

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

PRINTED: 11/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/29/2015
NAME OF PROVIDER OR SUPPLIER REGIS WOODS			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOVE RD LOUISVILLE, KY 40220		
(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 000	INITIAL COMMENTS	F 000	Regis Woods Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law.		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to promote care for residents in a manner and environment that maintains each resident's dignity on two (2) of four (4) units. On Nursing Facility One (NF1) and Nursing Facility Two (NF2), Staff were observed using cell phones and talking with each other rather than addressing residents while performing tasks for residents in the dining room prior to and during meal services. Further, the facility failed to maintain resident privacy of body while administering injection medication to one (1) of four (4) sampled residents, (Resident #4). The findings include: Review of the facility's Job Description for Certified Nursing Assistant (CNA), dated 11/08/12, revealed	F 241	F 241 1 The Social Worker completed BIMS re-assessments of residents on NF1 and NF2 on November 11, 2015 to determine if a decline in mood had occurred. No areas of concern were identified. Resident #2, #3 and #4 were reassessed by the Social Worker/Director on November 11, 2015 to determine if resident #2, #3 and #4 had experienced a decline in mood. No areas of concern were identified.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Christoph E. Bee, NHA

TITLE

** Administrator*

(X6) DATE

11/24/15

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 241	<p>Continued From page 1</p> <p>CNAs reported to the Charge Nurse, Supervisor, or Nursing Administrator. Nursing staff were to provide effective nursing care in a manner conducive to resident safety and comfort. Nursing staff were to provide care in a way that maintained the residents' confidentiality and privacy.</p> <p>Review of the policy titled Personal Cell Phones and Handheld Devices, Use of, dated 11/01/13, revealed the facility prohibited staff from using cell phones or any other personal handled device when in patient care areas including patient rooms, dining areas, community rooms, and adjacent hallways.</p> <p>Review of the facility's Resident Rights for the State of Kentucky, not dated, revealed the facility should have ensured staff treated each resident with consideration, respect, and full recognition of the resident's dignity, including privacy in treatment and in care for personal needs. Staff should have assured the resident's visual privacy while providing care.</p> <p>Observation, on 10/27/15 at 12:45 PM, revealed three (3) nursing staff sitting at a table in the NF1 dining room using personal cell phones and talking amongst themselves. Eighteen (18) residents sat at tables with drinks in the dining room. One staff was using her personal cell phone and two (2) staff were talking to each other.</p> <p>Observation, on 10/27/15 at 12:30 PM, revealed residents not receiving fluids while waiting for lunch service in the NF2 dining room. Forty-two (42) residents and three (3) CNAs waited in the dining room for meal service. Six (6) residents</p>	F 241	<p>Re-education was completed by Nurse Practice Educator on November 30, 2015 on Dignity and Respect to include no cell phone usage in resident care areas and assisting residents during meal times providing beverages and conversations with residents to promote dignity to Certified Nursing Assistances on NF1 and NF2 with a post-test given to determine competency. RN #1 was re-educated by the Nurse Practice Educator on October 30, 2015 to the policy of insulin administration to include promoting dignity by providing privacy during medication pass. A Post-Test was given to validate understanding.</p>	12/10/15	

