A Deep Dive into the Most Frequently Cited Clinical Areas

PACAH SPRING CONFERENCE

Affinity Health Services
Senior Community Management and Consulting Services

PADONA

PADONA/LTCN
Pennsylvania Association of Directors of Nursing Administration

PADONA

Sophie Campbell, RN, MSN,CRRN, RAC-CT, CNDLTC

Executive Director Educational Programming and Services

PADONA

Sharing our ***affinity*** to provide consulting and management services to senior living communities.

Affinity Health Services, Inc.

Affinity Health Services
Senior Community Management and Consulting Services

Candace McMullen, RN, NHA, MHA, CLNC, CNDLTC

Affinity Health Services, Inc.

Executive Vice President of Business Development and Consulting

Types of Surveys

- Standard Survey (annual)
- Extended Survey* (substandard quality of care)
- Abbreviated Standard Survey
- Partial Extended Survey
- Post-Survey Revisit
- Initial Certification Survey/Occupancy Survey
- State Monitoring Visits
- Infection Control Surveys

	SCOPE OF DEFICIENCY		
IMMEDIATE JEOPARDY to resident's health and safety	J	K	L
ACTUAL HARM that is NOT immediate jeopardy	G	H	I
NO actual harm but POTENTIAL FOR MORE THAN MINIMAL HARM	D	E	F
No actual harm and potential for ONLY MINIMAL HARM	A	B	C

Average Number of Deficiencies

PA Average — 8.0/facility

US Average — 8.6/facility

*** Data through 2/2022 www.medicare.gov/Care Compare*

Number	Tag	Description	Percent of Providers Cited
1	684	Quality of Care	30.5% of providers cited
2	689	Accident hazards/safety/Supervision	25.8% of providers cited
3	812	Food Procurement/Storage/Sanitation	24.1% of providers cited
4	656	Comprehensive Care Plan	21.6% of providers cited
5	880	Infection Prevention and Control	18.1% of providers cited
6	761	Labeling/Storage of Biologicals	17.8% of providers cited
7	686	**Treatment/Services to Prevent/Heal Pressure Ulcer**	16.6% of providers cited
8	600	**Prevention of Abuse/Neglect/Exploitation**	15.3% of providers cited
9	677	ADL Care Provided for Dependent Residents	15.2% of providers cited
10	584	Safe/Clean Homelike Environment	14.1% of providers cited

Data obtained from CMS Full Text of Citations through January 2023. Data reflects citations issued from Jan. 2022 thru December 2022.

Immediate Jeopardy Citations

Tag (Included in top 10)	Citation Level	Number of Times Cit
F880 – Infection Control	J	4
F880 – Infection Control	K	10
F689 – Accidents and Supervision	J	13
F689 – Accidents and Supervision	K	10
F689 – Accidents and Supervision	L	1
F684 Quality of Care	J	4
F684 – Quality of Care	K	3
F678 – CPR/BLS	J	1
F812 - Food Safety	L	1
F610 - Abuse Investigation & Reporting	J	1
F600 – Prevention of Abuse/Neglect	J	2
F600 – Prevention of Abuse/Neglect	K	1
F725 – Sufficient Nursing Staffing	K	2
F583 – Confidentiality of records	J	1
F835 - Administration	J	1
F760 – Significant Medication Errors	K	1

F684 – Quality of Care (#1)

F684 – Quality of Care

§ 483.25 Quality of Care

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

INTENT

To ensure facilities identify and provide needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs.

F684 – Quality of Care

The following sections describe some, but not all of the care needs that are not otherwise covered in the remaining tags of §483.25, Quality of Care.

- Resident with Non-Pressure-Related Skin Ulcer/Wound
  - Arterial Ulcer
  - Diabetic Neuropathic Ulcer
  - Venous or Stasis Ulcer
- Review of a Resident at or Approaching End of Life and/or Receiving Hospice Care and Services
  - Assessment
  - Care planning
  - Resident Care Policies
  - Hospice Care and Services
  - Coordinated Care Plan
  - Physician Services
  - Communication
  - Facility Practices/Written Agreement for Hospice Services

F684 –Immediate Jeopardy Citations

The facility failed to provide care and services after an unwitnessed fall, and the facility failed to give the physician an accurate physical assessment to include description of the fall and that the resident was on anticoagulant medication

- Resident found by the licensed nurse on the floor at the foot of the bed and stated that he fell and hit his head.
- Neurochecks were started per policy and ended in 90 minutes from the time the resident was found on the floor, when the LPN completing them left for the shift – not per facility policy after an unwitnessed fall
- 6 hours later resident found on the floor prone and unable to move with muscle rigidity
- RN assessment of resident at time of fall noted 1 hematoma; LPN reported that evaluation of resident noted 3 hematomas and was actively bleeding
- LPN was told by the RN that the MD had been notified and there was no call back and no new orders
- Physician stated that no call had been received that evening about a resident who had fallen twice with 3 hematomas and 1 actively bleeding who was receiving anticoagulants or they would have been transferred to the hospital immediately.
- Call made by the RN was retrieved from the answering service which stated that resident fell, was ok and no call back was required.
- Resident was sent to the hospital but there was a delay in treatment and could have been more significant and policies were not followed, as well as the completed resident assessment was not complete or accurate

Additional F684 Citation Examples

The facility failed to be in compliance with the care plan and provide the resident care deemed necessary by assessment resulting in a resident fall and injury that resulted in resident hospitalization

- Resident admission assessment and subsequent quarterly assessments noted resident required one person assistance with ambulation and transfers or use of the wheelchair
- Care plan interventions stated the resident would have 1 person assistance with transfers and ambulation with the goal of reducing the number of falls and potential injuries from falls
- Documentation noted resident had transferred without assistance frequently – at least daily for the previous 4 weeks
- Documentation and incident reports noted the resident had fallen twice weekly for the previous 4 weeks
- Event report stated that an LPN observed the resident ambulating in the hall going toward the dining room
- Resident was allowed to walk the length of the care unit hall unassisted and go to the empty dining room (not a meal time)
- Resident fell in the dining room and hit head and was taken to the hospital.

