STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165033	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Davenport	815 East Locust Street Davenport, IA 52803

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 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** 25855 Based on observation, record review, resident and staff interview, the facility failed to obtain a physician order to obtain Lorazepam from the facility's Med Bank for one of six residents reviewed, (Resident #30). The facility reported a census of 70 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #30 with a BIMS (Brief Interview for Mental Status) score of 15, intact cognitive status and had the following diagnoses: Atrial Fibrillation (an abnormal heart rhythm), Peripheral Vascular Disease, Anxiety Disorder and Chronic Obstructive Pulmonary Disease. The MDS also identified Resident #30 required only set up or clean up assistance with most activities of daily living. In an interview on 5/20/24 at 11:08 AM, Resident #30 reported he had trouble getting his Lorazepam. When he had trouble breathing, he got anxious. When he no longer received hospice services, the nurses told him he could not get the Lorazepam until he saw the doctor tomorrow. He reported he was afraid to sleep as he was afraid he would stop breathing. On 2/12/24, the Care Plan identified Resident #30 with the problem of using Psychoactive medications related to adjustment disorder with anxiety and depression and directed staff to: a. Administer the medications as ordered. b. Monitor for adverse or allergic reaction; Call the Physician for any changes in condition. c. Monitor for any ill effects related to medication. A review of the May 2024 Medication Administration Records (MARs) revealed the following: 5/4/24 Ativan (Lorazepam) Oral Tablet 0.5 milligrams (mg) Give one tablet by mouth one time only for anxiety for one day and no documentation to show the dose had been given. A review of the Progress Notes revealed the following: (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/18/24 at 8:59 AM The Med Aide reported the resident is having a panic attack and insists on being given a PRN (give as needed) Lorazepam at this time. The Night Nurse reported speaking with pharmacist who told her to take two 0.5 mg Lorazepam tablets from the med bank (to equal 1 mg). The Nurse was not able to pull the medication from med bank. The Nurse called pharmacy representative and left a voicemail with request for return call to obtain medication necessary. On 5/19/24 at 3:04 AM Call placed to Hospice to request Ativan (Lorazepam) prescription, stated they would work on getting one sent as soon as possible. On 5/19/2024 at 4:16 AM Call received from hospice stated will work on resident Ativan. On 5/19/2024 at 8:49 PM The resident requested Lorazepam and none in facility. Nurse spoke on phone with pharmacy and there was no quantity remaining on script. Unable to send and unable to pull from med bank. The Nurse spoke on phone with the facility Nurse Practitioner to request a prescription, she reported she would not write a script for Lorazepam since Resident #30 was now off hospice and stated the primary care physician needed to see Resident #30 and review his medications. On 5/20/24 at 1:54 PM Call placed to Resident #30's primary care physician to request an order for Ativan to be sent to the pharmacy. She was under the impression that he was still under Hospice Care. She would send in the prescription. An observation on 5/21/24 which began at 7:50 AM revealed Resident #30 turned on his call light. Staff G, RN and Staff J, CMA stood outside Resident #30's room discussed that Resident #30 was asking for Lorazepam which Staff J stated he no longer had in the medication drawer. At 7:53 AM, the Social Worker entered room and Resident #30 asked for his Lorazepam. Staff J, CMA stated it had to be re-ordered by the doctor and they did not have any. The Social Worker informed Resident #30 that they needed to talk to the doctor about the Lorazepam since he is no longer on hospice. Resident #30 appeared to be very upset about it. At 8:02 AM, Staff G, RN walked into Resident #30's room. Resident #30 asked for his Lorazepam and a box of tissue. Resident #30 stated, that's 4 times now. At 8:04 AM Staff G gave Resident #30 a box of tissue and said, here's this, I'm working on the rest At 8:06 AM Staff G asked Staff J if Resident #30 had a med card for Lorazepam because he checked the MAR and he still has an order for it and he said he would get it from the med bank. At 8:25 AM Resident #30 stated he was very upset that its been 6 days since he's been able to get his Lorazepam. When surveyor asked Staff J, CMA if he could have Benadryl, she said he doesn't have an order for it and that Staff G was still working on getting the Lorazepam. At 12:39 PM Resident #30 reported he still had not received his Lorazepam A review of the May 2024 MARS revealed Lorazepam 1 mg orally had been given on 5/21/24 at 12:51 PM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/23/24 at 10:15 AM, the Director of Nursing (DON) reported the following: Resident #30 was discharged from hospice services