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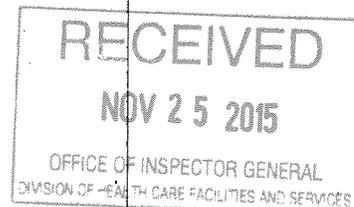
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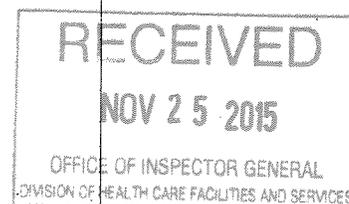
F 241	<p>Continued From page 2</p> <p>had drinks in containers from their rooms. The remainder of the residents did not have fluids served while waiting on meal service.</p> <p>Review of the clinical record for Resident #4 revealed the facility admitted the resident on 03/19/14 with diagnoses of Hypoxemia, Type II Diabetes, Hypertension, Depression, Dementia, and Dysphagia.</p> <p>Review of Resident #4's quarterly Minimum Data Set (MDS) assessment, completed on 08/28/15, revealed the facility conducted a Brief Interview Mental Status (BIMS) assessment in which the resident scored a four (4) out of fifteen (15) indicating the resident was not interviewable.</p> <p>Observation, on 10/27/15 at 3:45 PM, revealed a Registered Nurse (RN) #1 giving an injection to Resident #4 in the hallway near the NF2 nurse's station and in view of the resident common area. Five (5) other residents sat in the common area at the time of the injection. The nurse asked the resident to lift his/her shirt, the resident complied, and the nurse administered the injection in the resident's stomach. The nurse then transported the resident over to the common area and told him/her to "stay here and wait for dinner".</p> <p>Observation, on 10/28/15 at 10:05 AM, revealed CNA staff walking down the NF1 hallway looking at his cell phone or handheld device.</p> <p>Observation, on 10/28/15 at 10:15 AM, revealed staff leaning against a wall in the hallway of NF1 near the nurse's station typing on a cell phone or handheld device.</p> <p>Review of clinical record for Resident #3 revealed the facility admitted the resident on 04/10/08 with</p>	F 241	<p>2 All residents of the facility have the potential to be affected. The facility Unit Managers completed visual observations over all 3 shifts on November 14, 2015 to determine if staff were treating residents with dignity and respect to include no usage of personal hand held device and or cell phones in resident care areas and insulin was administered with privacy provided, Resident room /bathroom doors and privacy /window curtain closed during care and staff were interacting with residents during meal time. Areas of concern were corrected upon discovery.</p> <p>3. Re-Education on Dignity regarding the need for the facility to promote care for residents in a</p>	12/10/15
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F 241	<p>Continued From page 3</p> <p>diagnoses of Hypertension and Anxiety. Review of the resident's quarterly Minimum Data Set (MDS) assessment, completed on 09/04/15, revealed the facility conducted a Brief Interview Mental Status (BIMS) assessment in which the resident scored a fifteen (15) out of fifteen (15) indicating the resident was interviewable.</p> <p>Interview with Resident #3, on 10/27/15 at 4:20 PM, revealed the facility did not consistently provide privacy in care. The resident stated the staff would leave the bathroom door or the door to the bedroom open when providing care. Resident #3 stated staff would shut the door if the resident told them to shut the door, and staff would continue closing the door when providing care for a short time, but then would revert to leaving the door open when providing care. The resident stated he/she was able to transfer and ambulate independently during the day, but often requested assistance at night due to the lights being low and unable to see in the dark. The resident stated he/she had a history of falls and falls with fractures and would request assistance when he/she needed to use the bathroom in the night. The resident further stated they felt the staff did not treat him/her with dignity when they left the door open while providing care and it made the resident feel angry. The resident stated it made him/her feel like they were treated like a dog and not a person.</p> <p>Review of the clinical record for Resident #2 revealed the facility admitted the resident on 10/06/12 with diagnoses of Heart Failure, Hypertension, Type II Diabetes, Hyperlipidemia, Anxiety, and Depression. Review of the resident's quarterly Minimum Data Set (MDS) assessment, completed on 09/08/15, revealed</p>	F 241	<p>manner and environment that maintains each resident's dignity including providing privacy with insulin administration, closing room door/bathroom door and curtain when care is provided, staff interaction during meal times and cell phone usage will be completed for Licensed Nurses and Certified Nurses Assistants on or before November 30, 2015 by Nurse Practice Educator. A post-test will be administered at the time of re-education to validate understanding of information presented. Staff not available during this timeframe will receive education with post-test by the Nurse Practice Educator upon their return to work and to new hires during orientation.</p>	12/10/15	



