

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/10/2008
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045181 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/27/2008 |
| NAME OF PROVIDER OR SUPPLIER PRESCOTT MANOR NURSING CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 700 MANOR DRIVE PRESCOTT, AR 71857 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 164 SS=D | <p>483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure privacy was maintained during care for 1 (Resident #6) of 6 (Residents #2, #4, #6, #8, #9 and #13) case mix residents who were dependent on staff for incontinent care. This failed practice had the potential to affect 24</p> | F 164 | | |

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 164 | Continued From page 1 residents who were dependent on staff for incontinent care, according to the Director of Nursing (DON) on 3/27/08 at 8:55 a.m. The findings are: Resident #6 had diagnoses of Schizophrenia, Agitation, Depression and Psychosis. The Quarterly Minimum Data Set dated 2/1/08 documented the resident was severely impaired in cognitive skills for daily decision making and required total assistance for activities of daily living. a. On 3/24/08 at 2:18 p.m., the surveyor knocked on the resident's room door. Certified Nurse Assistant (CNA) #1 and CNA #2 were in the room with the door closed and stated "Come in." The surveyor opened the door and the resident was lying on the bed on the left side; the CNA's were performing care. The resident was bare from the shoulders to the toes. b. The "Resident Bill of Rights" provided by the facility documented: "The resident is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in case of his personal needs." c. The facility policy on "Peri Care" documented: "Steps in the Procedure: 3. Provide privacy (close door, pull privacy curtains, close blinds, bring into bathroom when necessary and close door)." | F 164 | | | |
| F 221 SS=D | 483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. | F 221 | | | |

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| F 221 | Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a pre-restraining assessment for medical justification was completed prior to the application of a pelvic restraint, to use alternative measures prior to restraint use and to obtain a consent for a pelvic restraint for 1 (Resident #10) of 2 (Resident #2 and #10) case mix residents who had physician orders for physical restraints. This failed practice had the potential to affect 8 residents in the facility who had orders for physical restraints, as documented on the Resident Census and Conditions of Residents form dated 3/25/08. The findings are: 1. Resident #10 had diagnoses of Dehydration, Malnutrition, Severe Rheumatoid Arthritis and Dysphagia. An Admission Minimum Data Set (MDS) dated 3/24/08 documented the resident had moderately impaired cognitive skills for daily decision-making, required limited physical assistance of one person for transfers and ambulation and had no restraints. a. The Physician order dated 3/17/08 documented, "May use Pelvic Restraint." b. The Overall Plan of Care dated 3/24/08 documented, "Problem; Injury, potential for due to unsteady gait. Approaches; ...2. Use restraints if ordered..." c. On 3/26/08 at 1:40 p.m. and 3:30 p.m., the resident was in her recliner with a pelvic restraint on. When asked if she knew why the restraint was on she stated, "I'm not sure, I think they are | F 221 | | | |

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| F 221 | Continued From page 3 trying to keep me from walking, I have fallen." d. On 3/26/08, during review of the clinical record, no documentation was found of an assessment made prior to the use of the restraint, a consent and use of alternative measures prior to restraint use. e. On 3/26/08 at 3:35 p.m., the Director of Nursing (DON) stated, "No, I did not get a consent and I did not do a pre-restraint assessment, I guess I forgot. She tried to walk and fell two nights in a row." We tried ativan but it did not work." f. The Policy and Procedure on Restraints, Use and Reduction documented, "Purpose; Restraints may be used to prevent injury to resident related to falls, behavior, and medical symptoms that require restraints at the lowest level possible. Procedure; Documentation of assessment should reflect the following based on resident condition, ...History of Falls, ...Medical Symptoms that require use of restraint, ...Least Restrictive restraint. Pre Restraining assessment will be completed prior to application." | F 221 | | |
| F 314 SS=D | 483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. | F 314 | | |

