STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455001	A. BUILDING _____ B. WING _____	**09/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PHP THE OAKS AT BEAUMONT	**4195 MILAM ST BEAUMONT, TX 77707**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the physician and resident's family were immediately informed regarding a change in condition for 1 of 21 residents reviewed for change in condition. (Resident #48) The facility did not consult with Resident #48's physician after her roommate tested positive for COVID (infection with a new coronavirus) on 9/10/20 and when Resident #48 complained of a headache, sore throat, and chills on 9/14/20. The facility did not notify Resident #48's family or responsible party when her roommate tested positive for COVID. This failure could place residents at increased risk for complications due to delayed physician intervention. Findings included: Physician orders [REDACTED].#48 admitted [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. An MDS assessment dated [DATE] indicated Resident #48 was cognitively intact and was able to make herself understood and she understands others. Resident #48's care plan dated 02/13/20 indicated she was at risk for signs and symptoms of COVID. Approaches included observe for signs and symptoms of COVID, and document and report signs and symptoms. An undated list provided by the facility indicated Resident #48's roommate was positive for Covid on 9/10/20. During an observation on 9/14/20 at 9:40 a.m., Resident #48 was in her bed and complained of a sore throat, chills and headache to the surveyor. This surveyor went to the nurse's station and reported the resident's complaints to LVN B. LVN B said she was going to check on the resident right now. During an interview on 9/15/20 (a day later) at 9:14 a.m., LVN B said that she gave Resident #48 Tylenol yesterday for the symptoms. She said she did not call the residents' physician, but gave report to another nurse who came in. During an interview on 9/15/20 at 2:34 p.m., the infection control nurse said Resident #48 tested positive for COVID today. During an interview on 9/16/20 at 9:38 a.m., the ADON said Resident #48's family had not been notified when the resident's roommate (Resident #43) tested positive for COVID on 9/10/20. The ADON said all families were supposed to be notified any time there was a new case of COVID that day or by 5:00 p.m. the next day. During an interview on 9/16/20 at 10:48 a.m., the DON said LVN B should have called Resident #48's physician when the resident complained of a sore throat, headache and chills on 9/14/20. The policy titled Novel Coronavirus prevention and response dated 8/1/20 indicated .this facility will respond promptly upon suspicion of illness associated with novel coronavirus in efforts to identify, treat, and prevent the spread of [MEDICAL CONDITION]. . 2. Staff shall be alert to signs of Covid and notify the resident's physician if evident: a. Fever or chills . f. Headache . h. Sore throat . During the exit conference on 9/16/20 at 6:15 p.m., the facility was asked for any additional information related to these findings. No additional information was provided.
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an accurate PASRR was completed for 1 of 4 residents reviewed for PASRR Level 1 screenings. (Resident #22) The facility did not conduct an accurate PASRR level 1 screening for Resident #22. The PASRR level 1 screening indicated Resident #22 did not have a mental illness. Resident #22 had a [DIAGNOSES REDACTED]. Findings included: Physician orders [REDACTED].#22 readmitted [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. A physician's orders [REDACTED].#22 was prescribed [MEDICATION NAME] 2 milligrams (mg) twice a day for [MEDICAL CONDITION]. A PASRR level 1 screening completed by the DON dated 05/01/20 indicated Resident #22 was negative for mental illness, intellectual disability, and developmental disability. A Quarterly MDS dated [DATE] indicated Resident #22 had severely impaired cognition and a [DIAGNOSES REDACTED].#22 met the criteria for a serious mental illness/developmental or related condition subject to PASSR requirements as evidenced by a [DIAGNOSES REDACTED].#22 was in her room in the bed. She was rambling and had disorganized thinking during the interview. During an interview on 09/16/20 at 2:35 p.m., the DON said he completed Resident #22's PASRR level 1 screening and Resident #22 had a [DIAGNOSES REDACTED].#22's PASRR was inaccurate and another PASRR screen would be uploaded to the portal. The DON said Resident #22 was admitted with a [DIAGNOSES REDACTED].(b) Definitions (1) An individual is considered to have a serious mental illness (MI) if the individual meets the following requirements on diagnosis, level of impairment and duration of illness: (A) A [MEDICAL CONDITION], mood, paranoid, panic or other severe anxiety disorder .