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F 241	Continued From page 4 the facility conducted a Brief Interview Mental Status (BIMS) assessment in which the resident scored a fifteen (15) out of fifteen (15) indicating the resident was interviewable. Interview with Resident #2, on 10/28/15 at 9:16 AM, revealed the facility did not treat residents with dignity and respect. Resident #2 stated the CNAs were often talking and typing on their telephones in the facility. The resident stated this was especially true on the weekends. Resident #2 further stated CNAs have entered his/her room asking to step into the room to make phone calls. The resident stated CNAs would explain they had an emergency, but he/she could hear it was not an emergency. Resident #2 stated he/she had tried to talk to a CNA who was on the phone and was told to wait. The resident stated the treatment was undignified and made him/her feel helpless. Resident #2 also stated he/she received injection medication for the treatment of Type II Diabetes. The resident stated staff administered those injections into his/her arm or belly. The resident stated nursing staff prompted the resident to go into the hallway to receive the injections. The resident stated this bothered him/her and would sometimes ask the nurse to go into his/her room to administer the injection. The resident stated the next time an injection was due; the nurse prompted the resident to go to the hallway again. Interview with CNA #1, on 10/28/15 at 1:15 PM, revealed nursing staff had received training on dignity. CNA #1 stated she received training to promote dignity by making people feel more at home. CNA #1 stated providing dignity in the care for residents included ensuring residents	F 241	Visual observation with rounding audit completed over all 3 shifts by Unit Managers, Director of Nursing, Administrator, Assistant Administrator and/or Nurse Practice Educator daily times two weeks, three times per week times two weeks, weekly times four weeks, monthly times four months then as determined by the monthly Quality Improvement Committee review to determine care is provided with dignity including during resident care, medication administration, cell phones and or hand held devices are not used in Resident care areas and staff is interacting with residents at meal times. Areas of concern will be corrected immediately upon discovery.	12/10/15
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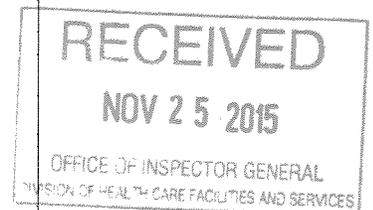
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F 241	<p>Continued From page 5</p> <p>looked clean and were dressed appropriately and by ensuring privacy when providing care by shutting doors. The CNA also stated the facility did not allow nursing staff to use cell phones while on the unit. She stated the facility permitted staff to carry their cell phone, but they had to step into the break room if they needed to take a call. The facility prohibited nursing staff from using cell phones while providing care, while feeding residents, or while in any care area such as the hallway or in any resident's room.</p> <p>Interview with Licenced Practical Nurse (LPN) #1, on 10/28/15 at 1:40 PM, revealed nurses supervised the CNAs by making observations of the work that CNAs completed and by helping the CNAs as needed. LPN #1 stated the facility prohibited nursing staff from using cell phones. If a nurse observed a CNA using a cell phone, the nurse was to give the CNA a verbal warning. If the nurse observed it a second time, the nurse should have reported the violation to the Unit Manager. The LPN stated nursing staff using cell phones would be a problem because it would have taken staff away from the residents and the work. Staff using cell phones while providing care would have been a violation of the residents' dignity because the staff would not have been giving personalized care to the resident. Further, LPN #1 stated nursing should have been providing privacy with Adult Daily Living (ADL) care, in conversations about care, and when giving care or medications such as injections. LPN #1 stated nurses should have administered injections to residents in the resident's room, behind closed doors.</p> <p>Interview with LPN #2, on 10/28/15 at 2:30 PM, revealed it is against policy for nursing staff to</p>	F 241	<p>4 The Director of Nursing and/or Nurse Practice Educator will submit a summary of the visual observation audits monthly times six months to the Quality Improvement Committee consisting of the Administrator, Assistant Administrator, Director of Nursing, Activity Director, Housekeeping Supervisor, MDS Coordinator, Maintenance Supervisor, Director of Dining Services, Health Information Manager Coordinator, Social Service Director, Business Office Manager and Medical Director for any additional follow up and/or inservicing needs until the issue is resolved and on-going thereafter.</p>	12/10/15	

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F 241	<p>Continued From page 6</p> <p>use cell phones except in the break room. If a nurse observed a CNA using the cell phone, they were to inform the Unit Manager for disciplinary action.</p> <p>Interview with Unit Manager #2, on 10/29/15 at 10:30 AM, revealed providing treatment, including administering injection medications, and talking on cell phones in resident areas was not consistent with providing dignity in care. The Unit Manager stated she received information that a nurse administered an injectable medication to a resident in a public area of the facility. She stated this was a violation of the resident's rights and privacy. The Unit Manager stated this was a concern because providing care without ensuring privacy was not providing dignity with care and did not support residents' psychosocial wellbeing. She stated other residents who observed the medication administration could have been embarrassed or uncomfortable. The Unit Manager stated she monitored staff by watching and assisting staff as needed. She further stated nursing staff were not permitted to use cell phones in the building except in the break room. Nurses who observed a CNA using a cell phone should have reported that CNA to the Unit Manager.</p> <p>Interview with the Director of Nursing (DON), on 10/29/15 at 1:15 PM, revealed the facility nursing staff did not provide care with dignity when they used cell phones. Further, nursing did not provide care with dignity when they gave care without respecting the resident's right to privacy. The DON stated she was concerned staff would do this as it could negatively affect the residents' psychosocial wellbeing.</p>	F 241		12/10/15	