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| F 314 | <p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure a pressure relief device was utilized as ordered by the Physician for 1 (Resident #4) of 6 (Residents #1, #2, #4, #6, #8 and #13) case mix residents with pressure relief devices. This failed practice had the potential to affect 5 residents with pressure ulcers and 16 residents who received preventive skin care, according to the Resident Census and Conditions of Residents form dated 3/25/08. The findings are:</p> <p>Resident #4 had diagnoses of Cerebral Artery Occlusion, Skin Disorders, Vitamin Deficiency and Osteoporosis. The Minimum Data Set dated 1/10/08 documented the resident was severely impaired in cognitive skills for daily decision making and had limitation in range of motion with full loss of voluntary movement in a leg and a foot.</p> <p>a. The Physician order dated 9/28/07 documented, "Continue Pressure Relief with (Prato Boot) to L (left) heel."</p> <p>b. The Plan of Care dated 1/10/08 documented, "Problem #13 Continue to be at risk for additional pressure sores related to decline physical health and decreased mobility."</p> <p>c. On 3/25/08 at 8:10 a.m., the resident did not have a boot on her left foot.</p> <p>d. On 3/25/08 at 9:10 a.m., after Certified Nurse Assistant (CNA) #4 and CNA #5 completed care, they did not put a heel protector or a boot on the resident.</p> | F 314 | | | |

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| F 314 | Continued From page 5 | F 314 | | |
| F 322 SS=E | <p>e. On 3/26/08 at 2:45 p.m., Licensed Practical Nurse (LPN) #1 could not find the Prato boot in the resident's room and stated that the boot must be in the laundry to be cleaned.</p> <p>483.25(g)(2) NASO-GASTRIC TUBES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure placement was checked prior to starting a tube feeding for 1 (Resident #4) and a tube feeding was not discontinued or restarted by non-licensed nursing staff to decrease the potential for aspiration for 1 (Resident #9) of 3 (Resident #4, #8 and #9) case mix residents with feeding tubes. This failed practice had the potential to affect 10 residents in the facility with a feeding tube, according to the Resident Census and Conditions of Residents form dated 3/25/08. The findings are:</p> <p>1. Resident #4 had diagnoses of Cerebral Artery Occlusion and Dysphagia. The Minimum Data Set (MDS) dated 1/10/08 documented the resident was severely impaired in cognitive skills for daily decision making and received 100 % of total calories and fluids via a feeding tube.</p> | F 322 | | |

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| F 322 | <p>Continued From page 6</p> <p>a. On 3/25/08 at 9:10 a.m., Licensed Practical Nurse (LPN) #1 disconnected the resident's feeding tube. The LPN did not flush the resident's tube after disconnecting it. While the resident's feeding tube was disconnected, Certified Nursing Assistant (CNA) #4 and CNA #5 provided a partial bed bath, performed incontinent care, changed the resident's gown and changed the resident's bed linens.</p> <p>b. On 3/25/08 at 10:00 a.m., LPN #1 reconnected the resident's feeding tube, but did not check placement or flush the gastrostomy tube prior to reconnecting the feeding.</p> <p>2. Resident #9 had a diagnosis of Down's Syndrome. The MDS dated 2/26/08 documented the resident was severely impaired in cognitive skills for daily decision making and received 100 % of total calories and fluids via a feeding tube.</p> <p>a. The Plan of Care dated 2/26/08 documented, "Alteration in nutrition: Gastrostomy tube... 1. Nurse's to monitor and supervise feedings and site care..."</p> <p>b. On 3/26/08 at 8:40 a.m., CNA #2 turned the resident's feeding pump off and laid the head of the bed flat. During care, the tubing for the feeding came unthreaded from the pump. Upon completion of care, the CNA raised the head of the bed and turned the feeding pump back on. After a couple of minutes the feeding pump began to beep. It showed 'no flow' on the display. The CNA looked at the pump and retreaded the tubing through the pump. She then restarted the feeding.</p> <p>c. On 3/27/08 at 9:20 a.m., the Director of Nurses</p> | F 322 | | | |

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| F 322 | Continued From page 7 stated that the CNAs had not been trained on how to operate the feeding pumps and that they were not supposed to touch them. | F 322 | | | |
| F 323 SS=E | 483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a transfer was not performed using the axillae and was conducted using a lift to decrease the potential for injury for 1 (Resident #6) of 6 (Residents #1, #2, #4, #6, #9, and #13) case mix residents who were dependent on staff for transfers, physical restraints were applied according to manufacturer's instructions for 1 (Resident #2), doors were free of sharp edges, showers were free of sharp edges and multiple plug outlets were not in use. These failed practices had the potential to affect 27 residents who were non weight bearing and dependent on staff for transfers, 25 independently mobile residents and 8 physically restrained residents, as identified by Director of Nurses on 3/27/08. The findings are: 1. Resident #6 had diagnoses of Schizophrenia, Agitation, Psychosis, Depression and Degenerative Joint Disease. The Quarterly Minimum Data Set (MDS) dated 2/1/08 documented the resident was severely impaired | F 323 | | | |

