STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235243	A. BUILDING _____ B. WING _____	09/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF GTC	**2950 LAFRANIER RD TRAVERSE CITY, MI 49686**

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain proper positioning of a right upper extremity for one (Resident #75) of two residents reviewed for quality of care. This deficient practice resulted in preventable swelling and potentially irreversible skin damage. Findings include: A review of the face sheet in the electronic medical record (EMR) for Resident #75 (accessed on 9/10/20 at 10:04 AM) revealed admission to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the comprehensive admission Minimum Data Set (MDS) assessment for Resident #75, dated 8/28/20, revealed a Brief Interview of Mental Status (BIMS) assessment of 12, indicating moderately impaired cognition. Resident #75 also required extensive assist of two staff for bed mobility, dressing and toileting. On 9/8/20 at 2:13 PM, Resident #75's right arm was observed dangling dependently (lower than the level of the heart) from the right side of the bed. Significant [MEDICAL CONDITION] (swelling) was noted in the right upper extremity and the skin over the hand appeared tight and translucent (see through). Certified Nurse Aide (CNA) J was observed replacing the arm directly onto the bed surface. CNA J did not elevate the Resident's extremity. There were no pillows or blankets observed on or around the bed of Resident #75 that could be used for elevating the right arm. On 9/9/20 at 9:46 AM, Resident # 75's right arm was again observed dangling dependently from the bed. Significant [MEDICAL CONDITION] was noted and the skin again appeared tight. The [MEDICAL CONDITION] again appeared to make the skin appear translucent, particularly in the hand. Again, there were no pillows or blankets observed on or around the bed of Resident #75 available for elevating the right arm. On 9/9/20 at 3:30 PM, the right arm of Resident #75 was observed with right hand dangling from the bed in the same condition as above. On 9/10/20 at 9:57 AM, the right arm of Resident #75 was observed propped in an elevated position. The [MEDICAL CONDITION] had substantially subsided, and the skin on the right hand was observed sagging from the skin being stretched tight by the [MEDICAL CONDITION]. A review of the care plan in the EMR accessed on 9/10/20 at 10:04 AM revealed no interventions to address the [MEDICAL CONDITION] issue for the right upper arm. On 9/10/20 at 11:57 AM, an interview with Licensed Practical Nurse (LPN) H revealed the following: LPN H acknowledged Resident #75's extremity should be elevated, and when asked why the care plan did not specify this intervention, LPN H stated she was surprised the care plan did not reflect the intervention. On 9/10/20 at 4:34 PM, an interview with Registered Nurse (RN) Unit Manager K revealed the following: When asked how long Resident # 75 experienced swelling in the right arm, RN K stated, Only for the past few days. RN K was informed the right arm of Resident #75 was dangling from the bed and had caused [MEDICAL CONDITION] and skin tightness to the point of the skin appearing translucent. RN K stated Resident #75 had difficulty keeping the right arm on the bed and elevated. RN K stated the hospice provider was contacted to obtain a bariatric bed to help keep the right arm of Resident #75 elevated. RN K stated Resident #75 still had trouble keeping the right arm on the bed and elevated. A review of the Progress notes (written by RN M) for Resident #75 revealed the following: 8/29/2020 11:25 (AM) Alert Note Late Entry: Note Text: Spoke with (co-worker nurse) + (and hospice provider nurse) regarding resident (#75) right arm pain + (and) swelling. Elevated on pillow. 8/30/2020 17:26 (5:26 PM) Alert Note Note Text: Left (?) arm with increased swelling; resident (#75) hanging arm off side of bed. Assisted with positioning. Notify Hospice nurse in am for bigger bed . 9/4/2020 16:23 (4:23 PM) Alert Note Note Text: Call to (Hospice Provider) to request a bigger bed r/t (related to) resident(#75's) arms hanging off side. Resident (#75) assisted with elevation of swollen arms/elevated on pillows. The following note (written by RN K) was entered after discussion with the facility about the concern: 9/10/2020 20:14 (8:14 PM) Alert Note Note Text: Bariatric bed was delivered 9/5/2020. There was no evidence of Resident #75 having continued difficulty with keeping the right arm elevated on pillows following the delivery of a bariatric bed. The bariatric bed was delivered on 9/5/20 according to the facility documentation and a receipt provided by the facility. On 9/11/20 at 12:55 PM a follow up interview with RN K revealed the following: When asked if the right arm positioning was added to the care plan on 9/10/20 following identification by this Surveyor, RN K stated, Yes, I did put it (elevate right upper extremity intervention) on there (9/10/20). When asked if the intervention was on the Kardex (CNA Care Guide) so CNAs (Certified Nurse Aides) know to elevate the right upper extremity, RN K stated, Let me check . It is now, I just added it. A review of the facility provided RN hospice start of care dated 8/28/20 revealed the following: .INDICATE LOCATION AND SCALE OF [MEDICAL CONDITION] (MARK ALL THAT APPLY) UPPER RIGHT EXTREMITY/HAND LOWER RIGHT EXTREMITY/ANKLE LOWER LEFT EXTREMITY/ANKLE INDICATE AMOUNT OF [MEDICAL CONDITION] IN UPPER RIGHT EXTREMITY +3 (MODERATELY SEVERE) . .IN WHAT EXTREMITIES DO PAIN /STIFFNESS EXIST (MARK ALL THAT APPLY) UPPER RIGHT EXTREMITY IN WHAT EXTREMITIES DOES DECREASED STRENGTH EXIST (MARK ALL THAT APPLY) UPPER RIGHT EXTREMITY . .INDICATE LOCATION OF PAIN (MARK ALL THAT APPLY) .EXTREMITY(S) UPPER . .HOW DOES THE PATIENT (Resident #75) DESCRIBE THE CHARACTER OF PAIN: (MARK ALL THAT APPLY) BURNING PRESSURE INDICATE DESCRIPTION OF PAIN FOR EACH IDENTIFIED SITE: BURNING UPPER RIGHT EXTREMITY . .INDICATE DURATION OF PATIENT'S (Resident #75's) PAIN: INTERMITTENT . .INDICATE WHAT RELIEVES PAIN (MARK ALL THAT APPLY): MEDICATIONS POSITIONING . ._DECREASED SKIN INTEGRITY - AEB (as evidenced by): FRAGILE SKIN. RIGHT ARM IS VERY RED AND PAINFUL, RELATED TO [MEDICAL CONDITION]; RECENTLY treated for [REDACTED]. A review of the facility policy Repositioning with a revised date of 3/24/17 revealed the following: The purpose of this procedure is to provide guidelines for the assessment of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed- or chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. .Review the resident's care plan to assess for any special needs of the resident . .Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief. .Assessment of a resident's skin integrity after pressure has been reduced or redistributed should guide the development and implementation of repositioning plans. Such plans should be addressed in the comprehensive plan of care consistent with the resident's needs and goals. .Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. .Check the care plan, assignment sheet or the communication system to determine resident's specific positioning needs including special equipment, resident level of participation and the number of staff required to complete the procedure. .Place the resident in a comfortable position in accordance with the resident's individualized care plan. .The act of repositioning. This may be on a flow sheet or summarized in a note. .If the resident refused the care and the reason(s) why. .Observations of anything unusual exhibited by the resident. .Notify the supervisor if the resident refuses the procedure. .If the resident refuses care, an evaluation of the basis for refusal, and the identification and evaluation of potential alternatives is indicated .
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**

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.

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the wheelchair safety device interventions were implemented to prevent injury for one Resident (#73) and failed to ensure safe room environments for one Resident (#21) out of six Residents reviewed for safety. This deficient practice resulted in the potential for continued use of wheelchairs without proper safety devices causing injury for Residents and injury from clutter in Resident rooms. Findings include: Resident #73 A review of Resident #73s 'Face Sheet' with a print date of 9/11/20 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. A review of the 8/20/20 Minimum Data Set (MDS) assessment revealed he had scored a 3/15 on the Brief Interview for Mental Status (BIMS) assessment, indicating severely impaired cognition. Resident #73 required one-person supervision for locomotion on the unit and he used a wheelchair for mobility device. An observation was made of Resident #73 on 9/10/20 at 12:10 p.m. Resident #73 was noted coming out of the small dining room located at the end of the hallway in his wheelchair and was visibly upset. Non-Certified Nurse Aide L approached Resident #73 in an attempt to calm him down and stated, Let us do some laps, and proceeded to push him down the hallway in his wheelchair without the use of foot pedals. Resident #73's shoes were heard dragging across the floor. This Surveyor requested from the Nursing Home Administrator (NHA) via e-mail the policy/procedure for foot pedal usage for transporting Residents on 9/11/20 at 11:53 a.m. The NHA replied confirming there was no policy/procedure for foot pedal usage and that it (foot pedal usage during transport) was a standard of care. Review of Resident #73's Activity of Daily Living (ADL) Care plan dated 5/15/20 was reviewed. The ADL care plan did not mention the use of a wheelchair for mobility or the proper use of foot pedals when assisting Resident #73 down the hallway. Resident #21 On 9/8/20 at 11:38 AM, the room of Resident #21 was observed with fall mats located on both sides of the bed. There was a long coiled power cord originating from the air conditioner sitting on top of the left hand fall mat. On 9/8/20 at 3:37 PM the power cord was still laying on top of the left-hand floor mat. A review of the quarterly MDS assessment dated [DATE] revealed admission to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #21 also required extensive assist of two staff for bed mobility, transfers, dressing, toileting, hygiene, and bathing. On 9/10/20 at 4:00 PM, The DON (Director of Nursing) was shown the power cord laying all over the bedside mat. The DON acknowledged the concern of the cord presenting a hazard to Resident #21. When asked what would happen if she were to roll out of bed, the DON stated, I see what you mean, she is calm now, but she is quite flexible, and has been known to roll out of bed. The Administrator also observed the power cord, and acknowledged the concern as a potential hazard to Resident #21.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory equipment was used to effectively manage [MEDICAL CONDITION] care for one (Resident #21) of three residents reviewed for respiratory care. This deficient practice resulted in the potential for respiratory complications. Findings include: A review of the quarterly Minimum Data Set (MDS) assessment For Resident #21 dated 7/10/20 revealed admission to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #21 also required extensive assist of two staff for bed mobility, transfers, dressing, toileting, hygiene, and bathing. Section O of the MDS indicated Resident #21 was receiving care while a resident for suctioning and treacheostomy care. On 9/8/20 at 11:38 AM, Resident #21 had a [MEDICAL CONDITION] and was observed with a compressor for humidification in use. The humidification chamber was observed nearly empty with approximately 1 centimeter (cm) of water left in the chamber. The tubing was observed dependent to the reservoir bag due to the length of tubing on the compressor side. This allowed for the opportunity for condensate to accumulate outside of the bladder and obstruct the flow of humidified air to Resident #21. No condensate was observed in the reservoir bag. On 9/8/20 at 3:39 PM, the humidification chamber water for the compressor in place on Resident #21 was observed empty. The tubing section between the compressor and reservoir remained dependent to the collection reservoir. No condensate was observed in the reservoir bag. On 9/8/20 at 4:10 PM, the humidification chamber water remained empty, and the tubing was observed in the position stated above. On 9/9/20 at 4:00 PM, the collection chamber and tubing was observed resting on the floor with the tubing between the compressor and reservoir laying dependent to the reservoir. There was an observed blockage of water condensate in the tubing which was observed to be gurgling. The condensate was making its way to the reservoir bag located between the compressor and Resident #21. The Director of Nursing (DON) was shown the concern present on 9/8/20 and 9/9/20 in regard to placement and function of the reservoir collection bag and tubing. The DON acknowledged the concern and stated she recognized the issue and then stated she would figure something out. On 9/10/20 at 11:37 AM, the tubing and reservoir issue seen on 9/8/20 and 9/9/20 had been resolved and fixed upon the bedside stand to allow for proper flow of the condensate to pass into the reservoir. There was condensate observed in the reservoir bag. On 9/11/20 at 10:59 AM, an interview with Registered Respiratory Therapist (RRT) N (Local Equipment Provider Representative) revealed the following: When asked about why tubing should be off the floor, RRT N stated there was .more potential for infection. When asked about how the tubing should be configured, RRT N stated, The rule of thumb is the shorter the better. They should use gravity and the provided plastic hook for the drain bag. When the set-up and observations above were described, RRT N stated, We need to shorten that distance to allow for proper drainage. When asked if water backing up into the first part of the circuit would impede the desired amount of humidification, RRT N stated, Yes, it would. A review of the (equipment provider) instruction sheet dated 2018 and titled Instructions for Cleaning & Maintaining Air Compressor revealed the following: .Please change corrugated tubing,[MEDICAL CONDITION] mask, and jet nebulizer (humidification chamber) weekly or when visibly soiled. Change drain bag every two weeks and oxygen adapter every month. Keep supplies from laying on the ground .
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication error rate less than five percent, with four medication errors, out of 32 opportunities (12.5% error rate) observed during the medication administration task. This deficient practice resulted in the potential for ineffective therapeutic medication levels and adverse side effects. Findings include: Medication Error #1 On 9/9/20 at 7:16 a.m., Licensed Practical Nurse (LPN) H handed Resident #44 an inhaler containing a [MEDICATION NAME][MEDICATION NAME] medication. LPN H did not provide instruction to Resident #44 regarding how many puffs of medication to inhale. Resident #44 inhaled two separate puffs of the medication. When asked how many puffs of the medication Resident #44 was ordered to have, LPN H reported Resident #44 was to have one puff of the medication. LPN H confirmed Resident #44 had taken two puffs of the medication. LPN H reported they would, talk to (Resident #44) about it next time. A review of the physician order, dated 6/9/20 at 2:08 p.m., revealed the following, in part: ([MEDICATION NAME][MEDICATION NAME] medication), 1 puff inhale orally every 4 hours as needed for [MEDICATION NAME][MEDICATION NAME]. A review of the policy, titled, Administering Medications through a Metered-dose Inhaler, dated 12/21/10, revealed the following, in part: The purpose of this procedure is to provide guidelines for the safe administration of inhaled medications . 9. Explain the procedure to the resident. Medication Error #2 On 9/9/20 at 7:32 a.m., LPN H was observed administering a dose of rapid-acting insulin to Resident #28 via (using) an insulin pen. LPN H inserted the needle of the pen, pushed the plunger to release the dose of insulin and immediately removed the needle from the resident. In an interview immediately after exiting Resident #28's room, LPN H was asked how long the needle should be left inserted after releasing the insulin. LPN H reported the needle should be left inserted for 10 seconds. LPN H reported they had not kept the needle inserted for 10 seconds following pushing the plunger to release the medication. LPN H confirmed she was aware by failing to keep the needle inserted for 10 seconds, there was a risk the resident did not receive the full dose of insulin. A review of the pharmacy instructions, provided by the Nursing Home Administrator (NHA), titled, How to use your (rapid-acting insulin pen), revealed the following, in part: Step 4 . when the needle is under your skin, inject the insulin by pressing the push button all the way in. Leave the needle under the skin for at least 10 seconds after injecting your insulin. Keep the push button fully depressed until withdrawing the needle. This will ensure that you received the full dose of insulin. An interview with the Director of Nursing (DON), on 9/10/20 at 12:18 p.m., confirmed the procedure for administering insulin via pen was to hold the needle inserted for 10 seconds to ensure the resident received the proper dose of insulin. Medication Error #3 and #4 On 9/9/20 at 7:02 a.m., LPN H was observed administering 300 milliliters (mls) of tube feeding formula through Resident #9's PEG tube (percutaneous endoscopic gastrostomy tube used to administer medication and nutrition directly into the stomach) with a 60 ml syringe. After administering the formula, LPN H filled the 60 ml syringe used to administer the formula with 30 mls of water and reported they were flushing the tube. On 9/10/20 at 11:15 a.m., LPN I was observed in the process of administering tube feeding

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F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) formula through Resident #9's PEG tube with a 60 ml syringe. After administration of the formula, LPN I used a clear 50 ml cup to pour approximately 30 mls of water into the 60 ml syringe inserted in Resident #9's PEG tube. LPN I reported, I usually flush (the PEG tube) with 30 to 50 mls, of water after administration of the tube feeding. A review of the physician order, dated 8/20/20 at 4:11 a.m., revealed the following, in part: (nutritional supplement), give 300 ml via PE[DEVICE] 5 times a day related to dysphagia (difficult swallowing) . 100 ml flush before and after each feeding. A review of the policy, titled, Administering Meds through an Enteral Tube, undated, revealed the following, in part: When the last of the medication begins to drain from the tubing, flush the tubing with 30 to 50 ml of warm water (or prescribed amount). An interview with the DON, on 9/10/20 at 12:18 p.m., revealed staff should be reviewing the physician order [REDACTED].
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.** Based on observation and interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety as evidence by: A. Failing to ensure potentially hazardous food stored in the walk in cooler was maintained at proper temperatures (below 41 F) B. Failing to ensure staff conducting dish washing operations washed their hands after handling soiled dishes and before handling clean dishes C. Failing to ensure the ice machine was clean and free of mold, mildew or other contaminants D. Failing to ensure proper cooling procedures were followed for potentially hazardous foods observed in the walk-in cooler. E. Failing to ensure proper sanitizing practices were followed for thermometers placed in food products F. Failing to ensure all cooking equipment was working properly G. Failing to ensure refrigerator door gaskets were maintained in a sanitary condition. H. Failing to discharge water draining from the ice machine directly into a floor drain. I. Failing to ensure one juice machine was properly installed with a back flow preventer device on the water supply line. This deficient practice has the potential to result in food borne illness among any or all the 77 residents in the facility. Findings include: A. On 9/8/2020 at 10:45 Am, observations of the kitchen's walk-in cooler were conducted. The exterior digital thermometer was observed to read 50 F. Two additional thermometers were identified inside the walk in cooler and were read as 50F and 52F respectively. An interview was conducted with Staff B at this time and was requested to identify food products which would have been stored in the refrigerator constantly since the previous day. Containers of soup base, a Lexan container labeled with soup and the date of 9/7. Using a Thermapen Super Fast digital thermometer, the soup base was measured have an internal temperature of 49F, the soup was measured to have an internal temperature of 54F. The temperature log sheet was reviewed with Staff B and was revealed the temperature documented for the current day was 34F. When asked what time the temperature of the refrigerator was documented, Staff B stated 6 AM. Two additional products in the walk in were identified as being in the unit since the previous day and included a large container of salad dressing and a container of beef stock. Both products had an internal temperature measured of 52F. Staff B was asked how it was possible that the products, having been stored in the refrigerator all night, and having a temperature of 34F that morning, could reach temperatures being read. Staff B responded I don't know. On 9/9/20 at 8:30 AM observations were made of the walk in cooler and an interview with Staff B conducted. Staff B stated that all protein foods had been disposed of that were present in the walk in cooler the previous day. Observations of the walk in revealed a container of beef soup stock, dated 9/5, two large containers of salad dressing, and a container of chicken still in the refrigerator which had been observed the previous day. These products were identified to Staff B who stated Oh, I didn't see those, I'll throw them out. A review of the FDA Food Code 2013 was conducted and it states: 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under 3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135oF) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54C (130F) or above; P or (2) At 5C (41F) or less. B. On 9/8/20 at 12:55 PM, observations were made of the dish washing operations at the mechanical dish wash machine. Staff F was observed to use the overhead sprayer, above the garbage disposal, to remove soil and food debris from dishes, then placing them on the cassette and pushing them into the dish machine. Following this, Staff F proceeded to the clean side of the dish machine and began taking clean dishes from the cassette and placing them with other clean dishes without washing her hands between the two functions. Staff F repeated this practice two more times, at which time she was instructed by this surveyor, in the presence of CDM (certified dietary manager) A that she must wash her hands after handling soiled dishes and prior to handling clean dishes. This surveyor stopped Staff F from proceeding, instructing her she must wash her hands before handling clean dishes. Staff F stated Oh. I didn't know. On 9/9/20 at 9:02 AM, Staff G was observed conducting dish washing operations at the mechanical dish machine while in the presence of the Corporate Registered Dietician (RD) C. Staff G was observed rinsing soiled dishes above the garbage disposal, placing them on the cassette, then pushing the cassette into the machine. Following this, and without washing his hands, proceeded to the clean side of the dish machine and began handling clean dishes and putting them away. This was brought to the attention of Staff C who immediately halted the process and instructed Staff G to wash his hands before continuing. A review of the FDA Food Code 2013 was conducted and it states: 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLESERVICE and SINGLE-USE ARTICLESP and: (E) After handling soiled EQUIPMENT or UTENSILS; C. On 9/8/20 at 11:15 AM the ice machine located in the kitchen was opened and observed to have a pink slime on the plastic ledge directly above the storage bin for the ice. A white paper napkin was used to rub an area of the pink which easily transferred to the white napkin. CDM A was asked when the last time the unit had been cleaned and she stated It is supposed to be cleaned every three months. Documentation was requested showing the most recent cleaning. This documentation was never received. A review of the FDA Food Code 2013 was conducted and it states: 3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; D. On 9/8/20 at 10:45 AM, observation of the walk in cooler were made. A Lexan container of cut up chicken was observed on a shelf and measured to have a temperature of 108F. A Lexan container of approximately 2 gallons of soup, dated 9/7 was measured to have an internal temperature of 54F. An interview with Staff B was conducted while showing him the temperature of the soup. Staff B stated I'm not surprised, as I am sure you are not. That was put in here yesterday. I don't have to tell you that product is thick and won't cool very quickly. The chicken was identified as having been prepared earlier in this same day (9/8/20)but could not identify the time it was placed in the cooler. No record of temperatures and times of monitoring were made available. At 2:00 PM the container of chicken was identified still in the walk in cooler. The internal temperature of the product was measured to be 84F. This was brought to the attention of CDM A, who then disposed of the product due to not meeting proper cooling procedures. A review of the FDA Food Code 2013 was conducted and it states: 3-501.14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57C (135F) to 21C (70F); P and (2) Within a total of 6 hours from 57C (135F) to 5C (41F) or less. E. On 9/8/20 at 10:45 AM while conducting observations of the kitchen, Staff B was requested to provide alcohol pads for this surveyor to sanitize the thermometer used for compliance monitoring of facility food. Staff B stated they did not have any alcohol pads and they had been trying to get them for a few weeks now. When asked how kitchen staff were sanitizing their thermometers, Staff B pointed to a bucket of cloudy water, containing a wiping cloth, stating You can dunk it in there. This surveyor left the kitchen, obtained alcohol pads from the nursing department and returned to the kitchen to conduct compliance monitoring of potentially hazardous foods (PHF). When using the alcohol pads, Staff B asked how this surveyor got them, and when told stated I didn't even think of that. A review of the FDA Food Code 2013 was conducted and it states: 4-602.11 Equipment Food-Contact Surfaces and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be cleaned: (4) Before using or storing a FOOD TEMPERATURE MEASURING DEVICE; F. On 9/9/20 at 9:05 AM an interview with kitchen staff E was conducted. Staff E expressed frustration that much of the cooking equipment in the kitchen did not work properly. this included the tilt skillet, which was stated heated in the center, but either side did not heat properly, the oven, could not be regulated to a constant heat, and either burned food or did not cook it properly, and that both steamer units failed to properly heat food. Food was observed in one of the steamers, still frozen, which Staff E stated had been in the unit for a long time. No steam escaped when the door was opened. The door was also observed to be installed upside down on the unit. When this was

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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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 3) pointed out, Staff E stated I never even saw that! A review of the FDA Food Code 2013 was conducted and it states: 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. G. On 9/9/20 at 10:03 AM the single door and triple door Victory refrigerator doors were observed to have gaskets which were torn, dirty and otherwise poor condition, rendering them ineffective in sealing the units and uncleanable. An interview with CDM A was conducted and stated We saw that and are ordering them right away. A review of the FDA Food Code 2013 was conducted and it states: 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. H. On 9/8/20 and 9/9/20 during each of the observation opportunities in the kitchen, the drain from the ice machine was observed to be discharging approximately 4 away from the floor drain, flooding an area of approximately 2' x 2' around the floor drain. The floor tile grout was observed to be black (from an original light gray) due to the constant moisture being discharged to it. I. On 9/8/20 at 11:10 AM, a juice machine was observed in the kitchen connected to the potable water supply line and without any proper back flow prevention device. This condition was shown to CDM A. At 1:30 PM an interview with CDM A was conducted at which time she was on the phone with a representative of the vendor for the juice machine. CDM stated the representative was saying the machine did not require a back flow prevention device as there was one built into the machine. CDM A was instructed to tell the representative to demonstrate this via documentation for the specific machine to show it was in compliance. CDM A was then directed to a label on the machine which read: ATTENTION THIS EQUIPMENT MUST BE INSTALLED WITH ADEQUATE BACKFLOW PROTECTION TO COMPLY WITH FEDERAL, STATE AND LOCAL CODES. A review of the FDA Food Code 2013 was conducted and it states: 5-202.14 Backflow Prevention Device, Design Standard. A backflow or backsiphonage prevention device installed on a water supply system shall meet American Society of Sanitary Engineering (A.S.S.E.) standards for construction, installation, maintenance, inspection, and testing for that specific application and type of device.