Additional F684 Citation Examples

- Facility failed to ensure that resident wound dressings were changed per physician order. Treatment Administration Record revealed blank spots at the wound dressing change for 9/24. Observation of the wound dressing revealed the last date on the wound dressing was 9/23. The missed dressing change was reported by the resident.
- System failure where the facility failed to obtain and record blood glucose levels for residents with a diagnosis of type 2 diabetes; failed to report blood glucose levels per physician orders to the physician; failed to obtain resident weights weekly when physician orders were revised and failed to provide correct enteral nutrition for residents based on a revised physician order.
- Facility failed to address resident change of condition promptly. Resident was noted with multiple bruises of unknown origin on the evening shift. Evaluation by the CRNP during routine rounds discovered the bruises and documentation did not note any falls and there were no incident reports. Resident had fallen on the day shift and nothing had been documented and no event report or investigation was completed. Physician or CRNP were not notified and family was not notified.
- Facility failed to provide the highest practicable level of care regarding wounds. A resident with skin wounds was noted without at least weekly documentation of assessment, measurement and treatment review in the medial record.
- Facility failed to provide treatments for the resident per the physician orders. Treatment administration record did not include the right leg splint the resident was to wear to stabilize the knee joint. The splint was not applied for 3 weeks since admission and the resident experienced decline in the stability of the right knee joint.

F684 – Quality of Care - Tips

- Evaluate Treatment and medication administration records for completion and evaluate blank spaces – determine cause and address
- Review care during change of shift report
- Are supervisors and/or charge nurses checking on incomplete documentation prior to end of shift
- Empower all staff to report what they hear from residents and what they see – CNAs should report when the date on the wound dressing is incorrect, when they have not seen the resident receive a blood glucose check and anyone should report if a resident states they have not received care
- Evaluate trends and patterns of quality of care items and address in QAPI

F689 – Accidents/Supervision/ Assistance Devices (#2)

F689 – Accidents/Supervision/Assistance Devices

§483.25(d) Accidents.

The facility must ensure that –

§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

INTENT: §483.25(d)

The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:

- Identifying hazard(s) and risk(s);
- Evaluating and analyzing hazard(s) and risk(s);
- Implementing interventions to reduce hazard(s) and risk(s); and
- Monitoring for effectiveness and modifying interventions when necessary.

F689 – Accidents/Supervision/Assistance Devices

"Avoidable Accident"

An accident occurred because the facility failed to:

- Identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices; and/or
- Evaluate/analyze the hazards and risks and eliminate them, if possible, or, if not possible, identify and implement measures to reduce the hazards/risks as much as possible; and/or
- Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of an accident; and/or
- Monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice.

"Unavoidable Accident"

An accident occurred despite sufficient and comprehensive facility systems designed and implemented to:

- Identify environmental hazards and individual resident risk of an accident, including the need for supervision; and
- Evaluate/analyze the hazards and risks and eliminate them, if possible and, if not possible, reduce them as much as possible;
- Implement interventions, including adequate supervision, consistent with the resident's needs, goals, care plan, and current professional standards of practice in order to eliminate or reduce the risk of an accident; and
- Monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current professional standards of practice.

F689 – Immediate Jeopardy Citations

The facility failed to adequately supervise residents reviewed who exhibited wandering behaviors. The lack of supervision resulted in actual harm to a resident who came to a local coffee shop 5 miles from the facility, bruised and with a fractured ankle. The resident had eloped on the evening shift and walked the 5 miles and was able to report falling several times since he has a diagnosis of reduced functional mobility including walking. Police were called and resident was transported to the local hospital. Resident was diagnosed and admitted.

- Resident with Alzheimer's disease and BIMS score on the MDS of 6 and noted with reduced functional mobility.
- Staff report that they had not seen resident during the evening shift but assumed he was out with his family and they forgot to sign him out.
- No one checked the courtyard and resident missed evening medications and dinner meal.
- Documentation does not include that resident was not available for routine rounds in the facility.

F689 – Immediate Jeopardy Citations

- Facility failed to ensure that each resident environment residents remained free of accident hazards by failing to test the temperature of hot coffee prior to being served to residents. This failure resulted in an Immediate Jeopardy situation to resident who spilled hot coffee on the left lateral thigh and developed a second degree burn for one of five residents reviewed.
  - Coffee machine is programmed at 160 degrees. The coffee temperature is checked prior to serving to ensure palatable temperature range (120-140 degrees).
  - Resident nursing progress notes indicated the resident called for a nurse and stated she had spilled some liquid on herself. When the nurse removed the wet clothing, Redness was noted to her left side. The nurse applied a cool compress and once removed, noted blister to left hip 2 cm x 1.cm Treatment was ordered for the blister.
  - This could have happened to all residents.

F689 – Immediate Jeopardy Citations

- Facility failed to ensure one resident with a history of non-consensual sexual intercourse with a resident was supervised to prevent it from occurring again or to any other residents.
  - The lack of supervision of the resident allowed him to sexually assault a second resident.
  - Resulting in actual harm to the assaulted resident.
  - Facility policy stated that when there was any incident the facility would immediately implement safeguards to prevent any additional incidents from occurring.
  - Resident had been known to make sexually inappropriate comments to staff.
  - Care plan stated that resident should be redirected and should be monitored when out of his room to protect the rights and safety of other residents.
  - Both residents involved were cognitively impaired and had BIMS scores of below 5.

F689 - Additional Citation Examples

- Resident with a diagnosis of dementia approached staff in the hall and pulled scissors out of his back pocket. He began making stabbing motions toward the staff member. Staff removed the scissors from the resident and transferred him to the hospital for evaluation. It was noted in the event report that the treatment cart was left unlocked and the resident found the scissors in the treatment cart and took them.
- Resident sent to the hospital following ingesting a clear liquid in a medicine cup on the stand next to his bed. Resident stated he thought it was water and he was thirsty. Staff reported they had left wound cleanser in the cup in preparation for wound care when the resident awakened.
- Surveyors observed medications including nasal spray left at the resident bedside. Documentation did not demonstrate that resident had been assessed for self-administration of medications. Interview with resident noted that resident has been administering his medications.
- Resident with a diagnosis of dementia and a BIMs score on the MDS of 5 with a care plan intervention to ensure that her call light was always at her reach and that she was monitored every hour. Resident got up from her wheelchair and fell with a hematoma. There was no documentation to demonstrate hourly monitoring and when the resident was found her call light was on the bed rail on the opposite side of the bed from where she was sitting in the wheelchair.