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| F 323 | <p>Continued From page 8</p> <p>in cognitive skills for daily decision making and had total dependence on staff for transfers.</p> <p>a. The resident's plan of care dated 2/1/08 documented, "Problem: 6. At risk for falls r/t (related to) immobility, impaired physically. Approaches: 4. Transfer resident to Geri-Chair via Hoyer lift X's (times) 2 CNA's (Certified Nurses Assistants)."</p> <p>b. On 3/25/08 at 9:23 a.m., CNA #2 and CNA #3 transferred the resident from a Geri-chair to the bed. Both CNAs put their arms under the residents's armpit area, explained to the resident what they were doing, and lifted the resident under the armpits. The resident's feet were dragging the floor during the move from the chair to the bed. The effect of the resident's weight being supported by the axillae was visible on the shoulders, with the shoulders moving upward during the transfer.</p> <p>c. The facility policy on "Transfer Activities" documented, "Note: ... Do not support the resident under the arms..."</p> <p>2. On 3/25/08 at 2:45 p.m., during the environmental tour, the following hazards were identified:</p> <p>a. Resident Room #104 had the plastic cover on the bottom of the door torn on the hinged side of the door, approximately 18-inches up from the floor, exposing sharp edges on the plastic.</p> <p>b. Resident Room #213 had the plastic cover on the bottom of the door torn on the hinged side of the door, approximately 18-inches up from the floor, exposing sharp edges on the plastic.</p> | F 323 | | |

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| F 323 | Continued From page 9 c. Hall-1 shower room had an area, approximately one-foot in length and four-inches in width, along the back wall where the tiles were missing, exposing the sharp edges of the cement and grout. 3. On 3/25/08 at 11:42 a.m., Resident Room #107 had a 6 outlet multi-plug located between bed-A and bed-B, above the call light outlet. The items plugged into the multi-plug outlet included the resident's feeding tube pump, air flow mattress and bed. 4. Resident #2 had diagnoses of Dementia with Huntington's and Alzheimer's with Agitation. The MDS dated 2/6/08 documented the resident had modified independence in cognitive skills for daily decision making, required extensive assistance with transfers and ambulation and had a trunk restraint daily. a. The manufacturer's instructions for the Pelvic Holder documented, "...2. Position Pelvic Holder between patient's legs placing the loops at the patient's waist. 3. Thread the left rear strap through the left front loop. Thread the right rear strap through the right front loop. 4. Pull both straps completely through the loops so that the device fits snugly. Note: Straps should not be so tight as to interfere with patient's breathing. You should be able to slide your open hand between the device and the patient. 5. Wrap the right strap once around the right metal bar behind the armrest pad. Repeat on left side. 6. Bring both straps behind the wheelchair and tie them together in a bow. b. On 3/24/08 at 11:33 a.m. and at 2:20 p.m., the | F 323 | | | |

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| F 323 | Continued From page 10 pelvic restraint was applied with the straps beneath the resident's breasts and straight back, to go behind the backrest of the wheelchair. | F 323 | | |
| F 333 SS=E | 483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure residents were free of significant medication errors. Physician orders were not followed for 1 (Resident #6) of 2 (Residents #6 and #9) case mix residents who received lorazepam, which resulted in a significant medication error. This failed practice had the potential to affect 11 residents who received lorazepam (Ativan), as identified by the Director of Nurses on 3/27/08. The findings are: Resident #6 had diagnoses of Schizophrenia, Psychosis, Behavioral Problems and Agitation. The Quarterly Minimum Data Set dated 2/1/08 documented the resident was severely impaired in cognitive skills for daily decision making and required antipsychotic medications 7 of 7 days. a. The "Consultant Pharmacist Monthly Report January 21st, 2008" documented, Response: "Reduce Ativan to 0.5 mg PO (by mouth) Q (every) AM and PM." The physician marked the response and added, "at change out," signed and returned it to the facility dated 1/22/08. b. The resident's plan of care revised on 2/1/08 documented, "Problem: Potential for adverse | F 333 | | |