on 5/17/24 and the facility Nurse had notified the Nurse Practitioner (NP) of the concern that he needed a refill for the Lorazepam. The NP reported Resident #30's Primary Care Physician would need to write the order. The facility Nurse contacted the Primary Care Physician and received a one time order initially and later another order to re-instate the PRN order for Lorazepam. The DON also reported he would have expected the Nurse to check the order to make sure it was an active order. The nurse should have been able to pull it from our med bank as that is a medication that the facility had available. Resident #30's specific dose was not in the facility Med Bank. The Nurse can only pull what the prescription is for. The facility's available stock was for 0.5 mg and his order was for 1 mg. The nurse should have contacted the provider for an order for that specific dose in order to pull it from the Med Bank. A review of the Facility Policy titled: Medication Administration dated as last reviewed May 2023 did not address the process of obtaining medication from the Med Bank if the resident did not have the medication ordered.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, record review, resident and staff interview, the facility failed to follow the care plan and transfer the resident with the use of the stand lift for one of one resident reviewed, (Resident #55). The facility reported a census of 70 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] identified Resident #55 as cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15 and had the following diagnoses: Diabetes Mellitus, Multiple Sclerosis and Depression. The MDS also identified Resident #55 was totally dependent on staff for all transfers. On 3/21/24, the Care Plan identified Resident #55 required assistance with ADL's (Activities of Daily Living) related to immobility, Multiple Sclerosis with impaired range of motion and directed staff to transfer with the stand lift. A review of the Progress Notes dated 3/29/24 at 3:32 PM had documentation of the following: Was informed by staff that resident had fallen and was on the floor. Upon entering the resident room, resident was laying on her back with a pillow under her head. Resident #55 had a red mark on her left cheek which she said a fist sized crystal rock had fallen off her bedside table and hit her in the face during the fall when she fell into the bedside table and knocked it over. Resident #55 was lifted off the floor with a hoyer and assist of 3. Resident #55 refused to have an x-ray done and denied pain at the time. In an interview and observation on 5/20/24 at 11:45 AM, Resident #55 reported Staff F, CNA had transferred her from the bed to the wheelchair without anyone helping her, did not use a lift or use a gait belt. Staff F grabbed Resident #55's arm and they locked arms. Resident #55 stood up and Staff F tried to transfer Resident #55 to the wheelchair which she did not lock. Resident #55 reported she fell on her knees and hit her head on the front side on the bottom of the tray table. The care plan was not updated with any new interventions after the fall on 3/29/24. In an interview on 5/21/24 at 4:54 PM, the Administrator reported the following regarding the facility's investigation of Resident #55's fall on 3/29/24: On 3/29/24 at 2:47 PM, Staff F, CNA transferred Resident #55 without any staff assistance into a wheelchair. Resident #55 started to slide onto floor and aid lowered her to the floor at that time. Resident #55 fell to her left side from a kneeling position into her bedside table which caused a rock from on top of the bedside table to fall and hit her on her right cheek. Staff G, RN assessed Resident #55 who denied the need for any treatment or x-ray. The assessment and vitals were normal. Resident #55 was care planned to transfer with assist of two using Sara lift. Staff F did not correctly transfer Resident #55 and was educated on following correct transfer protocol. The Physician was notified of fall and intervention and no new orders were received. The family were notified of fall and plan, verbalized understanding and agreement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/22/24 at 3:48 AM, Staff B, CNA reported before the fall on 3/29/24, Resident #55 was care planned to be transferred with the assist of two using the Hoyer lift. In an interview on 5/22/24 at 3:56 AM, Staff C, LPN reported Resident #55 was care planned to be transferred with the assist of two using either a stand lift or Hoyer lift. In an interview on 5/22/24 at 4:36 AM, Staff D, LPN reported before the fall on 3/29/24, Resident #55 was care planned to be transferred with the assist of one using a gait belt and now should be transferred with the assist of one using the stand lift. In an interview on 5/22/24 at 5:00 AM, Staff E, CNA reported before the fall on 3/29/24, Resident #55 was care planned to be transferred with the assist of one using a gait belt and now should be assist of one using the stand lift. In an interview on 5/22/24 at 11:02 AM, Staff F, CNA reported the following: a. When Resident #55 fell in March 2024, it happened because she could not get help in