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation and interview, the facility failed to ensure respiratory care was provided according to professional standards for 1 of 21 residents reviewed for respiratory care and services. (Resident #3) The facility did not ensure the two filters on Resident #3's oxygen concentrator were clean and free of debris while the oxygen concentrator was in use. This failure could place residents who required respiratory care at risk of receiving improper care and treatment and decreased quality of life. Findings included: Physician orders [REDACTED].#3 admitted [DATE], was [AGE] years old, and had a [DIAGNOSES REDACTED]. The orders included Oxygen [MEDICAL CONDITION] 28-40% to keep sa 92% or greater every shift. The most recent MDS Significant Change assessment dated [DATE] indicated Resident #3 had moderate cognitive impairment, and received oxygen therapy and [MEDICAL CONDITION] care. A care plan dated 9/10/20 indicated Resident #3 had a [MEDICAL CONDITION] with appliance in place and she required oxygen therapy 24/7 related to shortness of breath. A MAR indicated [REDACTED]. During an observation on 9/14/20 at 10:36 a.m., Resident #3 was using oxygen continuously at 2 liters per minute (LPM). The two filters on the concentrator were covered with a thick layer of white dust. Resident #3 had the oxygen connected to [MEDICAL CONDITION] at this time. During an observation on 9/14/20 at 2:26 p.m., Resident #3 was in bed with oxygen in progress. The two oxygen concentrator filters were covered with a thick layer of white dust. During an observation on 9/15/20 at 3:55 p.m., Resident #3 was in bed with oxygen in progress. The two oxygen concentrator filters were covered with a thick layer of white dust. During an observation and interview on 9/15/20 at 4:00 p.m., LVN D acknowledged Resident #3's two oxygen concentrator filters were covered with a thick layer of white dust and should not have been. She also said the filters should have been changed every 7 days and were not. During an observation and interview on 9/15/20 at 4:05 p.m., the DON acknowledged Resident #3's two oxygen concentrator filters were covered with a thick layer of white dust and should not have been. He said the filters should have been changed weekly and were not. An Infection Control Plan: Overview policy dated 2016 indicated .The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455001	A. BUILDING _____ B. WING _____	**09/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PHP THE OAKS AT BEAUMONT	**4195 MILAM ST BEAUMONT, TX 77707**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Based on interview and record review, the facility failed to ensure residents who required [MEDICAL TREATMENT] received such services, consistent with professional standards of practice and the comprehensive person-centered care plan for 2 of 4 residents reviewed for [MEDICAL TREATMENT]. (Resident #'s 40 and 70) The facility did not assess Resident #40's AV (arteriovenous) fistula site (a surgical connection made between an artery and a vein used for [MEDICAL TREATMENT]) to assure adequate blood flow by checking for bruit (a rumbling sensation you can hear) and thrill (a rumbling sensation you can feel). The facility did not assess Resident #70's AV fistula site to assure adequate blood flow by checking for bruit and thrill. This failure could place residents receiving [MEDICAL TREATMENT] at risk for decreased blood flow, blockage and infection at the AV fistula site. Findings included: 1. Physician orders [REDACTED].#40 admitted [DATE], was [AGE] years old, and had a [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. There were no orders included to monitor for sign/ symptoms of complications related to [MEDICAL TREATMENT] for Resident #40. The most recent MDS dated [DATE] indicated Resident #40 had moderately impaired cognition, a [DIAGNOSES REDACTED]. A MAR indicated [REDACTED]. A care plan dated 4/11/20 for Resident #40 indicated the resident had [MEDICAL CONDITION], goes to [MEDICAL TREATMENT], and the facility was to monitor the [MEDICAL TREATMENT] site every shift for thrill and bruit. During an interview on 9/15/20 at 2:45 p.m., the DON said Resident #40's [MEDICAL TREATMENT] shunt is not being monitored for bruit and thrill and should be. During an interview on 9/15/20 at 3:45 p.m., LVN A said Resident #40's [MEDICAL TREATMENT] shunt is not being monitored for a thrill and bruit and should be. A physician's orders [REDACTED].#40's shunt was to be checked every shift for bruit and thrill and the physician and [MEDICAL TREATMENT] unit were to be notified if none was noted. 2. Physician orders [REDACTED].