STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555517	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KERN VALLEY HEALTHCARE DISTRICT DP SNF	**6412 LAUREL AVE LAKE ISABELLA, CA 93240**

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 observation, interview, and record review, the facility failed to notify resident's family of refusal of care and change in medication for one of two sampled residents (Resident 3). This failure had the potential to result in the violation of Resident 3's family's right to be informed of current health status and plan of care. Findings: During an observation on 3/9/20, at 3 PM, in Resident 3's room, Resident 3 was lying in bed, confused and unable to be interviewed. During an interview on 3/11/20, at 1:29 PM, with Family Member (FM) 3, FM 3 stated, she was not aware Resident 3 was refusing all her medications for several months and decreasing appetite. FM 3 stated, she was not aware of any new medication for Resident 3. FM 3 stated, they have not received any phone call or notification of Resident 3's recent change in health status. FM 3 stated, she noticed Resident 3 was more and more confused and becoming very frail but no one informed her of Resident 3's condition. During a review of Resident 3's Administration Record (AR) dated 1/20, 2/20, and 3/20, the AR indicated, Resident 3 had the following medication orders [REDACTED]. Give one capsule by mouth three times a daily. Dx (Diagnosis): Diabetic [MEDICAL CONDITION] (nerve damage). b. [MEDICATION NAME]-acetami (medication for severe pain) 5-325 mg tablet. Give one tablet by mouth three times daily. Dx: Pain. c. [MEDICATION NAME]-[MEDICATION NAME] (medication for nervous system disorder) 25-100 tab. Take one tablet by mouth three times a day. Dx: Parkinson Disease (nervous system disorder that affects movement). d. [MEDICATION NAME] Hcl (medication for elevated blood sugar) 500 mg tablet. Give one tablet by mouth twice daily with food. Dx: Diabetes (uncontrolled blood sugar disorder). e. [MEDICATION NAME] (medication for elevated blood pressure) 5 mg tablet. Take one tablet by mouth daily. Dx: Hypertension (high blood pressure)/Renal (kidney) Protectant. f. [MEDICATION NAME] Acet (appetite stimulant) 40 mg/ml suspension. Administer 400 mg (10 ml) by mouth once daily for decreased appetite. g. [MEDICATION NAME] (medication for elevated blood sugar) 100 unit/ml. Administer 22 units sub (subcutaneous-fatty tissue under the skin) daily at bed time. Dx: Diabetes. h. [MEDICATION NAME] R (medication for elevated blood sugar) 100 units/ml vial. Fingerstick with sliding scale. Dx: Diabetes. i. [MEDICATION NAME] (supplement) 3 mg tablet. Give one tablet by mouth daily at bed time. j. Multiple Vitamin with Minerals (supplement) tab. Give one tab by mouth daily. Dx: Vitamin Deficiency. k. Vitamin D3 (supplement) 1000-unit tablet. Give one tablet by mouth daily. Dx. Hypovitaminosis (low vitamins in the body). l. [MEDICATION NAME] EC (supplement) 325 mg tablet. Give one tablet by mouth daily with food. Dx: [MEDICAL CONDITION]. m. Vitamin C (supplement) 500 mg tablet. Take one tablet by mouth daily with food. Dx: Aid [MEDICATION NAME] absorption. n. Fish Oil (supplement) 1000 mg capsule. Give one capsule by mouth twice daily. Dx: triglyceride o. [MEDICATION NAME] Sodium (medication for constipation) 100 mg tablet. Give one tablet by mouth twice a day. Dx: Constipation. The AR dated 1/20 was reviewed. The AR indicated, Resident 3 refused all her medications 31 times. The AR dated 2/20 was reviewed. The AR indicated, Resident 3 refused all her medications 31 times. The AR dated 3/20 was reviewed. The AR indicated, Resident 3 refused all her medications 10 times. During a review of resident 3's Departmental Notes (DN) dated 12/13/19, the DN indicated, Staff noted resident has been refusing meals and meds. Call placed to (physician) and labs (laboratory tests) were ordered and new script for [MEDICATION NAME] (medication to increase appetite). During an interview on 3/11/20, at 11 AM, with Assistant Director of Nursing (ADON), ADON reviewed the clinical record but was unable to find documentation of staff notified FM 3 of Resident 3's refusals of medications and meals. During an interview on 3/11/20, at 2:28 PM, with Registered Nurse (RN) 1, RN 1 stated, she did not notify FM 3 of Resident 3's refusal of medications and meals. RN 1 stated, she should have notified FM 3 of any new order of medications and refusal of care. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 8/24/15, the P&P indicated, .B. Unless otherwise instructed by the resident, the Care Manager/Charge Nurse will notify the resident's family or representative (sponsor) when:. 2. There is a significant change in the resident's physical, mental, or psychosocial status. D. Regardless of the resident's current mental or physical condition, the Care Manager/Charge Nurse will inform the resident of any changes in his or her medical care or nursing treatment.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep residents' personal and medical records private and confidential.** Based on observation, interview, and record review, the facility failed to ensure privacy was provided during personal care for four of four sampled residents (Resident 1, Resident 30, Resident 44, and Resident 31). This failure resulted in violation of residents' right to privacy and dignity. Findings: During a concurrent observation and interview on 3/10/11, at 11:16 AM, with Licensed Vocational Nurse (LVN) 2, in Resident 1's room, LVN 2 was observed not closing the privacy curtain during a blood sugar check (checking sugar level in the blood) on Resident 1. At 11:11 AM, in Resident 30's room, LVN 2 was observed doing a blood sugar check on Resident 30. There was a second resident in the next bed. The privacy curtain was not closed between the two resident and the bedroom door was left open by LVN 2. At 11:22 AM, in Resident 44's room, LVN 2 was observed performing a blood sugar check on Resident 44, and the privacy curtain was not closed to provide privacy to the resident. At 12:30 PM, LVN 2 was observed administering insulin to Resident 1, and the privacy curtain was left open. LVN 2 confirmed the findings and stated he did not provide privacy to the residents. During a concurrent observation and interview on 3/11/20, at 9:36 AM, with Registered Nurse (RN) 2, in Resident 31's room, RN 2 administered a treatment to the intravenous site (IV - into the vein) on Resident 31's left wrist. RN 2 pulled the webbed dressing down exposing the IV site and proceeded to flush the IV tubing. Resident 31's privacy curtain was not closed and the bedroom door was left open. Staff and residents could be seen walking outside the door. At 9:43 AM, RN 2 was observed inserting a new IV line into Resident 31's right arm. RN 2 was observed not closing the bedroom door or the privacy curtain. RN 2 verified she had not provided Resident 31 privacy when administering treatments. During a review of the facility's policy and procedure (P&P) titled, Privacy of Residents, dated 6/4/14, the P&P indicated, The staff on the Skilled Nursing Facility will ensure adequate privacy for residents during nursing care and treatment. The resident's privacy will be maintained at all times by the use of closed doors, cubicle curtains, screens, or drapes.Procedure: A. It shall be the responsibility of the nursing staff to guarantee that all residents have their privacy maintained while in the Skilled Nursing Center.1. Cubicle curtains are to be closed when any procedure is being carried out.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its policy and procedure to ensure the Minimum Data Set (MDS-comprehensive assessment tools) assessments were accurate for three of three sampled residents (Resident 3, Resident 11 and Resident 47). This failure had the potential to result in the facility not addressing residents' health care needs due to inaccuracy of medical records and plan of care. Findings: 1. During a review of Resident 3's MDS, dated [DATE], the MDS indicated, Rejection of Care-Presence and Frequency (Did the resident reject