time. She did not have another staff member on the floor, there wasn't a gait belt in the room, and she did not have a gait belt on her. b. The other CNA that was supposed to be there, left before 2nd shift staff came. This happened a couple times a week. c. Every staff person should have their own gait, but that day she left her gait belt at home. d. That day she helped Resident #55 sit up at the edge of the bed. She assisted her to stand to move to the wheelchair, but her left leg wouldn't turn, she said she was going to fall, she lowered her down to the floor. Resident #55 fell on her knees when she left the room to get help. When she came back, Resident #55 was laying on her side and her face hit the bottom of the tray table. In an interview 5/22/24 at 11:18 AM, Staff G, RN reported the following: a. When Resident #55 fell in March 2024, one of the CNA's told him Resident #55 fell . He could not recall the name of the CNA. When he arrived to the room, he saw a Sara lift (sit to stand lift) in the room and the aide had tried to transfer Resident #55 by herself. b. Resident #55 was laying on her back by the bed, on the side of the bed. He did not see any bleeding. When she fell , she said she had a large crystal which fell off her bedside table and hit her on the left side of her cheek. The distance from the table to her face would be 1.5 to 2 feet. c. There should have been 2 CNA's helping with the transfer with the Sara lift. The CNA should have pulled the call light for help. d. He was not sure how Resident #55 had been care planned to be transferred, but thought she was supposed to be (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transferred using the [NAME] (stand lift). In an interview on 5/23/24 at 9:25 AM, the Director of Nursing reported the following: a. When Resident #55 fell on [DATE], she was being transferred and staff lowered her to the floor. There was one CNA in the room with the resident. The Incident Report did not specify that she put a gait belt on the resident. b. When he did the investigation, therapy had already been working with her on transfers. c. Before the fall, Resident #55 was care planned to have two staff transfer her using a Sara lift. d. Based on the documentation, Staff F, CNA did not use a Sara lift or a gait belt, it is not documented. When she fell , Resident #55 fell on to the bedside table which the salt lamp fell off the table (about the size of a fist) and dropped possibly 2 to 3 feet before it hit her right cheek. There was no bleeding. She did report pain to her face. e. The nurse came in to assess her and denied the need for x-rays to her face. She was able to move all extremities. She was alert and oriented per baseline. Vital signs were within normal limits. f. The staff used a hoyer lift to assist her back to bed. g. He would expect an intervention to be added to the care plan after a fall within 24 hours. h. The fall could have been prevented if the staff would have checked the Kardex first on the electronic record. The aide should have had another staff member in the room with her and should have had a lift with her. i. Staff F thought that Resident #55 was a pivot transfer.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49976 Based on observation, record review, policy review, and staff interview the facility failed to date feeding tube equipment, flush for patency with the correct water amount, and confirm correct settings on a feeding tube pump in order to follow physician orders for 1 of 1 resident reviewed, (Resident #4). The facility reported a census of 70 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #4 identified the resident had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating no cognitive impairment. The MDS reported diagnoses including: sarcoidosis of the lung (lung cancer), paraplegia (inability to voluntarily move lower parts of the body), and pneumonia. The Care Plan updated 2/2/24 documented the resident's risk for altered nutritional status related to his inability to eat or drink by mouth, and a PEG tube (feeding tube directly into the stomach) due to dysphagia (difficulty swallowing). It instructed staff to provide nutrition through the PEG tube. The Physician Order dated 3/7/24 instructed staff to flush the G-tube with 60 mL of water every shift for G-tube care. The order dated 4/27/24 instructed staff to administer Pivot 1.5 feeding solution at 50 mL per hour continuously until 1200 mL is reached per day; water flush at 40 mL per hour until 960 mL is reached. Staff may turn the pump off during cares and as needed. During an observation on 5/22/24 at 2:32 PM Staff H, Licensed Practical Nurse (LPN) donned a gown, performed hand hygiene, and applied gloves. Staff I, LPN brought in a covered tray with a Pivot 1.5 feeding solution bottle, a flush syringe, a new water flush bag, and a graduated cylinder. Staff I donned a gown, completed hand hygiene, and put on gloves. Staff H listened to the resident's abdomen with a stethoscope and assessed the site dressing. She then unhooked the feeding tube and placed it on a clean towel on the resident's abdomen. She used the syringe to check for residual fluid and got