F689 – Additional Citation Examples

- Failing to provide supervision or necessary level of supervision to prevent accidents
  - Resident with a care plan and diet order for soft foods received a meal tray with regular foods and had an episode of choking.
  - Activities team member served a resident cookies and left the resident alone. Resident has a care plan for supervision with meals. Resident was not supervised with the cookies and had a choking episode.
  - Resident was not be left alone in the bathroom secondary to impulsivity and a diagnosis of dementia with reduced safety awareness. Staff member assisted the resident to the bathroom and left the door open while cleaning up in the room. Resident was unable to be seen by the staff. Resident arose from the toilet and fell. Resident received a laceration on her head.
  - Resident was transferred into a Geri Chair to “remind the resident” not to try to get up from the chair. The resident continued to want to arise from the chair and climbed over the side of the Geri Chair resulting in a fall to the floor. This fall resulted in a wrist sprain.
  - Licensed nurse who was not aware of the care plan and was transferring the resident from bed with assist to meals, assisted the resident with a one-person transfer. Resident care plan stated the resident used a mechanical lift and was dependent for transfers. The licensed nurse had difficulty with the transfer and the resident hit her head on the headboard resulting in a laceration and bleeding.

F689 – Accidents/Supervision/Assistance Devices - Tips

- Are team members following standards of practice?
- Are team members aware of the plan of care/care plan for the residents they are providing care to/for?
- Team members should not provide care they are not familiar with
- Ensure the IDT members are aware of care plan changes
- Review the levels of supervision with team members and what each means?
- Are care plans updated when resident conditions change?
- Ensure RNACs are updating the care plans based on the MDS
- Ensure all equipment concerns are addressed immediately
- Educate and audit practices constantly with correction as needed
- Annual education and competency evaluation to cover standards of practice, facility standards and protocols and policies

F656 – Comprehensive Care Plans (#4)

F656 – Comprehensive Care Plans

§483.21(b) Comprehensive Care Plans

§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following —

- (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
- (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
- (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
- (iv)In consultation with the resident and the resident's representative(s)—
  - (A) The resident's goals for admission and desired outcomes.
  - (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
  - (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

F656 Citation Findings

- **Facility failed to update the resident's care plan to reflect the resident's current care needs for five of five residents reviewed. All residents had been admitted to hospice care which was not included in the care plans.**
- **Facility failed to include information in the care pan related to the resident having a criminal background of indecent assault and the probation status of the resident.**
- Facility failed to revise resident care plan for transition from at risk for pressure ulcers based on the Braden scale to actual pressure ulcer in 2 areas at stage 2.
- Facility failed to revise resident care plan to include adaptive equipment being used during meals that was ordered by occupational therapy.
- Facility failed to develop baseline care plans for two of eight residents reviewed within 48 hours from admission.
- Facility failed to revise a resident care plan when RNP services were initiated for the resident following discharge from Part B rehabilitation therapy for both ambulation and grooming programs.
- Facility failed to include non-pharmacologic interventions for pain management for a resident with new pain.
- Facility failed to include anticoagulant therapy in the care plan when the resident had been receiving Coumadin.
- Facility failed to update care plan with the addition of new active diagnosis of malnutrition.

F656 Citation Findings

- Facility failed to update care plan for addition of CPAP to resident care needs
- Facility did not update the care plan for the removal of ¼ siderails and transitioning to enabler bar for bed mobility.
- Facility failed to follow policy and standard of practice to review and updates resident care plans at least every 90 days
- Care plan did not include that resident required an interpreter for major health decisions because English was not the primary language and the resident spoke mostly Russian.
- Resident care plans were not updated for 3 of 8 residents reviewed when significant change in status MDS assessments were completed.
- Resident care plan did not include the diagnosis of morbid obesity and the impact of the diagnosis on functional mobility and dietary needs.
- Facility failed to revise resident care plan to include new onset verbal and physical aggressive behaviors toward others.
- Resident care plan was not completed – a baseline care plan remained in the medical record in the second month after admission to the facility.

F 656 – Comprehensive Care Plans - Tips

- Include care plans in chart audit checklists to ensure they are completed
- Assessment nurses should evaluate care plans and update when assessments are being completed
- Educate IDT members on the revision and update of care plans so they can update care plans
- Care plan updates should be flagged in the EMR for review and revision at least every 90 days
- Care plans can be included in night shift chart checks to ensure all new orders, diagnoses and treatment changes have been added to the care plans
- Ensure staff are aware that care plans for risk should be revised when there is an actual – behavior, weight loss, fall, pressure ulcer or other change in condition.
- Ensure all departments include items from their admission and quarterly assessments in the care plan
- Ensure changes noted during resident interviews for the MDS assessments are noted in the care plans

F880 – Infection Control Program (#5)

F880 – Infection Control Program (#2)

- ***§483.80 Infection Control*** **-** The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.
- ***§483.80(a) Infection prevention and control program.*** The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:
- ***§483.80(a)(1) A system*** for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

F880 - Infection Control Program

- ***§483.80(a)(2) Written standards, policies, and procedures for the program***, which must include, but are not limited to:
  - (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
  - (ii) When and to whom possible incidents of communicable disease or infections should be reported;
  - (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
  - (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
  - (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
  - (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

F880 – Infection Control Program

- ***§483.80(a)(4) A system*** for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.
- ***§483.80(e) Linens***. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.
- ***§483.80(f) Annual review***. The facility will conduct an annual review of its IPCP and update their program, as necessary.

F880-Immediate Jeopardy Citations - COVID Related

All involving multiple system failures with positive COVID.