#70 admitted [DATE], was [AGE] years old, and had a [DIAGNOSES REDACTED]. The resident had an order dated 04/18/20 to attend [MEDICAL TREATMENT] Tuesdays, Thursdays, and Saturdays. There were no orders included to monitor for sign/ symptoms of complications related to [MEDICAL TREATMENT] for Resident #70. During an observation and interview on 9/14/20 at 11:00 a.m., Resident #70 was lying on his back, had a gastrostomy feeding infusing, and had a left above the knee amputation. Resident #70 said he received [MEDICAL TREATMENT] 3 times a week through a [MEDICAL TREATMENT] shunt in his left upper arm. The most recent annual MDS assessment dated [DATE] indicated Resident #70 had moderately impaired cognition, a [DIAGNOSES REDACTED]. A care plan updated 8/14/20 for Resident #70 indicated the following: PROBLEM: at risk for alteration in fluid balance related to [MEDICAL CONDITION] requiring [MEDICAL TREATMENT] with additional risk associated with daily fluid restrictions . INTERVENTION: .4/18/20 [MEDICAL TREATMENT] port to left arm check every shift thrill and bruit. During an interview on 9/16/20 at 11:45 a.m., the DON reviewed Resident #70's medical record and stated his [MEDICAL TREATMENT] shunt is not being monitored for bruit and thrill and should be. The resident had an order to check the resident's left arm shunt for bruit and thrill every shift and notify the physician and [MEDICAL TREATMENT] unit if none were noted with a start day of 9/16/20 after surveyor intervention. A policy titled [MEDICAL TREATMENT] revised November 2013 indicated, .7. The site will be assessed for bleeding, bruising, lack of pulsations, aneurysm every shift the nurse will palpate the access . A thrill, the feeling of turbulent blood flow, should be felt along the course of the vessel . The procedure should be conducted once per shift. Auscultate the access in the same manner. A bruit, the rushing sound of turbulent blood flow, should be heard along thee course of the vessel or shunt . Conduct this procedure every shift. Record the results of the examination . During the exit conference on 9/16/20 at 6:15 p.m., the facility was asked for any additional information related to these findings. No additional information was provided.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs used without adequate monitoring for 2 of 21 residents reviewed for drug regimen. (Residents #57 and 64) The facility did not document or monitor side effects of Resident #57's Xarelto (an anticoagulant medication). The facility did not document or monitor side effects of Resident #64's Eliquis (an anticoagulant medication). This failure could place residents at risk of adverse consequences of medication. Findings included: 1. Physician orders [REDACTED].#57 admitted [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. The resident had an order for [REDACTED]. Resident #57's clinical record contained no evidence of monitoring for side effects of the anticoagulant medication Xarelto. A care plan dated 7/30/20 to 10/15/20 for Resident #57 indicated the resident was at risk for impaired circulation, and the facility needed to watch for excessive bleeding each shift, monitor for petechiae, bruising, and bleeding from the resident's gums. The most recent MDS dated [DATE] indicated Resident #57 had moderately impaired cognition, had a [DIAGNOSES REDACTED]. During an interview on 9/15/20 at 3:45 p.m., LVN A said Resident #57 was not monitored for side effects of Xarelto and should be. During an interview on 9/16/20 at 2:05 p.m., the DON said Resident #57 was not monitored for side effects of Xarelto before 9/15/20 and should have been. 2. Physician orders [REDACTED].#64 admitted on [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. The resident had an order for [REDACTED]. Resident #64's clinical record contained no evidence of monitoring for side effects of the anticoagulant medication Eliquis. A care plan dated 9/14/20 for Resident #64 indicated the resident was on Eliquis 5 mg for [MEDICAL CONDITION]. The facility was to monitor/document/report signs and symptoms of anticoagulant complications as needed. The most recent MDS dated [DATE] indicated Resident #64 had moderately impaired cognition, [DIAGNOSES REDACTED]. During an interview on 9/15/20 at 3:53 p.m., LVN A said Resident #64 should be monitored for side effects of Eliquis and was not. During an interview on 9/16/20 at 2:10 p.m., the DON said Resident #64 was not monitored for side effects of Resident's #64's Eliquis from 9/1/20 to 9/15/20 and should have been. A policy titled Adverse Consequences and Medication-Related Problems revised April 2007 indicated . 1. Residents receiving any medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported The manufacturer's website for Eliquis accessed on 9/18/20 at https://packageinserts.bms.com/pi/pi_eliquis.pdf indicated .WARNINGS AND PRECAUTIONS ELIQUIS (apixaban) can cause serious, potentially fatal, bleeding. Promptly evaluate signs and symptoms of blood loss. . ADVERSE REACTIONS . Advise patients of signs and symptoms of blood loss and to report them immediately or go to an emergency room . . 