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F 241	Continued From page 7 Interview with the Administrator, on 10/29/15 at 1:50 PM, revealed the facility staff should not have used cell phones in any resident areas, while providing care, or in any public area of the building. The Administrator stated as he received resident grievances or reported issues he had been providing education and individual disciplinary action to staff. However, the Administrator reported he had not provided education to the entire staff pertaining to cell phone usage and providing dignity with care. The Administrator stated that staff did not provide dignified care and this could prevent staff from meeting the needs of the residents.	F 241			
F 362 SS=F	483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to maintain sufficient dietary support personnel to prepare and serve palatable meals at appropriate times on four (4) of four (4) units. The findings include: Review of the policy Meal Times and Delivery, dated 05/01/07, revealed the facility would consistently provide meals at predictable times, three times per day. The meal times would be determined by the Food Service Director in	F 362	F 362 1. Medical record reviews were completed by Unit Managers on NF1 and NF2 on October 30, 2015 to determine if residents on NF1 and NF2 had experienced a change of condition as a result of meals not arriving on time to the unit. No concerns were identified. Resident #3 was re-assessed by the Unit Manager on November 12, 2015 to determine if a change in condition had occurred, no change was identified. The Unit Manager completed a review of Resident #2 blood sugars	12/10/15	

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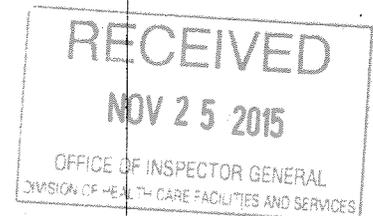
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F 362	<p>Continued From page 8 in conjunction with the Administrator and Director of Nursing (DON).</p> <p>Review of the facility's policy regarding Meal Service, dated 03/16/15, revealed the facility would serve meals that were accurate and timely.</p> <p>Review of the facility's Dining Times, dated 06/08/15, revealed the facility scheduled dining times. The facility would serve breakfast to the first unit from 7:15 AM to 7:30 AM. The facility would serve breakfast to the last unit between 8:10 AM and 8:30 AM. For lunch service, the facility would serve lunch to the first unit from 11:15 AM to 11:30 AM and on the last unit at 12:30 PM. The facility scheduled lunch service to the Nursing Facility One (NF1) unit dining room from 11:30 AM to 11:45 AM. The facility scheduled lunch service to the Nursing Facility Two (NF2) unit dining room from 12:10 PM to 12:30 PM. The facility scheduled the kitchen to deliver the room service meal trays to NF1 at 12:15 PM.</p> <p>Observation of NF1 dining room, on 10/27/15 at 1:00 PM, revealed the kitchen delivered the first meal tray to the dining room via a service window at 1:00 PM.</p> <p>Observation, on 10/27/15 at 1:25 PM, of the kitchen revealed the kitchen started preparing the room service meal trays for the last meal delivery at 1:25 PM. Kitchen staff delivered the last meal cart to the NF1 unit at 1:46 PM. Several residents on the NF1 hallway were in the common area of the unit and complained loudly about the facility not serving the food on time.</p> <p>Interview with Resident #3, on 10/27/15 at 4:20</p>	F 362	<p>on November 12, 2015 to determine resident has not experienced any change in condition as a result in meals arriving late to the units. Blood glucose level remained in normal limits, no change was identified.</p> <p>2. All residents of the facility have the potential to be affected.</p> <p>The Unit Managers completed an audit of the residents to determine if any negative outcome had occurred as a result of the meals arriving late to the units on November 6, 2015 with no additional findings. The audit consisted of review of blood glucose levels and change in condition documentation. No areas of concern were identified. The Administrator/Assistant Administrator reviewed</p>	12/10/15	