- Residents negative for COVID-19 who were cohorted with COVID-19 positive residents.
- Facility failed to appropriately relocate and cohort potentially exposed residents
- Facility failed to preclude COVID-19 positive staff members from providing direct care to COVID-19 negative residents.
- Staff members who worked with COVID symptoms (i.e. failed screening)
- New admissions cohorted with COVID negative residents despite having open rooms.
- Resident presented with a temperature of 100.3 F, chills and slight shortness of breath. Precautions were NOT implemented.
- Resident presented with COVID symptoms. Refused testing. Facility did not implement precautions.
- No documented evidence that employees, residents or resident responsible parties were notified that there could have been a possible exposure to COVID-19 by coming in close contact with an employee who had tested positive for COVID-19.

F880-Immediate Jeopardy Citation - Non-COVID

Facility failed to maintain an infection prevention and control program through system failure in multiple areas of the facility and in multiple infection prevention and control opportunities. This was noted across all days and on all units during the survey.

- Nursing Unit observed with two linen carts in the hallway uncovered and open to air.
- Soiled linen dragged on floor in halls to container and no hand hygiene before obtaining clean linen from cart.
- Staff observed leaving resident room wearing gloves, lifted cover from linen cart, removed several linen items and left line cart uncovered. Did not leave soiled gloves in room or clean hands before going to clean linen cart.
- LPN observed leaving resident room wearing gloves with glucometer, cleaned glucometer with hand sanitizer and paper towel; entered another resident room and used glucometer without changing gloves and picked up soiled gloves and soiled dressing material from floor and discarded it; cleaned glucometer with hand sanitizer and paper towel and rooted through the medication cart wearing the same gloves; poured medications for a third resident and administered them in the same gloves.
- Staff observed removing full urinals and bedpans from resident rooms and walking in the halls with them uncovered to the soiled utility room.
- It was noted that the soiled utility rooms had empty paper towel and soap dispensers and no hand sanitizer station.

F880-Immediate Jeopardy Citation - Non-COVID

- Facility failed to maintain an infection prevention and control program by failing to investigate, document surveillance of and implement preventative measures timely, to address an outbreak of gastrointestinal illness resulting in actual harm to 29 of 95 residents. This facility also failed to provide education to staff members regarding Norovirus and the precautions they should be taking to prevent spread.
  - There was no documentation of notifying family members and visitors of the Norovirus in the facility.
  - Congregate meals and activities were not stopped.
  - There was no documentation of any additional cleaning of high touch surfaces in the facility.
  - No documentation of staff education regarding precautions to prevent the spread to other residents and to protect them.

F880- Additional Citation Examples Non-COVID Citations

- **Infection Prevention During Wound Treatments** -
  - Staff observed removing soiled dressing and cleaning the wound without changing gloves or completing hand hygiene.
  - Staff observed not changing gloves after contact with the environment and before cleansing wound.
- **Infection Prevention During Resident Care** -
  - Staff observed not completing hand hygiene or wearing gloves while completing incontinence care.
  - LPN observed to not clean glucometer after use with a resident and placed it directly into the medication cart.
  - LPN observed to not complete hand hygiene between residents during mediation administration and to touch pills with ungloved hands before administering to residents.
  - Staff in resident dining room observed not completing hand hygiene before assisting residents with feeding.
  - Hand hygiene materials and equipment sanitizing items were not observed on any unit in a facility. This included empty glove boxes and empty paper towel dispensers
  - Resident indwelling catheter bag observed resting on the floor or held by staff above resident waist during transfers.

F880- Additional Citation Examples Non-COVID Citations

- Infection Control for Residents on Precautions or in Isolation -
  - Activities staff observed in a clearly marked isolation room without any PPE or gloves and stated to the surveyor that PPE was not required because they were not providing care.
  - Failure of the facility to complete terminal cleaning of resident rooms when isolation or precautions were discontinued and before a new resident was admitted to a room.
  - Staff observed to remove resident care equipment from the isolation room and take it into other resident rooms for use.
  - Resident on precautions for C-Diff was observed with oxygen tubing draped in a soiled feces incontinent brief during care and the tubing was not cleaned by the staff.
  - Residents with confirmed Norovirus were noted to be sharing a bathroom.
  - Staff observed not wearing masks when providing care for resident on droplet precautions with active productive cough.

F880- Additional Citation Examples Non-COVID Citations – Tips

- Ensure infection prevention and control audits are not only nursing staff but all staff.
- Complete rounds to observe care and if protocols are being followed but also standards of practice and CDC infection prevention and control guidelines.
- Complete immediate education when a deficiency is observed – don't let it become a practice that has to be broken.
- Use staff meetings for infection prevention and control education snippets. Use the information gathered on rounds and in audits.
- Discuss infection prevention and control during QAPI and management meetings to ensure all team members are aware of their roles.
- Audit for the items that have been cited most frequently – learn from others and use the information from the audits for education and in QAPI.

F761 – Labeling/Storing of Drugs and Biologicals (#6)

F761 – Labeling/Storing of Drugs and Biologicals

- **§483.45(g) Labeling of Drugs and Biologicals Drugs** and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.
- **§483.45(h) Storage of Drugs and Biologicals**
  - **§483.45(h)(1)** In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls,and permit only authorized personnel to have access to the keys.
  - **§483.45(h)(2)** The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

Interpretive Guidance

LABELING OF MEDICATIONS AND BIOLOGICALS

- The medication label at a minimum includes the medication name (generic and/or brand), prescribed dose, strength, the expiration date when applicable, the resident's name, and route of administration.
- When medications are prepared or compounded for intravenous infusion, the label contains the name and volume of the solution, resident's name, infusion rate, name and quantity of each additive, date of preparation, initials of compounder, date and time of administration, initials of person administering medication if different than compounder, ancillary precautions as applicable, and date after which the mixture must not be used.
- For over-the-counter (OTC) medications in bulk containers (e.g., in states that permit bulk OTC medications to be stocked in the facility), the label contains the original manufacturer's or pharmacy-applied label indicating the medication name, strength, quantity, accessory instructions, lot number, and expiration date when applicable.
- Facility staff should date the label of any multi-use vial when the vial is first accessed and access the vial in a dedicated medication preparation area:
  - If a multi-dose vial has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial.
  - If a multi-dose vial has not been opened or accessed (e.g., needle-punctured), it should be discarded according to the manufacturer's expiration date.