17. PATIENT COUNSELING INFORMATION Advise patients of the following: . That it might take longer than usual for bleeding to stop, and they may bruise or bleed more easily when treated with ELIQUIS. Advise patients about how to recognize bleeding or symptoms of hypovolemia and of the urgent need to report any unusual bleeding to their physician. . The manufacturer's website for Xarelto accessed on 9/16/20 at www.xarelto.com indicated .Warnings: . Increased risk of bleeding. XARELTO can cause bleeding which can be serious, and may lead to death. This is because XARELTO is a blood thinner medicine (anticoagulant) that lowers blood clotting. During treatment with XARELTO you are likely to bruise more easily, and it may take longer for bleeding to stop. You may be at higher risk of bleeding if you take XARELTO and have certain other medical problems. During the exit conference on 9/16/20 at 6:15 p.m., the facility was asked for any additional information related to these findings. No additional information was provided.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 21 residents reviewed for antipsychotic medications were monitored for the side effects specific to the medication. (Resident #68) The facility did not monitor Resident #68 for side effects or behaviors of [MEDICATION NAME]. This failure could place the resident at risk for adverse consequences of the antipsychotic medication. Findings included: Physician orders [REDACTED].#68 admitted [DATE], was [AGE] years old, and had [DIAGNOSES REDACTED]. The resident had an order for [REDACTED]. Resident #68's clinical record contained no evidence of monitoring for side effects or behaviors of the antidepressant medication [MEDICATION NAME]. A care plan dated 7/22/20 for Resident #68 indicated the resident was treated for [REDACTED]. The facility was to monitor and document side effects and effectiveness of the medication. The most recent MDS dated [DATE] indicated Resident #68 was cognitively intact and needed total assistance for bathing and extensive assistance for all other ADL's. During an interview on 9/15/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455001	A. BUILDING _____ B. WING _____	**09/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PHP THE OAKS AT BEAUMONT	**4195 MILAM ST BEAUMONT, TX 77707**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) 20 at 3:54 p.m., LVN A said Resident #68 was not being monitored for side effects of [MEDICATION NAME] or for behaviors and should be. During an interview on 9/16/20 at 2:00 p.m., the DON said Resident #68 was not being monitored for side effects of [MEDICATION NAME] or for behaviors and should be. A policy titled Antipsychotic Medication Use revised April 2007 indicated . Policy Statement Anti-psychotic medication therapy shall be used only when it is necessary to treat a specific condition. . Policy Interpretation and Implementation . 14. Nursing staff shall monitor and report any; of the following side effects to the Attending Physician: a. Sedation; b. orthostatic [MEDICAL CONDITION]; c. Lightheadedness; d. Dry mouth; . During the exit conference on 9/16/20 at 6:15 p.m., the facility was asked for any additional information related to these findings. No additional information was provided.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. The facility did not ensure the kitchen was free of the following: *standing water under the 3-compartment sink; *expired milk in the milk refrigerator; *undated food stored in the refrigerator; *a plate warmer was not working; and *dietary staff were not correctly wearing a face covering while plating food. This failure could place residents who consumed food prepared by the kitchen at risk of cross contamination and food-borne illnesses. Findings included: During an observation in the kitchen on [DATE] at 8:42 a.m., the floor under the 3-compartment sink was covered with standing water. 13 half pint cartons of 1% milk dated [DATE] were in the milk box refrigerator. During an observation and interview on [DATE] at 8:45 a.m., Cook C said the tuna salad in the refrigerator should have been marked to show the date it was made and the expiration date, but it was not marked. During an observation and interview on [DATE] at 11:40 a.m., the plate warmer was not plugged in and was not warming the plates during the plating of the noon meal. Cook C said it had been broken for a while and was throwing the breaker. During an interview on [DATE] at 11:55 a.m., the maintenance supervisor said the plate warmer should be working. She was unaware of a leak in the kitchen. During an interview on [DATE] at 3:00 p.m., the DM said there should not be expired milk in the milk box or standing water in the kitchen. She said no one reported the plate warmer was broken. During an observation on [DATE] at 11:20 a.m., Cook C was plating the food and tray, an aide was assisting with tray preparation, and both had their masks pulled down under their chin with their nose and mouth exposed. After