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F 362	<p>Continued From page 9</p> <p>PM, revealed the facility often did not serve meals on time. Resident #3 stated that several mornings the facility ran so far behind in the kitchen the residents had to eat breakfast in their rooms. The facility told the resident it was because the kitchen could not serve the dining rooms. The resident stated all the residents on the unit had to eat breakfast in their rooms on 10/25/15. Resident #3 stated he/she usually ate in the dining room. The resident further stated the food was often cold and the service in the dining room was poor.</p> <p>Interview with Resident #2, on 10/28/15 at 9:16 AM, revealed the facility often served meals late after the scheduled meal times. Resident #2 stated he/she was a diabetic and was concerned with the timeliness of the food service because of blood sugar levels. The resident stated he/she often bought outside food because the meals were often considerably late and because the food was often cold or did not taste good.</p> <p>Interview with CNA #1, on 10/28/15 at 1:15 PM, revealed on NF2 the nursing staff was responsible for getting residents into the dining areas and ready for meal service. She stated nursing brought residents into the dining room for breakfast approximately 8:00 AM and for lunch approximately 11:00 AM. She stated nursing would pass out drinks and desserts to residents while waiting on the lunch to come out. The CNA stated meals in the dining room were sometimes late. When meals were late, nursing would have to rush afternoon care to complete all of the tasks. Tasks included assisting residents for naps, answering call lights, and completing documentation. She stated when nursing had to rush due to late meals; taking water to all of the</p>	F 362	<p>Grievance Logs, and Resident Council Meeting Minutes to determine concerns with food service were being addressed no additional findings. The Director of Dining Service observed meal delivery to all units on November 12, 2015 to ensure sufficient personnel were assisting with corrective action upon discovery.</p> <p>3. Dietary staff was re-education on the need to ensure the facility maintains sufficient dietary support personnel to prepare and serve palatable meals at appropriate times on all units and on the Meal Service Delivery policy by the Regional Food & Nutrition Director on October 30, 2015. A post-test was given at the time of the re-education to validate understanding.</p>	12/10/15	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER REGIS WOODS			STREET ADDRESS, CITY, STATE, ZIP CODE 4804 LOVE RD LOUISVILLE, KY 40220		
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F 362	Continued From page 10 residents was put off until the next shift came on. Interview with the LPN #1, on 10/28/15 at 1:40 PM, revealed the kitchen did sometimes serve resident meals late. LPN stated if the kitchen served a meal significantly late then this was a medical problem for some residents due to medications that needed to be taken with food. Nursing staff give insulin just before the meal service and if a resident did not eat shortly after receiving the insulin, they risked having low blood sugar. Further, the kitchen did not communicate consistently with nursing staff when they would serve meals outside of the scheduled timeframes. Interview with LPN #2, on 10/28/15 at 2:30 PM, revealed meal times were not consistent. She stated breakfast was scheduled to be served in the dining room at 7:30 AM, but that it may be 8:30 AM or 9:30 AM by the time the kitchen served breakfast. She stated the kitchen served lunch as late as 1:00 PM. LPN #2 stated this was a problem because some residents have medication that nurses had to administer with food, including insulin dependent residents. Interview with Unit Manager #2, on 10/29/15 at 10:30 AM, revealed the kitchen had problems with timeliness for the last eight (8) weeks. She stated the problem existed since the previous Director of Food Services ended employment with the facility. She stated the meals were late two (2) to three (3) days per week. The Unit Manager stated the kitchen served lunch at 1:00 PM when it was scheduled for service at 11:30 AM or 12:00 PM. She stated kitchen staff would sometimes communicate to whoever was in the dining room at the time when a meal would be	F 362	Staff not available during this timeframe will receive education with post-test by the Director of Dining Service upon their return to work and to new hires during orientation. The facility has hired a new Director of Dining Services on 10/26/15, a new Executive Chef on 10/19/15 in addition to hiring 3 cooks and 1 Dietary Aide. When the Executive Chef, Director of Dining Services and/or Supervisor determines a staff member is running behind with their assignment, they will step in to help with getting the staff back on track. The Weekend Supervisor and/or Manager on Duty will be providing supervision during the weekend to ensure all meals are prepared and served	12/10/15	

