on her head.
b. At 12:00 PM - dietary staff member #1 walked into the kitchen without a hair cover.

During an interview in the kitchen on 4/29/13 at 2:15 PM, dietary staff members #2 and #3 confirmed everyone that enters the kitchen must wear hair coverings, and when the dietary staff come to work, someone in the kitchen must hand them a hair covering because the coverings are kept in the back room.

During an interview in the day room on 4/30/13 at 2:15 PM, the CDM was asked why the hair coverings were not kept close to the entry door of the kitchen. The CDM replied, "I thought the same thing..."

3. Review of the facility’s "Food Preparation and Service" policy documented, "...Food service staff, including nursing services personnel, will wash their hands before serving food to residents. Employees also will wash their hands after collecting soiled plates and food waste prior to handling food trays..."
Continued From page 3

Review of the facility's "Handwashing/Hand Hygiene" policy documented, "...The facility considers handwashing/hand hygiene as the primary means to prevent the spread of infections... All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents... If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% [percent] ethanol or isopropanol for all the following situations... Before direct contact with residents; After contact with a resident's intact skin; After contact with objects (medical equipment) in the immediate vicinity of the resident..."

Observations in the 400 hall on 4/28/13 at 12:00 PM, Certified Nursing Assistant (CNA) #2 did not wash her hands prior to or after serving trays in rooms 400, 403, 407 bed - 2, 417 beds 1 and 2.

Observations in the central dining room on 4/28/13 revealed the following:

a. At 12:05 - CNA #1 went to the food cart, obtained a tray of food, served the tray to a resident, opened all food items removing cellophane and covers from the food. CNA #1 returned to the food cart to obtain another tray and did not sanitize her hands.

b. At 12:10 PM - CNA #1 touched all of the trays left on the cart, obtained a tray and served the tray to a resident. CNA #1 did not use gel or wash her hands.

c. At 12:15 PM - CNA #1 obtained a tray from the food cart, served the tray to a resident, opened the food items on the tray, cut up food for resident, obtained another tray from the cart, opened the food items and did not sanitize her hands.
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<td>Observations in the 400 hall on 4/29/13 revealed the following:</td>
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<td>a. At 5:40 PM - Nurse #1 delivered a tray to room 400, touching the resident and the bedside table and set up the tray without washing her hands. Nurse #1 then went to room 410, set up the tray touching the bedside table without washing her hands. Nurse #1 then went to room 407 B, set up the tray touching the bedside table, she did wash her hands after this resident.</td>
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<td>b. At 5:57 PM - Nurse #1 knocked on the door, entered room 416, moved the resident's cane to the side of the bed and placed the over bed table in front of a wheelchair, went to the food cart and obtained a tray and placed the tray on the overbed table, assisted the resident to the wheelchair, and then set up the tray without washing her hands.</td>
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<td>During an interview in the Director of Nursing's (DON) office on 4/30/13 at 7:55 AM, the DON stated, &quot;All staff passing out trays should wash their hands prior to passing trays in the halls and dining areas... if the staff touch any objects prior to passing out trays or following I expect them to wash their hands.&quot;</td>
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<td>4. Review of the facility's &quot;Food Preparation and Service&quot; policy documented, &quot;...Areas for cleaning dishes and utensils are located in a separate area from the food service line to assure that a sanitary environment is maintained...&quot;</td>
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<td>Review of the facility's &quot;Sanitation&quot; policy documented, &quot;...Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime...&quot;</td>
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<td>Review of the facility's &quot;Monthly Preventative...&quot;</td>
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The Facility will adhere to the rule of reporting all allegations of abuse to the State Department of Health.

A. This resident was not harmed by the situation that the situation that was reported as the arm that she was referring to was due to a rotator cuff issue.

B. All residents have the potential to be harmed if there is ongoing abuse in the facility not being investigated and reported. No others have been found to have been harmed.

C. 1. Any allegation of abuse will have the investigation started immediately with notification to the Abuse Coordinator which will give direction to the staff on duty to proper procedure and per company policy. The resident will be assessed for harm and the employee accused will be suspended until the investigation is complete. The Administrator, Abuse Coordinator and/or designee will come to the facility to assist in the investigation at the earliest possible time and ensure that it is being completed correctly and that statements are obtained and that policy is being followed. The Abuse Policy and the Resident Rights were both serviced to the entire staff on Friday April 19, 2013.

2. All allegations of abuse will be reported within 5 days from the date of notification through the Incident Reporting Service.
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supervisor must complete a Resident Abuse Form..."

Review of the facility's "Abuse Investigations" policy documented, "...All reports of resident abuse... shall be promptly and thoroughly investigated by facility management... Should an incident or suspected incident of resident abuse, mistreatment... be reported, to the administrator, or his/her designee, will appoint a member of management to investigate the alleged incident... The individual conducting the investigation will... Review the completed "Resident Abuse Form"... Interview the resident's... family members, and visitors... Interview other residents to whom the accused employee provides care... The results of the investigation will be recorded on the "Resident Abuse Investigation Report Form."

Review of the facility's "Protection of Residents During Abuse Investigations" policy documented, "...Within five (5) working days of the alleged incident, the facility will give the... state survey and certification agencies... a written report of the findings of the investigation..."

Review of the facility's "Reporting Abuse to Facility Management" policy documented, "...Upon receiving reports of physical or sexual abuse, a licensed nurse or physician shall immediately examine the resident. Findings of the examination must be recorded in the resident's medical record... The person performing the examination must complete a "Resident Abuse Report Form"... Upon receiving information concerning a report of abuse, the director of nursing services will request that a representative of the social services department monitor the resident's reactions to and statements regarding the incident and his/her involvement in the..."
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| N1102 | investigation... Unless the resident requests otherwise, the social service representative will give the administrator and the director of nursing services a written report of his/her findings... |

Review of the facility's "Staff Responsible for Coordinating / Implementing Abuse Prevention Program Policies and Procedures" documented, "...The administrator has the overall responsibility for the coordination and implementation of our facility's abuse prevention program policies and procedures..."

Medical record review for Resident #15 documented an admission date of 7/13/12 and a readmission date of 2/20/13 with diagnoses of Pneumonia, Muscle Weakness, Abnormal Gait, Deblility, Osteoarthritis, Dysphagia, Diabetes Type 2, Hypothyroidism, Hyperlipidemia, Leukocytosis, Depression, Obstructive Sleep Apnea, Tremor, Restless Leg Syndrome, Chronic Pain, Legal Blindness, Hypertension, Coronary Artery Disease, Congestive Heart Failure, Gastro Esophageal Reflux Disease, Gastric Diverticulum, Chronic Kidney Disease, Fibromyalgia, Anxiety, and Chronic Obstructive Pulmonary Disease. Review of the daily skilled nurses' notes dated 4/20/13 and 4/21/13 revealed no documentation of Resident #15 resisting care.

Review of the documentation of the investigation of the alleged abuse incident for Resident #15 documented, "Summary of Investigation... The Administrator was notified on Sunday April 21 [2013] of an Incident involving resident [#15] and C.N.A. [Certified Nursing Assistant #3] stating that [Named Resident #15] had commented that a C.N.A. named [CNA #3] had been in her room and had jerked her arm during the night. Upon arriving at the facility, statements were taken and
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discussion with resident and family and
determined that the placement of lap buddy was
when the incident occurred. [Named Nurse #4]
and C.N.A. [Named CNA #5] were the ones who
placed the lap buddy and [Named CNA #3] was
not in the room. There was never an allegation of
abuse by resident or family, but investigation was
conducted as such. There were no findings of
Abuse in the investigation." Review of the written
statement by Nurse #3, east wing charge nurse
on duty at the time of the incident, documented,
[Named CNA #4] came to me and told me that
[Named Resident #15] told her that the male CNA
[N3] that was working the night shift 4/20/13 had
pulled the Residents (#15) arm and Resident
[#15] stated he pulled it back and it hurt. Family
was here and came to the desk voicing their
concern. Charge nurse [N3] called the House
Supervisor and she came and spoke to the
Family..." Review of the written statement by CNA
#4 documented, "On 4-21-13 I was CNA on
Group 2 and...was giving [Named Resident #15]
a bath and she was telling me that [Named CNA
#3] had jerked [jerked] her arm and it was hurting
her and that he had twisted it...I told charge nurse
[Named Nurse #3] what she had said and that I
didn't think she was making it up..." Review of the
written statement by Nurse #5, House Supervisor
on duty at the time of the incident, documented,
"4/21/13 Was called to East Wing by charge
nurse. The son-in-law met me in the hallway to
speak to me about his mother-in-law [Named
Resident #15]...He said that [Named Resident
#15] said her "arm was sore"..." Review of the
documentation of the investigation of the alleged
abuse incident for Resident #15 revealed there
was no Resident Abuse Form or Resident Abuse
Investigation Report Form completed as required
per the facility's abuse prevention, reporting, and
investigating policies, and there was no report of
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the alleged abuse being filed with the state survey and certification agency.