several minutes, the cook placed his mask over his nose and mouth and continued plating the food. Then he motioned and told the aide to place his mask correctly. The cook nodded indicating they should have been wearing their mask over their nose and mouth. During an interview on [DATE] at 11:27 a.m., the DM said the staff should be wearing face masks and it should cover their nose and mouth while in the kitchen or in the building. The undated policy titled Covid Readiness indicated To prevent or reduce spreading infections through indirect contact requires cleaning, sanitizing, . Dietary Department are wearing appropriate PPE: mask, gloves, gowns or alternatives forms a recommended by the CDC. Texas Food Establishment Rules dated [DATE] indicated . (B) marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under paragraph (1) of this subsection; (C) marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under paragraph (2) of this subsection; or (D) using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the regulatory authority upon request. . (h) Ready-to-eat, time/temperature control for safety food, disposition. (1) A food specified in subsection (g) (1) or (2) of this section shall be discarded if it: (A) exceeds either of the temperature and time combinations specified in subsection (g)(1) of this section, except time that the product is frozen; P (6) (B) is in a container or package that does not bear a date or day; P (6) .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** . Based on interview and record review, the facility failed to ensure an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections was established and maintained to prevent the spread of infections to other persons in the facility. The facility did not track and trend infections for the months of June, July, and August 2020. This failure could place residents at risk for cross contamination and the development of infections. Findings included: 1. The facility's Infection Control binder did not include any documentation of infection tracking and trending for the months of June, July, and August 2020. During an interview on 09/15/20 at 11:10 a.m., the infection control nurse said she had only been in her position for a few weeks and had not been able to find infection surveillance tracking and trending for the months of June, July, and August of 2020. During an interview on 9/15/20 at 11:30 a.m., the infection control nurse said she tracked infections for the month of August but had not completed the trending. She indicated she had not logged the tracking and trending in the infection control binder. After surveyor intervention, she was able to review infections and record on a log to add to the tracking and trending binder. During an interview on 09/16/20 at 3:05 p.m. the administrator said she recognized the importance of tracking and trending of infections. During an interview on 09/16/20 at 3:00 p.m., the DON said he did not have documentation for tracking and trending of infections for June, July, and August 2020. He said unit managers had been filling out infection incident forms during the past months, but no tracking and trending had been completed. During an interview on 09/16/20 at 3:15 p.m., the administrator said there was no additional documentation of infection tracking and trending for June, July, and August 2020. She stated the full-time infection control nurse left in June 2020 and since that time there had been no one in the position until the current nurse was hired. The facility policy titled Infection Control Coordinator revised December 2009 indicated .The Infection Control Coordinator will collect, analyze and provide infection data and trends to nursing staff and health care practitioners .
F 0908 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Keep all essential equipment working safely.** Based on observation, interview, and record review, the facility failed to ensure all mechanical, electrical, and patient care equipment was in safe operating condition. The plate warmer was not being used and was not in working condition. This failure could place residents who ate from the kitchen at risk of foodborne illness and poor quality of food served. Finding include: During an observation and interview on 9/14/20 at 11:40 a.m., Cook C was plating the noon meal and the plate warmer was not plugged in and was not warming the plates. Cook C said the plate warmer had been broken for a while and would throw the breaker if they plugged it in. During an interview on 9/14/20 at 11:55 a.m., the maintenance supervisor said the plate warmer should be working. She was unaware the plate warmer was not working and said she would put in a system for the kitchen to report problems to the maintenance department. During the exit conference on 9/16/20 the facility was asked for additional information related to these findings. No additional information was provided