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| F 333 | <p>Continued From page 11</p> <p>effects from psychotropic medications. Approaches: 5. Medication as ordered. 6. Consult with Physician and Pharmacist to analyze and adjust drug regime."</p> <p>c. The resident's Medication Administration Record dated January and February 2008 documented the following physician orders, "Ativan 0.5 mg 1 tab PO @ (at) HS (bedtime)... Ativan 1 mg (milligram) tablet; 1 tab PO Q AM for anxiety." Everyday, from 1/1/08 through 2/29/08 the lorazepam (ativan) was signed off as given each day at 8:00 a.m. and 8:00 p.m.</p> <p>The resident's March 2008 Medication Administration Record documented the physician orders, "Ativan 0.5 mg 1 tab PO @ HS... Ativan 1 mg (milligram) tablet; 1 tab PO Q AM for anxiety." Everyday, from 3/1/08 through 3/26/08 at 8:00 a.m., the lorazepam (ativan) was signed off as given, for a total of 51 doses.</p> <p>d. The card of lorazepam on the medication cart on 3/26/08 documented, "Lorazepam (v) 1 mg tablet 60 ea (each); Generic for: Ativan; 1 tablet by mouth every morning for anxiety and 1 tablet every 6 hours as needed." There were 9 tablets remaining in the card.</p> <p>e. On 3/27/08 at 9:00 a.m., the Director of Nurses stated the medication reduction forms come back to the facility and are given to her or the MDS Coordinator and they are the ones who see that those forms get to the resident's chart and the nurse. When asked what happened with the Ativan reduction form, she stated, "We just didn't follow up on it."</p> <p>f. This was a significant medication error due to</p> | F 333 | | |

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PRINTED: 04/10/2008
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045181 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 03/27/2008 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER PRESCOTT MANOR NURSING CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 700 MANOR DRIVE PRESCOTT, AR 71857 | | |
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| F 333 | Continued From page 12 | F 333 | | | |
| F 363 SS=E | <p>the frequency of the error.</p> <p>483.35(c) MENUS AND NUTRITIONAL ADEQUACY</p> <p>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure their written menus for mechanical soft diets and pureed diets were followed. This failed practice had the potential to affect 14 residents on a mechanical soft diet and 9 residents on a pureed diet, as identified on the diet list dated 3/24/08. The findings are:</p> <p>1. On 3/26/08, the menu for mechanical soft and pureed diets for the lunch meal documented, 3-ounces rotisserie chicken per serving, 1/2-cup [4-ounces] carrots per serving and 1/2-cup [4-ounces] black-eyed peas per serving.</p> <p>a. On 3/26/08 at 10:38 a.m., Dietary Employee #1 deboned 5 pieces of chicken breast and 5 pieces of chicken thigh. She placed half of the chicken meat in the blender, added 3 slices of bread and ground it up for the 14 residents on a mechanical soft diet.</p> <p>She placed the remaining half of the chicken in the blender, added three slices of bread and black-eyed pea broth and pureed it for the 9</p> | F 363 | | | |

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| F 363 | Continued From page 13 residents on a pureed diet, instead of 3-ounces each of chicken, as per the written menu. b. On 3/26/08 at 10:46 a.m., Dietary Employee #1 was observed using a 4-ounce ladle serving spoon to scoop 4 servings of carrots into the blender. She added three slice of bread and pureed it, instead of the 9 servings of carrots, as per the written menu. c. On 3/26/08 at 11:10 a.m., Dietary Employee #1 was observed using a 4-ounce ladle serving spoon to scoop 4 servings of black-eyed peas into the blender. She then added an unmeasured amount broth from the black-eyed peas, an unmeasured amount of thickener and three slices of bread to the 4-servings of peas in the blender and pureed it all to provide 9 servings of black-eyed peas called for on the written menu. 2. On 3/27/08 at 9:15 a.m., Dietary Employee #1 stated, "I put 4 servings of carrots with a 4-ounce ladle spoon, 4 servings of black-eyed peas with lots of juice. I also had 10 pieces of chicken breast and thigh. I added 3 slices of bread to ground the meat and used pea juice to puree the meat. | F 363 | | |
| F 364 SS=E | 483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility | F 364 | | |