During the stage 1 resident interview in Resident #15's room on 4/29/13 at 8:52 AM, Resident #15 was asked have you ever been treated roughly by staff. Resident #15 stated, "Yes... They twisted my arm about 3 weeks ago... His name was [Named CNA #3]..." Resident #15's son-in-law was present during interview and confirmed the resident reported the incident to staff. Resident #15's son-in-law stated he reported this incident to the charge nurse on the hall at that time.

During an interview at the east nurses' station on 4/29/13 at 5:44 PM, Nurse #6, hall manager, was asked if she was aware of any reports of abuse involving Resident #15 on 4/20/13. Nurse #6 stated, "No one has reported anything to me." Nurse #6 was asked if Resident #16 ever resists care. Nurse #6 stated, "She does not like males caring for her... We had a male tech [Named CNA #3] up there..."

During an interview in the Administrator's office on 4/29/13 at 6:25 PM, the Social Services Director (SSD) was asked if she had any issues she had worked on with Resident #15 or her family. The SSD stated, "I haven't had any issues to deal with with that resident [15]..."

During an interview in the day room on 4/29/13 at 6:40 PM, the Administrator stated, "...We looked into that one [Named Resident #15]... The CNA [Named CNA #3] that she said she didn't even in the room that night... People have been talking and getting things stirred up..."

During an interview at the central nurses' station on 4/30/13 at 9:39 AM, the SSD was asked for
information regarding any abuse allegations by Resident #15. The SSD stated, "I don’t know anything about them [allegations]..." The SSD was asked if abuse allegations should be reported to her. The SSD stated, "I would expect them to... If they were already tending to it, I wouldn’t expect them to tell me though... I’m not here full time..."

During an interview in the day room on 4/30/13 at 9:49 AM, the Administrator was asked about the abuse allegation by Resident #15 on 4/20/13 and 4/21/13. The Administrator stated, "There was not an allegation of abuse..." The Administrator was asked to explain the written statement made by Nurse #4 who received the report of abuse. The Administrator stated, "That was not an allegation of abuse... I talked to the son-in-law... and other people on duty... I don’t think that was an allegation... they said it was resisting care..." The Administrator was asked would you not consider the statement by the resident that the male CNA pulled the resident’s arm and twisted it as an allegation of abuse. The Administrator stated, "No, it was during care... and he [accused CNA] was not even in the room..." The Administrator was asked what would you consider a full investigation of abuse. The Administrator stated, "...Talk to the person who was injured... son-in-law... all staff..." The Administrator was asked why the incident was not reported to the state agency as an abuse allegation. The Administrator stated, "If it was an allegation, I would have reported it... I didn’t see that as an allegation of abuse. I saw that as a resistance to care..."

During an interview in the Director of Nursing’s (DON) office on 4/30/13 at 2:14 PM, the DON was asked for information regarding the report of
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abuse by Resident #15. The DON stated, "I know they talked to the charge nurse... I didn't interview the resident or the son-in-law..."

During an interview in the Assistant Director of Nursing's (ADON) office on 4/30/13 at 2:30 PM, the Administrator stated, "I didn't interview the son-in-law directly... he wasn't here the next day when I came in..."

During an interview at the east nurses' station on 4/30/13 at 2:58 PM, Nurse #3 was asked for information of the incident reported to her on 4/21/13 involving Resident #15. Nurse #3 stated, "She [Resident #15] had voiced to a CNA about it... I talked to the son-in-law..."

The facility Administrator failed to recognize an allegation of abuse, the facility failed to thoroughly investigate an alleged allegation of abuse by not completing a Resident Abuse Form or Resident Abuse Investigation Report Form as required by the facility's policies. The facility failed to report an allegation of abuse to the state survey and certification agency.