Interpretive Guidance

MEDICATION ACCESS AND STORAGE

- A facility is required to secure all medications in a locked storage area and to limit access to authorized personnel
- When medications are not stored in separately locked compartments within a storage area, only appropriately authorized staff may have access to the storage area.
- Access to medications can be controlled by keys, security codes or cards, or other technology such as fingerprints.
- Schedule II-V medications must be maintained in separately locked, permanently affixed compartments.
- During a medication pass, medications must be under the direct observation of the person administering the medications or locked in the medication storage area/cart.
- Safe medication storage includes the provision of appropriate environmental controls, i.e. temperature, light, and humidity controls

F761 - Citation Findings

- Facility failed to ensure that emergency medications storage is compliant with requirements. Observation of the GEMS medication storage system noted multiple expired medications, and soiled areas. There was no documentation available to demonstrate that the consultant pharmacist had reviewed the medications in the GEMS storage system.
- No documentation was available of temperature checks for the medication refrigerator
- Medication room refrigerator also included staff lunches
- Facility failed to ensure safety and sanitation of medications administered to residents and accurate labeling. It was noted during medication administration that 1 resident was using medication brought from home in a bottle with a handwritten label.
- Resident eye drops and nasal spray were noted to be stored in the top drawer of the resident night stand in the resident room with a roommate who had a diagnosis of dementia and wandered
- Open insulin injection pens with no identified open or expiration date.
- Observation of medication cart in the hall unlocked with the licensed nurse in a resident room 3 rooms down the hall from the location of the cart.

F761 – Citation Findings

- Housekeeper noted alone cleaning in the medication room and no licensed nurse at the nurses' station. The housekeeper reported she had been given the key from the licensed nurse
- Medication cart noted with several medication tablets in the drawers out of the blister packs, spilled liquid medication in the medication drawers and a canister of Clorox wipes in the same drawer with bottles of liquid medication.
- Based on observation and staff interviews facility failed to adhere to medication expiration dates and storage requirements. 3 of 5 care units were noted with insulin pens being stored in the medication cart when the label stated that they should be refrigerated until opened and other insulin pens that had been opened were not dated.
- Observation during medication administration noted licensed nurses crushing medications that were noted in the MAR and on the blister pack as "not to be crushed".
- Observation of the medication cart noted expired blister packs and bottles of resident medications being stored in the medication cart.

F761 – Labeling/Storing of Drugs and Biologicals - Tips

- Ensure consultant pharmacist is checking the medication carts routinely and provide reports so you are aware of the findings and can ensure correction
- Ensure consultant pharmacist provides a report to you with each visit so you are aware of the emergency and medication label oversight and findings
- Ask supervisors to check the medication carts routinely
- Educate licensed nurses to know what medication labels should include
- Educate licensed nurses regarding policies and standards of practice regarding expired medications – include protocol where they can see it
- Educate licensed nurses regarding policies and standards of practice regarding medications brought from community and medication storage

F686 – Prevention/Treatment of Pressure Ulcers (#7)

F686 – Pressure Ulcers

- §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.
- Based on the comprehensive assessment of a resident, the facility must ensure that—
  - (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
  - (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

INTENT **-** The intent of this requirement is that the resident does not develop pressure ulcers/injuries (PU/PIs) unless clinically unavoidable and that the facility provides care and services consistent with professional standards of practice to:

- Promote the prevention of pressure ulcer/injury development;
- Promote the healing of existing pressure ulcers/injuries (including prevention of infection to the extent possible); and
- Prevent development of additional pressure ulcer/injury.

F686 – Immediate Jeopardy Citations

Based on review of facility policy, resident clinical record review, staff interviews, and family interview it was determined that the facility failed to provide care to prevent pressure ulcers, provide treatment and services necessary to promote healing and prevent infection of a pressure ulcer which all resulted in actual harm, the development of pressure ulcers which was a cause of death to one resident and required surgery for another resident which resulted in pain and inability to return to the community.

System failures noted for multiple residents:

- One resident was wearing a HKAF orthotic for an inoperable hip and the other resident was cognitively impaired with a stage 3 pressure ulcer on the right heel.
- The facility failed to complete wound assessments of the stage 3 pressure ulcer that included the size, depth, location, appearance, pain and physician ordered corrective measures.
- Facility failed to remove the HKAF orthosis until the resident went for the follow up orthopedic evaluation of the hip – although orders stated it should be removed per shift to check the skin.
- When the HKAF orthosis was removed during the orthopedic evaluation – the resident was noted with a stage 3 pressure ulcer on the hip and one on the ankle.
- Physician orders and care plan intervention for heel off loading was not followed for the stage 3 on the heel resulting in a worsening to a stage 4 and an infection requiring surgical intervention and a decline in functional resident mobility.

F686 – Additional Citation Examples

- Facility failed to ensure resident comprehensive care plan included goals and interventions for the care and treatment of 2 stage 2 pressure ulcers noted at the time of admission.
- Resident developed facility acquired stage 2 pressure ulcers to the left heel and ankle. MAR documentation demonstrates that the facility failed to prevent the worsening of these pressure ulcers by completing the physician ordered daily treatment for 6 days in one month.
- Facility failed to provide care and treatment to prevent the development of a new pressure ulcer for a resident admitted without a pressure ulcer when the documentation notes the resident had “soft, mushy, red and non-blanchable” heels bilaterally. No new interventions were entered into the resident care plan and nothing was implemented per the MAR and TAR documentation as well as observation of the resident and discussion with care staff. Resident developed facility acquired stage 2 pressure ulcers bilaterally.
- Two residents were noted with OT recommendations and physician orders for palm protectors to prevent palm pressure ulcers for residents who both had bilateral finger contractures. Review of the TAR noted the palm protectors were not used for 30 of 30 days in the month and the care plan did not include the palm protectors as an intervention under the problem of pressure ulcer risk or under the problem of hand contractures. Resident developed palm and finger stage 2 pressure ulcers and infections.
- Facility failed to complete quarterly standardized pressure ulcer risk assessments to determine resident risk levels and evaluate treatment pathway to prevent development of pressure ulcers for 6 residents
- Documentation noted 5 residents without routine turning and repositioning documentation. 2 of the 5 residents developed stage 2 coccyx pressure ulcers. Facility failed to prevent the development of pressure ulcers for residents admitted without pressure ulcers.