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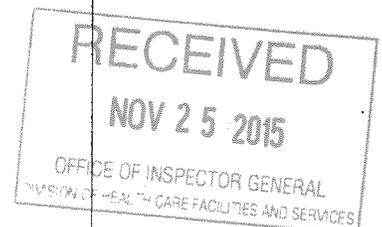
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F 362	<p>Continued From page 11</p> <p>late. However, nursing staff had no warning as to when meals were going to be late. Residents would be just sitting in the dining room waiting for the meal with no snacks. Alert and oriented residents do sometimes request and receive a snack when meals are late. Nurses have to wait to give some medications, including insulin, until meals come out of the kitchen.</p> <p>Interview with DON, on 10/29/15 at 1:15 PM, revealed the shift in management staff in the dietary department affected the timeliness of the meal service. The facility did not have the personnel to get the meals served to the residents on time. The facility has had to send nursing staff into the kitchen to assist with preparing and to serve meals to the residents. The DON stated that during the transition of kitchen staff it had been common for the kitchen to serve meals up to one (1) hour late due to not having enough kitchen staff.</p> <p>Interview with Lead Cook, 10/27/15 at 1:30 PM, revealed the facility has had changes with staffing. He stated the kitchen did not have enough staff and he was trying to do several jobs at one time, including serving the NF2 dining room and delivering meal carts to the allocated hallways. The Lead Cook stated he was unable to get the prep work completed for the next day's meal. Therefore, the kitchen runs the risk of serving the next day's meal late as well.</p> <p>Further interview with Lead Cook, on 10/28/15 at 2:00 PM, revealed the kitchen staffing consisted of six (6) positions in the kitchen. The Lead Cook stated the facility has had a lot of staffing changes and had been operating with a corporate director and, at times, few staff. He further stated</p>	F 362	<p>during the assigned meal schedule with corrective action upon discovery.</p> <p>Food and Nutrition Services will communicate to nursing staff when meals will be arriving later than 10 Minutes. In the event of delay in meal service, snacks will be available. The All hands on Deck program was re-implemented on November 2, 2015. The All Hands on Deck is a team of employees that can include Administrator, Assistant Administrator, Director of Nursing, Activity Director, MDS Coordinator, Scheduler, Benefit Designee, Health Information Manager Coordinator, Social Service Director, Social Service Specialist and Business Office Manager to assist bringing the residents to the dining room, serving beverages, and passing</p>	12/10/15	

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F 362	<p>Continued From page 12</p> <p>many of the kitchen staff had quit employment with the facility and the facility had been using temporary employees. The Lead Cook further stated meals were often late because of staffing shortages and maintenance issues. He stated on 10/27/15, two (2) employees walked off the job and the dishwasher broke, causing a nearly two (2) hour delay in meal service time. The Lead Cook stated the facility had no system in place for the kitchen to communicate directly with nursing when they know a meal would be late. He also stated that when the kitchen knew they would be very late with a meal, they served all the meals to residents in their rooms.</p> <p>Interview with Regional Director of Dining Services, on 10/28/15 at 3:30 PM, revealed the facility had not been fully staffed to ensure meals were served at scheduled times for the past eight (8) weeks. He stated the previous Director of Dining left the employment of the facility suddenly about eight (8) weeks prior. After this, several of the other kitchen staff also resigned from employment. The kitchen had been operating with no weekend supervisor, no facility dining director, and no lead supervisor. The facility had been working on replacing the vacant leadership positions. However, in the past eight (8) weeks, the kitchen had been late with meals. He stated meals were late more often on the weekends when there was less staff. In addition to not having consistent staff, the facility has had to use cooks from a temporary agency and the kitchen aide staff have had difficulty taking orders from the agency cooks. Kitchen staff did not communicate with the facility at large when meal services were running late. He did not know of any system in place to promote communication between the kitchen and the nursing staff. The</p>	F 362	<p>meal trays. The meal times have been adjusted to accommodate resident dining rooms and reviewed and approved by the Resident Council Committee on November 17, 2015.</p> <p>The Director of Dining Services and/or Executive Chef will audit the Meal Service daily across all meals times two weeks, then three times per week times two weeks, weekly times four weeks, monthly times four months then as determined by the monthly Quality Improvement Committee review with corrective action upon discovery to ensure sufficient personnel are available to ensure timely meal delivery.</p>	12/10/15	



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F 362	Continued From page 13 Director of Dinning Services stated that two (2) hour delays in meal service was uncommon; however, he stated that thirty (30) minute delays in meal service was common. Interview with the Administrator, on 10/29/15 at 1:50 PM, revealed the facility had problems with staffing the kitchen leading to problems in getting palatable meals served to residents in a timely manner. He stated the Regional Director of Dinning Services had been working in the facility four (4) days per week and the facility had utilized temporary employees to attempt to maintain meal service. The problems with staffing caused meals to be late. He further stated the late meals caused additional strain on the nursing services, including medication pass, and this placed residents at risk of receiving poor nursing services.	F 362	4. The Director of Dining Services and/or Executive Chef, will submit a summary of the audits results monthly times six months to the Quality Improvement Committee consisting of the Administrator, Assistant Administrator, Director of Nursing, Activity Director, Housekeeping Supervisor, MDS Coordinator, Maintenance Supervisor, Director of Dining Services, Health Information Manager Coordinator, Social Service Director, Business Office Manager and Medical Director for any additional follow up and/or inservicing needs until the issue is resolved and on-going thereafter.	12/10/15	