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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) evaluation or care (e.g., bloodwork, taking medications, ADL assistance): coded 0 (Behavior not exhibited). Resident 3's eMAR (electronic Medication Administration Record) dated 2/20 was reviewed. The eMAR indicated, Resident 3 refused all her medications 31 times. During an interview on 3/12/20, at 11:12 AM, with Social Service Director (SSD), SSD stated, she completed the MDS behavior section and evaluated Resident 3's behavior. SSD stated, she only looked at the nurses' notes when she did her evaluation. SSD stated, she did not assess Resident 3 comprehensively. 2. During a review of Resident 11's MDS, dated [DATE], the MDS indicated, Behavioral Symptoms-Presence and Frequency: coded 0 (Behavior not exhibited). During an interview on 3/12/20, at 11:12 AM, with SSD, SSD stated, she evaluated Resident 11's behavior but did not check on the behavior monitoring of Resident 11 to accurately code the MDS assessment. SSD stated, Resident 11 had behaviors of crying and delusions. 3. During a concurrent observation and interview, on 3/10/20, at 3:53 PM, with Certified Nursing Assistant (CNA) 3, and Licensed Vocational Nurse (LVN) 1, in Resident 47's room, LVN 1 stated, Resident 47 often refuses activities of daily living (ADL - term used in healthcare to refer to people's daily self-care activities). During a review of Resident 47's Bath Care Roster (BCR), dated 1/1/20 - 3/12/20, the BCR indicated, Resident 47 had refused his bath/shower on the following dates: 1/6/20, 1/9/20/, 1/13/20, 1/20/20, 1/27/20, 1/30/20, 2/3/20, 2/10/20, 2/13/20, 2/16/20, 2/20/20, 2/21/20, 2/23/20, 2/28/20, 3/1/20, 3/5/20, and 3/8/20. During a review of Resident 47's MDS dated [DATE], the MDS indicated, Rejection of Care-Presence and Frequency (Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance): coded 0 (Behavior not exhibited). During a concurrent interview and record review, on 3/12/20, at 10:03 AM, with Minimum Data Set Coordinator (MDSC), Resident 47's MDS dated [DATE] and BCR dated 1/1/20 - 3/12/20 was reviewed. MDSC verified the MDS was incorrectly coded. During a review of the facility's RAI Version 3.0 Manual dated 10/19, the RAI indicated, Steps for Assessment: 1. Review the medical record. 2. Interview staff, across all shifts and disciplines, as well as others who had close interactions with resident during the 7-day look-back period. 3. Review the record and consult staff to determine whether the care rejections was previously addressed and documented discussions or in care planning with resident, family, or significant other and determine to be an informed choice consistent with resident's values, preferences, or goals; or whether that the behavior represents an objection to the way care is provided, but acceptable alternative care and/or approaches to care have been identified and employed.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide documented notifications to the physician of refusal of medication and laboratory test for one of two sampled residents (Resident 3). This failure had the potential to result in compromised health not being addressed for Resident 3. Findings: 1. During a review of resident 3's Departmental Notes (DN), dated 12/13/19, the DN indicated, Staff noted resident has been refusing meals and meds (medications). Call placed to (physician) and labs (laboratory tests) were ordered and new script for [MEDICATION NAME] (medication to increase appetite). Resident 3's eMAR (electronic Medication Administration Record), dated 1/20, 2/20, and 3/20, the eMAR indicated Resident 3 refused the [MEDICATION NAME] 18 times in January 2020, 16 times in February 2020, and six times in March 2020. During an interview on 3/11/20, at 2:28 PM, with Registered Nurse (RN) 2, RN 2 stated, she did not notify the physician Resident 3 had been refusing the [MEDICATION NAME]. 2. During a review of Resident 3's Order Chronology (OC), dated 1/7/20, the OC indicated, Hemoglobin A1C (laboratory test for residents with elevated blood sugar disorder). Status: Canceled. During an interview on 3/11/20, at 11 AM, with Assistant Director of Nursing (ADON), ADON reviewed the clinical record and was unable to find documentation the physician was notified of the cancellation of the laboratory test. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 8/24/15, the P&P indicated, A. The Care Manager/Charge Nurse will notify the resident's Attending Physician or On-Call Physician and the Director of Nursing Services where there has been:.6. Refusal of treatment or medications (i.e., two (2) or more consecutive times.E. The Care Manager/Charge Nurse will record the resident's medical information relative to changes in the resident's medical/mental condition or status.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide restorative nursing aide (RNA - services to ensure residents' range of motion (ROM) does not decrease) services for one of one sampled resident (Resident 47). This failure had the potential to result in a decrease in range of motion and independence for Resident 47. Findings: During an observation on 3/10/20, at 9:41 AM, in Resident 47's room, Resident 47 was laying in his bed unable to move his right side independently. Resident 47 was observed repositioning his right arm using his left hand. His right wrist and hand were noted to have a contracture (limited movement of a joint). During an interview on 3/11/20, at 9:45 AM, with Certified Nursing Assistant (CNA) 1, CNA 1 stated, I am taking care of 13 residents today, and my responsibilities are for the resident's ADL's. CNA 1 stated, I do not have time to do restorative nursing care. She stated, I use to be the Restorative Nursing Aide (RNA), but we do not have that position anymore. During an interview on 3/11/20, at 9:50 AM, Resident 47 stated, he had not had anyone to provide exercise to him all week and he would like to exercise. During a review of Resident 47's physician's orders [REDACTED]. During a review of Resident 47's Progress Notes (PN), dated 3/9/20, at 1:48 PM, the PN indicated, Resident seen for OT assessment re (regarding) RUE (right upper extremity): he expressed willingness to participate with CNA active/assistive ROM. During a concurrent interview and record review on 3/11/20, at 1:31 PM, with CNA 2, and Director of Nursing (DON), Resident 47's Restorative Participation Roster (RPR) dated 2/1/20 - 3/11/20 was reviewed. The RPR indicated, Resident 47 had participated in ROM on two days (2/29/20 and 3/8/20) between 2/1/20 - 3/11/20. CNA 2 stated, CNA 1 used to be the RNA. CNA 2 stated, we do not have the time to do the passive range of motion on some days. I do not document when I have not been able to complete the passive range of motion. DON stated, we do not have a restorative nursing program anymore as there is no staffing to complete the program. During a review of the facility's policy and procedure (P&P) titled, Restorative Nursing Program, dated 2/03/10, the P&P indicated, The Skilled Nursing Facility offers a Restorative Nursing Program to residents in need of increasing and maintaining independence, self esteem, self determination, and maximum quality of life.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** Based on interview and record review, the facility failed to have a policy and procedure in place for blood sugar checks and insulin (medication for elevated blood sugar) administration. This failure had the potential to result in staff not being aware of the correct procedure for blood sugar checks and insulin administration. Findings: During a concurrent interview and record review, on 3/11/20, at 8:37 AM, with Assistant Director of Nursing (ADON), ADON stated, the facility did not have a policy and procedure regarding blood sugar checks and insulin administration. The ADON was unable to provide a policy and procedure regarding insulin administration, she provided a policy and procedure tiled, Insulin Vial - Usage and Distribution which did not address blood sugar checks or insulin administration. No other policy and procedure was provided.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two multi-dose vials were labeled with date it was opened. This failure had the potential for nursing staff to administer medications with reduced potency and to

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) adversely affect residents' health. Findings: During a concurrent observation and interview on 3/9/20, at 11:46 AM, with Registered Nurse (RN) 1, in the medication storage room refrigerator, there was one opened and undated multi-dose vial of influenza vaccine (given to prevent the flu virus) and one opened and undated multi-dose vial of [MEDICATION NAME] Purified Protein Derivative Diluted Aplison (used as an aid in the [DIAGNOSES REDACTED]. RN 1 verified the finding. During a review of the facility's policy and procedure (P&P) titled, Single and Multiple Dose Vials, dated 9/18/12, the P&P indicated, .B. Multiple Dose Vials (MVD) 1. Once opened, the staff that opens the vial is responsible for labeling the vial correctly. Staff will initial the label. b. Staff will put the EXPIRATION date on the label.'
F 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy and procedure on laboratory tests to be ordered routinely for two of two sampled residents (Resident 3 and Resident 24). This failure had the potential to result in lack of monitoring and tracking of baseline laboratory results of residents'. Findings: 1. During a concurrent interview and record review on 3/12/20, at 11 AM, with Assistant Director of Nursing (ADON), Resident 3's physician's orders [REDACTED]. Resident 3's eMAR (electronic Medication Administration Record), dated 3/20, indicated, Resident 3 had a [DIAGNOSES REDACTED]. Resident 3's last Laboratory Result (LR) were dated 7/26/19. During an interview on 3/12/20, at 11:20 AM, with Director of Nursing (DON), DON stated, the Director of Pharmacy Services (DPS) is in charge of the laboratory tests. DON stated the DPS recommends what laboratory tests to be done and does the monitoring and tracking of all residents' laboratory tests and results. During an interview on 3/12/20, at 11:45 AM, with DPS, DPS stated, he reviews the medications of the residents each month and recommends what laboratory tests were to be done. DPS stated, there was no routine laboratory test recommended. DPS stated, if a resident refused laboratory tests, he would wait another three months to recommend the laboratory tests again. 2. During a review of Resident 24's Physician order [REDACTED]. Resident 24's eMAR, dated 3/20 was reviewed. The eMAR indicated, Resident 24 had a [DIAGNOSES REDACTED]. ADON stated the DPS orders the annual laboratory tests. ADON stated there is no specific routine laboratory testing order for Resident 24. During an interview on 3/12/20, at 11:20 AM, with Director of Nursing (DON), DON stated routine laboratory testing should be done quarterly. During a review of the facility's policy and procedure (P&P) titled, Medication/Laboratory Monitoring, dated 10/19, the P&P indicated, .D. Laboratory tests will be ordered routinely per prescribing information or upon initiation of new medications that require obtaining a base line level, or when there is a change in dose (i.e. change in strength and frequency).
F 0807 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.** Based on observation, interview and record review, the facility failed to follow physician's order on fluid consistency for one of one sampled resident (Resident 41). This failure had the potential to place Resident 41 at risk for choking and aspiration. Findings: During an observation on 3/11/20, at 8:30 AM, in Resident 41's room, Licensed Vocational Nurse (LVN) 3 was pouring water into a cup from a pitcher of water stored on top of the medication cart. LVN 3 offered the cup of water to Resident 41 to drink with his medications. On the bedside table a pitcher and sippy cup had black and red writing on the lid which indicated nectar thicken liquid. During a concurrent observation and interview on 3/11/20, at 8:35 AM, with LVN 3, LVN 3 stated, Resident 41 was on nectar thick liquid. LVN 3 verified the water she used from the water pitcher on the medication cart was not a nectar thick liquid and the resident should have received nectar thick liquid. During a review of Resident 41's Physician Orders (PO), dated 2/20/20, the PO indicated, Resident 41 was to receive nectar liquids. During a review of the facility's policy and procedure (P&P) titled, Thickened Liquids, dated 3/11/20, the P&P indicated, To ensure residents and patients receive appropriate thickened liquids per ordered diet.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and record review, the facility failed to store, prepare, and distribute food in a sanitary manner when: 1. Cook 1 touched prepared food and kitchen utensils without changing gloves and performing hand hygiene during tray line. 2. Cook 1, Dietary Technician (DT) 1, and Technician/Cook (TC) 1 had thick strands of hair hanging out of their hairnets while serving food onto residents' plates. 3. 25 dozens of eggs in the kitchen refrigerator were not pasteurized. 4. A large plastic container of opened and loose coco powder had no expiration date. These failures had the potential to result in residents acquiring foodborne illnesses. Findings: 1. During an observation on 3/10/20, at 12:21 PM, in the kitchen during tray line, Cook 1 was observed wearing gloves, she used her gloved hands to remove several plates from the plate warmer. Wearing the same gloves, she then picked up meatballs and placed them on a plate. Continuing to wear the same gloves, she picked up a scoop and used it to pour sauce over the meatballs and picked up a bread stick and placed it on a residents' plate. Cook 1 did not changed her gloves or washed her hands after touching multiple surfaces while serving food. During an interview on 3/10/20, at 12:26 PM, with Nutrition Manager/Registered Dietitian (NMRD), NMRD stated, Cook 1 should not be touching food and other kitchen equipment with the same gloved hands. She stated, She's not supposed to be doing that (using the same gloved hands to directly touch the meatballs then touch other surfaces). During a review of the facility's policy and procedure (P&P) titled, Glove Use, dated 12/14/17, the P&P indicated, .b. Single use gloves will be used for one task only such as serving ready to eat food or working with raw meat. f. Change gloves whenever you change an activity, the type of food being worked with, or whenever you leave the work station. 2. During an observation on 3/10/20, at 12:38 PM, in the kitchen during tray line, Cook 1's hair was coming out of her hairnet on both sides of face while preparing plates for residents. DT 1 was observed with thick long strands of hairs sticking out from back of the neck area. TC 1 was observed with thick strands of hair sticking outside her hairnet. During an interview on 3/10/20, at 12:39 PM, with NMRD, NMRD verified the findings and stated, the hairnet should cover all the hair. During a review of the facility's policy and procedure (P&P) titled, Dress Code, dated 7/08, the P&P indicated, Nutrition Services: Cook and Technician: Hairnets will be worn in the food production areas of the kitchen. 3. During an observation on 3/9/20, at 11:39 AM, in the kitchen refrigerator, there were two large boxes with 25 dozens of unpasteurized eggs. During an interview on 3/9/20, at 11:44 AM, with NMRD, NMRD verified the findings and stated, the eggs were not pasteurized. During a resident group meeting on 3/10/20, at 9:30 AM, Resident 15 stated, she sometimes asks for a sunny side up eggs for breakfast. During a review of facility's policy and procedure (P&P) titled, Egg Preparation, dated 12/14/17, the P&P indicated, Pasteurized eggs must be used for residents requesting soft cooked, over easy, and soft poached eggs. Fried Egg 1. Pasteurized in-shell eggs should be used. 4. During an observation on 3/9/20, at 11:20 AM, in the kitchen, a large container of loose coco powder had no expiration date label. During an interview on 3/9/20, at 11:21 AM, with NMRD, NMRD verified the finding and stated, there should be an expiration date label. During a review of the facility's policy and procedure (P&P) titled, Food Storage, Labeling & Dating, (undated), the P&P indicated, It is the policy of Nutrition Services to wrap, cover, label, date, and cover all foods in a safe, appropriate manner.On each package, either write the expiration date, when the item was received or when it was stored after preparation.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure effective infection control practices were utilized when: 1. Housekeeping Technician (HT) was not aware of the use of disinfectant solution. 2. An assistive sippy cup was not cleaned and sanitized after each use. These failure had the potential to result in the spread of infectious diseases to residents, staff and visitors. Findings: During a concurrent observation and interview with HT, on 3/10/20, at 10:04 AM, at HT's housekeeping cart in Hallway one, HT stated, she was the only housekeeper on the unit today. HT stated, she used Micro-Kill (disinfectant) spray to clean in the residents rooms. HT was unable to identify the kill time or contact time (amount of time disinfecting products need to stay wet on the surface to kill all bacteria [MEDICAL CONDITION]). HT stated, I do not understand the kill time or contact time of the products. During an interview on 3/10/20, at 10:30 AM, with Housekeeping Supervisor (HS) and HT, HS stated, the kill time for Micro-Kill was three minutes. HS

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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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) verified HT 1 was unable to state the kill time for the disinfectant and did not understand the process of the disinfectant. During a review of the facility's Safety Data Sheet for Micro-Kill (SDSMK), (undated), the SDSMK indicated, Overall Kill time: 3 minutes. 2. During an observation on 3/11/20, at 8:30 AM, in Resident 41's room, on the bedside table a sippy cup was noted to have a hand written date of 1/29 in ink on the lid. During an interview on 3/11/20, at 9:26 AM, with Licensed Vocational Nurse (LVN) 3, LVN 3 stated, Resident 41's sippy cups get changed once a month. She stated the cup is taken into the rest room and rinsed out. The cup is not cleaned using any type of soap. During an interview on 3/11/20, at 9:30 AM, with Registered Nurse (RN) 2, RN 2 stated, she was not sure when the sippy cup for Resident 41 gets changed, she stated when she cleans the table she uses a sani wipe (disposable disinfecting wipe) to wipe down the outside of the cup. During a review of the facility's policy and procedure (P&P) untitled (under page 45), dated 2017, the P&P indicated, .X. Assistive Eating Devices.4. Assistive eating devices must be returned to the kitchen after each meal to be washed and sanitized.