F686 – Additional Citation Examples

- Facility failed to ensure that residents received care to prevent pressure ulcers, by failing to provide skin checks every shift, as follow through with wound clinic recommendations, and notify the physician of wound changes.
  - Resident was wearing bilateral braces on the upper extremities.
  - Pressure ulcer risk assessment noted resident at high risk for pressure ulcers.
  - No documentation of checking the skin under the braces every shift as ordered by wound clinic and the attending physician.
  - Resident developed multiple worsened pressure ulcers under the braces with odor and drainage leading to the removal and check of the skin and physician was not notified.
- Facility failed to assess the resident skin in a timely manner to develop a treatment plan for any present pressure ulcers. Resident noted with a sacral pressure ulcer on transfer record from the hospital on Friday evening. Pressure ulcer was not assessed with measurements and staging per the documentation until Monday morning when the wound care nurse returned.
- Facility failed to provide care and treatment as ordered to prevent development of pressure ulcers and to ensure that current pressure injuries did not worsen.
  - Resident admitted from the hospital with a DTI on the left buttock.
  - Physician orders written for pressure redistribution mattress and cushion.
  - Documentation notes neither were applied for one week after admission and DTI became and open pressure ulcer with infection for an incontinent resident.

F686 – Skin Integrity/Pressure Ulcers - Tips

- Evaluate admission orders on the day after admission to ensure all items have been care planned, have been entered into the MAR and TAR and are included as care interventions.
- Ensure all licensed nurses know they MUST evaluate skin – clear or with pressure ulcers at the time of admission and not wait for the wound care nurse.
- Check with physicians when there are external devices to determine wearing and skin check schedules.
- Ensure admission and routine quarterly risk assessments are being completed.
- Evaluate documentation in MAR and TAR to ensure dressings are being completed, devices are being removed and skin is being checked per facility policy.
- Routinely evaluate documentation to ensure that minimally weekly skin audits and pressure ulcer audits have been documented with measurements, location, exudate, edge description, wound bed description, treatment review and pain.

F600 – Freedom from Abuse, Neglect, & Exploitation (#8)

F600 – Freedom from Abuse, Neglect, & Exploitation

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a)The facility must –

§483.12(a)(1) not use verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion;

Immediate Jeopardy Citations

Based on clinical record review, review of facility policies, facility documentation and interviews with staff, it was determined that the facility failed to ensure that adequate nursing staffing was maintained resulting in the neglect of six of 27 residents as evidenced by nursing care, medications and treatments not being administered. This failure placed all 27 residents on the Nursing Unit in an Immediate Jeopardy situation during one of three nursing shifts (night shift).

- Residents did not receive blood glucose monitoring, or skin prep to bilateral heels as noted in the TAR
- Residents did not receive pain monitoring or blood pressure monitoring as noted in the TAR documentation.
- Residents did not receive routine pain medication ordered every 6 hours per the MAR.
- Residents did not receive Omeprazole which was ordered every 8 hours and Nicardipine for blood pressure.
- Scheduler reported during interview that she made NHA and DON aware that the night shift on Christmas was unfilled with a licensed nurse (made them aware several days prior to the shift).
- RN supervisor had already worked greater than 16 hours
- Ist floor LPN did not feel safe covering 2 nursing care units on 2 floors
- DON did not respond to calls or texts and NHA told supervisor to leave
- No agency staff available to fill the shift with last minute calls

Additional F600 Deficiencies

Facility failed to protect a resident from sexual abuse in the form of sexual assault by another resident. Resident with known episode of sexual intercourse with a resident was to be supervised when out of room.

- Resident was not supervised and entered another residents room and sexually assaulted her.
- Resident was found assaulting the female resident when the staff could not find the resident during routine rounds.

- Facility failed to protect residents by not completing criminal background checks in a timely manner for 4 of 5 recently hired direct care staff.
- Facility failed to protect resident from neglect during delivery of care by direct care staff.
  - Care plan stated resident required mechanical lift transfers with assist of 2 persons.
  - Documentation of ADLs stated resident had been consistently transferred using mechanical lift and 2 person assist.
  - Resident complained of hip pain for 3 days which was documented as increasing in severity and MD called with orders for x-ray.
  - Hip was fractured and staff were interviewed.
  - Witnesses to the resident transfers stated they were stand pivot transfers with 1 person assist for the previous week.

Additional F600 Deficiencies

- Based on resident interviews, review of clinical records, review of facility policies and facility provided documentation, and interviews with staff, it was determined that the facility failed to protect residents from staff initiated verbal abuse for three of 24 residents.
  - Resident 1 was crying at nurses station and was observed being told by CNA to "just stop it" and not to "be a big baby". Social services reported emotional distress experienced and reported by the resident with adjustment issues.
  - Resident 2 was observed being forcefully pushed in her wheelchair by OT when the resident was resisting having her wheelchair moved from the place where she was and planted her feet on the floor.
  - CNAs observed LPN pushing resident forcefully into the common area across from the nurses station and loudly saying to the resident "you see me coming with the trays so get moving into the room. I am trying to feed you!"
- Facility failed to protect the resident from verbal abuse when staff were noted to be discussing the residents weight during resident care and the resident was noted as cognitively intact.
- Based on observations facility failed to protect the resident from abuse when bruises of unknown origin were noted by the CNAs and reported to the charge nurse. No investigation was completed as to possible origin and no event report was completed. Only medical record documentation