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| F 364 | <p>Continued From page 14</p> <p>failed to ensure food was not prepared and left in the oven or on the stove top for prolonged periods to prevent food from being dried out, discolored and overcooked or burned to prevent potential loss of nutritive value and flavor. This failed practice had the potential to affect 46 residents who received their meal tray from the kitchen, as documented on the diet list dated 3/24/08. The findings are:</p> <p>1. On 3/26/08 at 2:30 p.m., the following observations were made:</p> <p>a. A pan of pureed vegetables, a pan of broccoli with cauliflower, a pan of pureed corn and a pan of mashed potatoes to be served at the supper meal, were in the oven at a temperature of 350 degrees Fahrenheit. The top of the mashed potatoes was dried out and burned.</p> <p>b. A pot of cooked gravy, to be served at the supper meal over the beef steak fingers, was on the stove. Dietary Employee #2 stated, "I took the corn directly from the can and pureed it. I did not cook it before pureeing it."</p> <p>2. The facility recipe for seasoned corn documented:</p> <p>a. Drain juice into pan. Boil to reduce juice to half volume; add vegetable</p> <p>b. Add margarine and salt or seasoning.</p> <p>c. Canned vegetables should be simmered in their own juice for 10 to 12 minutes.</p> <p>d. Canned vegetables should be heated as closely as possible to serving time.</p> | F 364 | | | |

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| F 364 | Continued From page 15 e. Hold and serve pureed corn and pureed vegetables at minimum internal temperature of 140 degrees F (Fahrenheit). 3. On 3/26/08 at 4:37 p.m., the temperature of the pureed corn on the steam table was 200 degrees F. The corn was discolored and the edges were burned. The temperature of the pureed vegetables was 190 degrees F. The pureed vegetables were discolored and the edges of the pan were burned. The broccoli with cauliflower was discolored. The temperature of the mashed potatoes was 200 degrees F., the mashed potatoes were dried out, with the edges crusty and burned. Dietary Employee #1 stated, "I put the vegetables in the oven at 2:00 p.m. and the pureed food items at 2:30 p.m." 4. On 3/26/08 at 5:39 p.m., Dietary Employee #1 tasted the mashed potatoes and stated, "The mashed potatoes had no taste to it and the broccoli with cauliflower was mushy." | F 364 | | | |
| F 371 SS=F | 483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure food items in the refrigerator, in the freezer and on shelves were covered to prevent the potential for cross contamination or freezer burn, the ice machine | F 371 | | | |

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| F 371 | <p>Continued From page 16</p> <p>and ice scoop holder were kept free of debris and spoiled food was not retained in the refrigerator and stored over fresh vegetables. This failed practice had the potential to affect 46 residents who received their meal trays from the kitchen, according to the diet list dated 3/24/08. The findings are:</p> <p>1. On 3/24/08 at 10:45 a.m., the following observations were made:</p> <p>a. A box of sausage in the refrigerator was not sealed, exposing the contents to air.</p> <p>b. A box of bacon in the refrigerator was not sealed, exposing the contents to air.</p> <p>c. A bag of gravy mix on the shelf in the storage room was not sealed, exposing the contents to air and pests.</p> <p>d. A scoop holder attached on the right side of the ice machine, located in the dinning room, had water standing in it with grayish and blackish matter floating on it.</p> <p>e. The ice machine in the dinning room had a yellowish substance on the panel where the ice was to shoot down in the ice collector.</p> <p>f. A bag of okra in the freezer in the dinning room was torn, exposing the contents to freezer burn.</p> <p>g. A bag of carrots in the freezer in the dinning room was torn, exposing the contents to freezer burn. There was a loose carrot on the shelf by the bag.</p> <p>h. A bag that contained pizza and a bag that</p> | F 371 | | | |

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| F 371 | Continued From page 17 contained sweet potato fries, in the freezer in the dining room, were not sealed, exposing the contents to freezer burn. 2. On 3/26/08 at 9:15 a.m., the following observations were made: a. A box in the refrigerator, located in the dining room, contained cucumbers and had three bags of cheese stored over the cucumbers. One bag of the cheese was molded. b. A box of chicken in the freezer, located in the dining room, was not covered, exposing the chicken to freezer burn. | F 371 | | | |