less than 5 mL out. She discarded it into the graduated cylinder. The Director of Nursing (DON) conducted hand hygiene, dated the cylinder, rinsed it, and filled it with water for flushing. Staff H used 40 mL to flush the feeding tube and check for patency. She then dated the feeding bottle. Hand hygiene was performed and gloves changed. Staff H opened the bottle and hooked it to new tubing. Staff I filled the cylinder with water and filled the new bag for the water flush. Staff H then hung the feeding solution and water bag. Staff failed to date the water bag and tubing. Staff H and I struggled to connect the tubing for the pump and did not ask for assistance. The DON intervened and connected the tubing to the pump. Staff H primed the water into the garbage after entering the settings into the pump. She could not get the feeding solution to prime down the tube and did not ask for assistance. The DON donned gown and gloves and intervened. Staff H then connected the tube to the resident and started the pump. Both Staff H and I removed gowns and gloves and left the room. Staff H failed to check the settings on the pump prior to exiting. The settings read: feeding 50 mL per 1 hour, flush 0mL per 0 hrs. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/24 at 3:07 PM Staff H explained the feeding is usually changed on third shift. This was her first time doing this. She does the morning flush and medications but never had to hook up a new feeding. She expressed she did not know how to connect the tubing to the pump correctly and didn't want to ask for help. She explained she put the 40 mL flush setting in and hit run but it kept saying hold. She thought the 50 mL feeding and 40 mL flush were set when she walked out. During an interview on 5/22/24 at 1:46 PM the DON explained he would have expected staff to contact someone for assistance when staff were struggling in this situation. There is a manager on-call in the evenings. He noted once set up is complete staff need to make sure the pump is set to the correct settings before exiting the room. He expressed he knew Staff H said she checked it so he was not sure what went wrong. He noted he felt Staff H got caught up with the hourly flushing of 40 mL instead of using the 30 mL for the patency check. The facility policy titled Enteral Tubes: Intermittent/Continuous (Pump) Feedings dated 2/2024 instructed staff to: Verify physician's order for formula, rate, and frequency. Label syringe and plastic bag with patient name and date. Label container and tubing with resident name, date, formula, rate, and time feeding is initiated. Verify enteral tube placement and check residuals. Check for patency by flushing with 30ml of tap water. Hang closed system of prescribed formula on IV pole. Prepare per manufacturers guidelines.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34821 Based on clinical record review, staff interviews and facility policy review the facility pharmacy failed to deliver medications ordered to the facility in a timely fashion for 4 out of 4 residents reviewed, (Resident #22, #30, #47, and #70). The facility reported a census of 70 residents. Findings included: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #7 included diagnoses of stroke, and hypercholesterolemia. The Medication Administration Record (MAR) for Resident #47 dated 4/25/24, lacked documentation of administration for the medication, ticagrelor (help prevent blood clot). The MAR directed to see Nurses Notes. The Medication Administration Nurses Note for Resident #47 dated 4/25/2024 at 11:03 PM reflected ticagrelor 90 mg unavailable. 2. The MDS for Resident #70 dated 4/27/24 reflected his admitted as 4/27/24. The MDS dated [DATE], listed diagnoses of coronary artery disease (CAD), high blood pressure, Alzheimer's disease, and psychotic disorder and post traumatic stress disorder (PTSD). The MDS identified short and long term memory problems with severely impaired decision making. The MAR for Resident # 70 dated April 27, 2024 revealed see Nurses Note for five of the medications scheduled bedtime medication. The Progress Notes dated 4/27/24, reflected waiting on the pharmacy for the missed medication that included an antipsychotics, cholesterol medication, heart medication, eye drop, and an antidepressant. On 5/22/24 at 10:39 AM, Staff I, Registered Nurse (RN) reported one time a week something ordered won't come from the pharmacy. She said she called the pharmacy and they told her the medication, it's in the next delivery, and it won't show up. She stated that she called the pharmacy again and then they told her it's too soon to replace or that they needed the prescription. She stated the Director of Nursing (DON) knew medications not delivered from the pharmacy is a problem. On 5/23/24 at 7:42 AM, Staff H, Licensed Practical Nurse (LPN) confirmed at times the pharmacy failed to bring the medication the nurses ordered. She said the pharmacy told them they required a prescription, it may be too soon, or it's on the next trip. She reported if it failed to come the next time they get the Director of Nursing (DON) involved. 49976 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The MDS dated [DATE] for Resident #22 identified a BIMS score of 15/15 indicating no cognitive impairment. The MDS indicated diagnoses including: diabetes mellitus, seizure disorder, and malignant neoplasm of upper lobe, left bronchus or lung (lung cancer). The Admission Record indicated an admitted for Resident #22 on 3/29/24. The Care Plan updated 3/29/24 instructed staff to administer pain medication per the physician orders. The Physician Order dated 3/29/24 at 12:57 PM instructed the resident to receive Lyrica 75 mg capsule (antiseizure medication), 1 capsule by mouth two times per day for pain. The Progress Note dated 3/29/24 at 10:42 PM noted medications had not yet been delivered from the pharmacy. On 3/30/24 at 8:56 AM nursing reported Lyrica was on order from the pharmacy. At 5:28 PM the note indicated the medication was still on order from the pharmacy. On 3/31/24 the note indicated Lyrica was still unavailable and the pharmacy was notified. At 5:51 PM the note indicated the medication was still unavailable and pharmacy was notified. On 4/1/24 the note indicated Lyrica was not available from the pharmacy to administer. The Registered Nurse (RN) was made aware. At 8:16 PM the note indicated the medication was still unavailable. The RN and physician were notified. On 4/2/24 at 11:17 AM the note indicated Lyrica was still not available. The pharmacy was called and the medication was to be sent. The physician, resident, and family were notified. At 9:03 PM the physician and family were notified the medication was still not present. On 4/3/24 at 8:38 AM the physician was notified that Lyrica had not arrived at the facility. The Medication Administration Record (MAR) for March 2024 showed the resident did not receive scheduled Lyrica the evening of 3/29/24, the morning and evening of 3/30/24, or the morning and evening of 3/31/24 as it was unavailable. The MAR for April 2024 reported the resident did not receive his schedule Lyrica the morning and evening of 4/1/24, the morning and evening of 4/2/24, and the morning of 4/3/24 due to the medication being unavailable. This resulted in 10 missed doses of the pain medication spanning 6 days. 25855 4. The MDS dated [DATE] identified Resident #30 with a BIMS score of 15 and had the following diagnoses: Atrial Fibrillation (an abnormal heart rhythm), Peripheral Vascular Disease, Anxiety Disorder and Chronic Obstructive Pulmonary Disease (COPD). The MDS also identified Resident #30 required only set up or clean up assistance with most activities of daily living. On 2/12/24, the Care Plan identified Resident #30 with the problem of being at risk for ineffective breathing pattern related to COPD, Chronic Respiratory failure with hypoxia and episodes of shortness of breath. The Care Plan failed to direct staff to administer the inhalers as ordered by the physician. A report from the Veteran's Administration revealed Resident #30 did not receive his inhalers as ordered on 4/19/24 and on 4/20/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of April Medication Administration Records revealed an order written 2/12/24 for Tiotropium Bromide-Olodaterol Inhalation Aerosol Solution 2.5-2.5 Mcg - 2 puffs inhale orally one time a day for shortness of breath, COPD (Chronic Obstructive Pulmonary Disease). On 4/19/24 the dose had been marked as UV (unavailable) and on 4/20/24 it had been marked as H (held). A review of the Progress Notes dated 4/1/24 through 4/30/24 did not have documentation to explain why the above two doses were unavailable and held. In an observation and interview on 5/20/24 at 11:08 AM, Resident #30 sat up in bed with continuous oxygen maintained at 4 liters per nasal cannula running per concentrator. He reported when he has trouble breathing, he gets anxious. He was afraid to sleep because he was afraid he would stop breathing. On 5/23/24 at 8:00 AM, the DON confirmed knowledge related to some delivery difficulty related to the pharmacy. The facility provided a policy titled Medication Administration - Medication Pass dated 5/2023, listed the purpose: To safely and accurately prepare and administer medication according to physician order and patient needs. The facility provided a Pharmacy Order Guide undated that reflected new orders and refill orders received before 11 am will arrive with the 1st scheduled delivery. New orders received after 11 PM (M-F) and after 4:30 PM on Sat/Sun/Holidays) will arrive on the first scheduled delivery the following day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165033	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Davenport	815 East Locust Street Davenport, IA 52803

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 - Some	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** 25855 Based on observation, policy review and staff interview the facility failed to maintain a sanitary kitchen, ensure the disinfectant solution was within proper test range, label food appropriately for storage, wear hair restraints appropriately and dispose of expired food items. The facility identified a census of 70 residents. Findings include: 1. The initial tour of the kitchen on [DATE] at 10:10 AM revealed the following: a. The Vulcan stove backsplash and sides by griddle were 50% covered with black/brown residue, both handles to oven doors with sticky residue, doors on outside with scattered areas of brown and white residue. b. The floor to all areas of kitchen with debris. c. The Hoshizaki ice machine with dispenser. Housing units with white debris noted along seams. d. The [NAME] dishwasher with debris noted along seams of outer doors. e. At 10:18 AM, the Dietary Director filled a bucket with water and sanitizer and put test strip in it and it read zero. The Dietary Director had run chemical directly from a dispenser, he placed another strip in to the solution and again the reading was 0. The Dietary Director reported these were new strips that start out as yellow and should turn a light green and should test from 200 to 400 ppm (parts per million). He emptied the bucket and refilled with water running from the Sunburst Sanitizer dispenser. He obtained another package of test strips which had not been opened before and submerged x 10 seconds and no color change noted on strip. He placed another strip into bucket and no change in color noted again. He reported there might be an issue with the strips and he will contact Sunburst to troubleshoot. 2. On [DATE] at 7:29 AM an observation on the 2 [NAME] kitchenette revealed the following: a. The Hoshizaki ice machine with white residue to right side of dispensing tray, splatters of red residue to housing unit under dispensing spout. b. The Frigidaire refrigerator did not have thermometer inside. It contained one ,d+[DATE] gallon of white skim milk outdated [DATE] and another ,d+[DATE] gallon jug of white skim milk outdated [DATE]. It also contained one uncovered plastic container with cake without a date. On [DATE] starting at 6:17 AM, the following observations revealed: a. Staff K, cook, ran test strip in a bucket of sanitizer which tested at 1000 ppm. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. The top of the stove with side and backsplash portions remain 50% covered with black/grown residue around the griddle. The floor to the kitchen still with scattered white particles. c. Staff K had a long braid down to middle of her back which had not been properly covered by the hair restraint. d. The housing unit to the Hoshizaki ice machine not cleaned from yesterday. The [NAME] dishwasher remains with crusty gray residue to bottom of the doors. e. The Vulcan oven with red panel on right side with brown residue noted to outer panels, Accutemp steamer with white residue streaks underneath the door. f. At 7:37 AM, during the breakfast meal service, Staff K donned new pair of gloves then began plating food again when her braid fell out of the hair restraint. g. At 7:52 AM, Staff K's braid fell out of the hair net again. She began plating more meals for residents in the dining room. Then went to the dried food storage room to remove her hairnet and pull up her braid and into hairnet. In an interview on [DATE] at 10:14 AM, the Dietary Director reported the following: a. Equipment such as the stove top, ice machine and ovens should be cleaned at least once a week. b. There is a deep cleaning schedule which happens once a month and as needed. c. There is a cleaning chart which is posted, however, it is not signed off on the schedules to show it had been done. d. All staff in the kitchen should have their hair completely covered by a hair net when in the kitchen. e. When asked who had the responsibility to check the kitchenette refrigerators for outdates, he reported he was not sure. He has had problems with items that are not labeled with dates or what the item is. f. There was no clear designation as to who had the responsibility to check the refrigerators A review of the facility policy titled: Sanitizing and Disinfectant Solutions dated 2020 had documentation of the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. If a dispensing system is used, appropriate concentration level will be tested at least daily. b. Sanitizing solutions are changed in accordance with manufacturer instructions or when they become visibly soiled. In general each shift should prepare fresh solutions. A test paper/strip should be used to verify the concentration. A review of the facility policy titled: Kitchen Sanitation dated as last reviewed [DATE] had documentation of the following: Purpose: To maintain the sanitation of the Food and Nutrition Services Department through compliance with written cleaning schedules developed by the Director of Food and Nutrition Services or other clinically qualified nutrition professional. Procedure: a. The Director of Food and Nutrition Services or other qualified nutrition professional shall record cleaning and sanitation tasks for the Food and Nutrition Services Department. b. A cleaning schedule shall be posted with tasks designated to specific positions in the department. c. Tasks shall be addressed as to frequency of cleaning. d. The Director of Food and Nutrition Services or other clinically qualified nutrition professional should check off assignments completed by using the employees initials to validate the task is completed.