F600 – Freedom from Abuse, Neglect, & Exploitation Tips

- Ensure documentation of care and treatment is completed prior to end of shift to represent care delivery
- Audit care delivery through resident interviews and observation to ensure it is being delivered
- Educate staff regarding behavior management to prevent verbal and physical abuse
- Ensure staff understand what constitute verbal and physical abuse
- Make all staff aware to report bruises or other changes in the resident to the licensed nurse and ensure the licensed nurses know to evaluate and investigate all condition changes, abuse reports and bruises
- Ensure staff understand the level of supervision residents need and why
- Ensure staff are aware of the care plan for residents before providing care
- Include the standards of practice for care in the policies/procedures/protocols
- Provide immediate feedback and education when resident care is not delivered per policy/standard of practice
- Ensure nursing care shifts are filled
- Ensure thorough investigations are completed when there is a resident event

F677 - ADL Care Provided for Dependent Residents (#9)

F677 - ADL Care Provided for Dependent Residents

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

- **§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; and**

- "**Oral care**" refers to the maintenance of a healthy mouth, which includes not only teeth, but the lips, gums, and supporting tissues. This involves not only activities such as brushing of teeth or oral appliances, but also maintenance of oral mucosa.

- **"Speech, language or other functional communication systems"** refers to the resident's ability to effectively communicate requests, needs, opinions, and urgent problems; to express emotion, to listen to others and to participate in social conversation whether in speech, writing, gesture, behavior, or a combination of these (e.g., a communication board or electronic augmentative communication device).

- **"Assistance with the bathroom"** refers to the resident's ability to use the toilet room (or commode, bedpan, urinal); transfer on/off the toilet, clean themselves, change absorbent pads or briefs, manage ostomy or catheter, and adjust clothes.

- **"Transfer"** refers to resident's ability to move between surfaces - to/from: bed, chair, wheelchair, and standing positions. (Excludes to/from bath/toilet.)

F677 - ADL Care Provided for Dependent Residents citations

- Based on observations of residents, review of clinical record documentation and interviews with staff it was determined that the facility failed to provide necessary ADL care to 3 residents of 30 who were dependent for ADL care needs.
  - One resident with finger contractures, was noted with a large band-aid on the palm of his had because there were several cuts caused by long fingernails that had dug into the resident's skin. Care plan included range of motion to the fingers at least daily, nail care weekly and monitoring of the skin. None of this care was documented as having been completed.
  - Second resident was noted as being incontinent of bowel and bladder. An odor was noted at the door of the resident room at 1 pm and the sheet was noted to be soiled with brown material leaking from the incontinent brief. The sheet remained soiled with brown material and the odor remained at the room door at 4 pm on the same day and the resident was lying in the same position in bed.
  - Third resident was noted wearing the same clothes on consecutive days and the shirt and pants were soiled with food and the pants with large urine stains.

F677 - ADL Care Provided for Dependent Residents citations

- Based on resident observations the facility failed to provide bathing, dressing and grooming assistance for 4 of 30 dependent residents.
  - Resident observed in the wheelchair in the dining room unshaven, hair not combed and wearing only a patient hospital gown that was soiled from food during the previous meal. There was also food on the wheelchair seat and on the arm and foot rests.
  - Female resident observed in activities in a patient gown and non-skid socks that were visibly soiled on the top and bottom. When resident was asked about why she was not wearing clothing, she responded that since she came to live here she has not had her clothing and that she has been told that “it is in storage”.
  - Resident stated during resident council, where he was seated in soiled pants and sweatshirt that he has been wearing the same clothes and slippers (non-skid socks) for days. Stated that he sleeps in the same clothes and has been told he has no clothes and the facility has no additional slippers to give. He stated he is showered and then the same clothes placed on him. Resident scored a 14 on his BIMS.
  - Review of resident bathing record noted that resident had only had 1 bath since returning from the hospital 3 weeks prior. The resident stated that he washes his face and hands at the sink in his wheelchair with a washcloth that is given to him.

F677 - ADL Care Provided for Dependent Residents - Tips

- Observe residents, walk the halls and look at the condition of the residents and their clothing and general body condition including facial hair, nails, moth, lips, tongue
- Ask questions of residents when you see them in the halls or in the dining room regarding their care to ensure they are receiving the ADL care required
- Attend Resident Council – with resident permission – to ask questions about ADL care and to ensure their needs are being met
- Talk with families when you can to ensure they are seeing what they want to see when they come to visit
- Ensure staff are asking social service to contact resident families if clothing or other items are needed for the resident
- Evaluate documentation to ensure resident ADL care has been documented and correlates to the care plan

F641- MDS Accuracy (#10)

F641- MDS Accuracy

§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.

INTENT §483.20(g) To assure that each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline.

- **Facilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.**
- **The determination of appropriate participation of health professionals must be based on the physical, mental and psychosocial condition of each resident. This includes an appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, medical social workers, dietitians, and other professionals, such as developmental disabilities specialists, in assessing the resident, and in correcting resident assessments. Involvement of other disciplines is dependent upon resident status and needs.**
- **The assessment must represent an accurate picture of the resident's status during the observation period of the MDS.**

F641- MDS Accuracy

- Section O – Hospice not coded when resident had been admitted to hospice
- MDS coded for Medicare as the primary payor and resident was private pay
- Section O – coded for inaccurate number of physician examinations and orders
- Section E – no resident behaviors coded when documentation notes physical and verbal aggression
- Section M – pressure ulcers not coded when documentation notes presence
- Section A – incorrect type of facility coded
- Section J – no falls coded and documentation noted resident falls with injury during assessment reference period
- Section L – coded for own natural teeth when resident was edentulous
- Section N – Anticoagulant medications not coded and MAR shows they were administered and physician orders are present
- Sections C and D not coded for resident interview when resident is cognitively intact and aware – staff assessments were completed
- Section H – not coded for indwelling catheter when documentation notes catheter
- Section A – PASRR level 2 not coded and resident meets criteria

F641- MDS Accuracy

- Section I – UTI coded and resident did not meet all required criteria
- Section J – major surgery not coded and resident had PEG tube inserted within 100 days of admission
- Section M – pressure ulcer treatment for pressure redistribution seat and bed were coded and there was no documentation support
- Section V – staff positions are not included in the signature section
- Section B – hearing aides not coded but they were documented in the TAR
- Section I – hypertension not coded and is being treated as an active diagnosis
- Section J – PRN pain medication not coded and MAR demonstrates that it was administered 10 times during assessment reference period
- Section J – coded for no history of falls when resident was admitted secondary to a fractured tibia and the need for rehabilitation
- Section K – resident weight coded did not correlate to chart documentation
- Section M – pressure ulcer documented as stage 2 when wound care nurse documented as stage 3 upon initial assessment
- Section N – number of injections of any type is incorrect per MAR

F641 – MDS Accuracy - Tips

- Ensure assessment nurses have most accurate and recent RAI Manual
- Support annual education for assessment nurses related to MDS changes
- Encourage reaching out for assistance when coding is uncertain
- Review documentation for accurate representation of resident care
- Empower assessment nurses to request documentation when not present and they have learned of a condition change
- Ensure assessment nurses educate licensed nurses and nursing assistants related to documentation
- Ensure assessment nurses review MDS changes with other department team members who complete those sections
- Request quality evaluation of coding prior to submission

F812 – Food Procurement/Storage/Sanitation/Preparation/Serve - (#3)

F812 – Food Procurement/Storage/Sanitation/Preparation /Serve

§483.60(i) Food safety requirements. The facility must-

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.

(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

F812 – Immediate Jeopardy Citation

- Facility failed to maintain a sanitary kitchen, store food in proper conditions, maintain kitchen equipment, and prevent potential food borne illness due to potential food contamination from damage from a water leak and leaking ceiling in the kitchen, for all residents.
  - The kitchen ceiling leaking and having debris falling out of it potentially contaminating food;
  - The kitchen windows were being propped open allowing possible insect contamination;
  - The food storage area had fans with water and debris on them, leaking onto foods and they had outdated or undated foods with the potential for food borne illness and contamination;
  - The falling water damaged ceiling tiles in the hall and dish area and had the potential for food contamination or staff injury.
  - The storage of cleaning products with items used for cooking of foods had the potential of food contamination.
  - The soiled sugar and flour bins had the potential for food contamination;
  - The ice machine air gap pipe was disconnected and allowed contamination of the facility ice machine, which was the only ice machine in the building;
  - The ice cream freezer being unclean and ice build- up had the potential for contamination.

F812 - Additional Citation Examples

- It was determined that the facility failed to store and prepare food in accordance with professional standards for food service safety. Including: a cart in the back, right-hand corner had a tray of 18 individual bowls of Jell-O, and two carts to the left of this cart had trays that contained five bowls of Jell-O. All the bowls of Jell-O were uncovered.
- A review of months of temperature documentation revealed many temperatures were not being taken for coolers, freezers, and the dish machine.
- Facility failed to properly store frozen food to maintain safety for residents, Frozen foods were stored uncovered and open to air so they were not labeled or covered.
- Hoagie rolls stored in the freezer that were not covered or dated; convection oven was noted with a large build up of back greasy material which was also noted in front of the over.
- A bag of chicken cordon bleu was open and not dated; several cardboard boxes were observed stacked around the perimeter of the freezer in close contact with ceiling and freezer fan potentially inhibiting proper air circulation required for temperature of frozen foods.
- A on a shelf in the dry storage area, there were two opened undated gallon containers of snow cone syrup; the pumps and gallon containers were sticky on the outside; inside the walk-in cooler two large clear tote bags were observed on top of shelf above the resident food for tray line which were staff lunches and personal.
- During a tray line operation observation, employee was observed with gloved hands touching the outside of a package of hot dog buns, with the same gloved hands reach inside the package and retrieve a hot bun and then proceeded to open the bun and place it onto a plate without performing hand washing and changing gloves.

F812 - Additional Citation Examples

- Observation revealed a case of thawed 4-ounce Mighty Shakes on the shelf in the walk-in cooler. The manufacturer label noted the nutritional beverages should be used within 14 days after thawing; there was no date on the case.
- Three bags of dry pasta were in a shelf in the dry storage area and were not closed or dated.
- Observed a build up of grease, dirt and grime on the floors of the kitchen with black dust on the ceiling tile above food preparation areas.
- Ceiling light cover above the food preparation area was splattered with food and the clean pans on the shelf 10 inches above the floor were splattered with grease and dusty.
- Fans in the kitchen directed at the food preparation area were observed with dust on the blades and wire and were running in the kitchen.
- Staff in the resident dining rooms observed making sandwiches for residents without gloves and touching the bread and the lunchmeat and lettuce for the sandwiches.
- Staff observed in the resident dining rooms to take food from one resident and serve it to another.
- Dining room staff moving from soiled work (emptying trash cans and rearranging dry goods) to clean work (putting bread in toaster and cutting raw fruit) without completing hand hygiene

F812 – Food Procurement/Storage/Sanitation - Tips

- Ensure main kitchen and all pantries and nourishment stations are audited for compliance with food storage including wrapping, dating and labeling
- If you open it - date it
- Ensure dining services team members are aware of the requirements and standards of practice to label and date – allow them to assist with audits
- Place reminder signs to label and date and for the allowable shelf life of cooked and raw foods
- Job descriptions for specific positions can include temperature checks of all coolers and freezers and cleaning at the end of the shift
- Weekly cleaning rounds in the kitchen and pantries – include housekeeping and environmental services
- Quarterly deep cleaning of the main kitchen for floors, corners, cove base, ceiling tile and fans
- Reminders posted after quarterly education regarding hand hygiene with examples of going from soiled to clean

Resources

Message Board

- www.health.state.pa.us

CMS Website

- www.cms.hhs.gov

Five Star Rating Website

- https://www.medicare.gov/care-compare/#search

State Operations Manual

- http://cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf

Full Text Statement of Deficiencies – February 2023

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS