

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

PRINTED: 09/21/2015
FORM APPROVED
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/03/2015
NAME OF PROVIDER OR SUPPLIER PROVIDENCE VALDEZ MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 911 MEALS AVENUE VALDEZ, AK 99686	
(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)

F 000 INITIAL COMMENTS

F 000

The following deficiencies were noted during an unannounced recertification Medicare/Medicaid survey conducted 8/31/15 - 9/3/15. The sample included 4 sampled residents, 1 closed record and 1 non-sampled resident.

Department of Health and Social Services
Division of Health Care Services
Health Facilities Licensing and Certification
4501 Business Park Blvd, Ste 24, Bldg L
Anchorage, Alaska 99503

F 176 483.10(n) RESIDENT SELF-ADMINISTER
SS=D DRUGS IF DEEMED SAFE

F 176

An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.

This REQUIREMENT is not met as evidenced by:

Based on record review, observation, and interview the facility failed to ensure 1 (#3) out of 3 sampled residents reviewed, had an assessment, periodic evaluation and a care plan related to the self-administration of an inhaler based medication. This failed practice had the potential to result in the resident incorrectly

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE LTC Administrator (X6) DATE 10/1/15

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 000	INITIAL COMMENTS The following deficiencies were noted during an unannounced recertification Medicare/Medicaid survey conducted 8/31/15 - 9/3/15. The sample included 4 sampled residents, 1 closed record and 1 non-sampled resident. Department of Health and Social Services Division of Health Care Services Health Facilities Licensing and Certification 4501 Business Park Blvd, Ste 24, Bldg L Anchorage, Alaska 99503			
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview the facility failed to ensure 1 (#3) out of 3 sampled residents reviewed, had an assessment, periodic evaluation and a care plan related to the self-administration of an inhaler based medication. This failed practice had the potential to result in the resident incorrectly	F 176	a) Immediate Corrective action: It was explained to the resident that facility had failed to follow our policy to assess her ability to effectively self-administer her medication. Reviewed the SAM program requirements to resident again, who, after understanding the required controls, indicated that she was still interested. A 5 day consecutive assessment of her training and ability to self-administer the medication was conducted as per a new occurrence. The Physician and IDT agreed that Resident was an appropriate candidate for the program. The necessary documentation was acquired. (See attached documents for Resident) b) Who else can be affected: Any Resident in the LTC who wishes to enter the Self Administration of Medication Program. c) Measure to correct deficiency: Consultant Pharmacist, Physician and Team Leaders made aware of this deficiency. Policy revised and reviewed with each of the parties together with accompanying forms and supportive documentation in order that all parties become familiar. (See attached Policy). This program and the need to follow our policy for assessment and –re-assessment was addressed.	

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

TITLE

(X6) DATE

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F 176	<p>Continued From page 1</p> <p>administering the medication and receiving inadequate medication therapy.</p> <p>Record review from 8/31/15 to 9/2/15 revealed Resident #3 had a diagnosis of chronic airway obstruction disease.</p> <p>Random observations from 8/31/15 to 9/2/15 revealed Resident #3 had an albuterol meter dosed inhaler on the bedside table.</p> <p>Review of the physician's orders, dated 9/15, revealed the Resident had an order for albuterol meter dosed inhaler to use as needed for dyspnea and wheezing.</p> <p>Review of the nursing progress notes, dated 3/22/15 to 8/24/15, revealed no assessment or evaluation of the Resident's ability to self-administer medication from an inhaler. Additional review revealed the Resident went to Anchorage twice for surgery.</p> <p>Review of the care plan, last reviewed 8/10/15, revealed no care plan in place for the self-administration of medications.</p> <p>Review of the interdisciplinary team meeting minutes, dated 8/19/15, 5/22/15 and 2/17/15, revealed no evaluation of the Resident's ability to self-administer inhalant medications.</p> <p>During an interview on 9/2/15 at 8:48 am, the Director of Medical Records stated the medical record did not contain any self-administration of medication evaluation and referred the Surveyor to the self-administration of medication policy 982.111.</p>	F 176	<p>Revised documents:</p> <p>i) Revised policy.</p> <p>ii) A letter for which the Resident signs that they wish to participate in, and will comply with, the requirements and controls of the program.</p> <p>iii) Revised IDT checklist template-there is a prompt hardwired into the document for Pharmacist or Nurse facilitator to ensure that this is discussed with the Physician, Resident and rest of the IDT every quarter.</p> <p>iv) The nurse will also be monitoring the resident accountability sign-off sheet to include this documentation into the MAR.</p> <p>iv) Also highlighted, is the need for a 3-day consecutive re-assessment of the resident's skill in delivering her own medication after she has gone to any Outpatient procedures or admission to hospital.</p> <p>d) How to assure this is working: -A list of all Residents who are participating in the SAM Program will be followed in the Quarterly P&T Committee meeting, effective immediately, and reports of their reassessment statuses will be discussed to ensure adherence to policy and compliance. Consultant Pharmacist, in his monthly reviews will be assessing that the program is being complied with. -This will also be reported at the LTC/UR Management meeting by the Case Manager/RN for accountability purposes.</p>	

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F 176	Continued From page 2 During an interview on 9/3/15 at 9:30 am the Director of Nursing (DON) stated that self-administration of medications should be evaluated during each interdisciplinary meeting. Review of the facility's policy "Self Administration of Medication...982.111," new effective date 12/10/14, revealed each resident is assessed for their ability to self-administer medication. In addition, residents who self-administer medication will be evaluated on their ability to continue self-administering on a weekly basis. The policy continued to state residents who are hospitalized will be reevaluated for at least 3 consecutive days for their ability to continue to self-administer medications.	F 176	e) Completion Date: 10/1/2015 f) Signature: 	
F 274 SS= D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 274		

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F 274	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview the facility failed to complete a comprehensive assessment after a significant change for 1 resident (#1) of 3 sampled residents. Specifically, the criterion necessitating a significant change assessment had been met in the areas of unplanned weight loss, overall deterioration of the resident's condition with concerns to activities of daily living (ADLs), and a change in behavior. Failure to complete a comprehensive assessment after a significant change had the potential for the residents most current needs not being addressed. Findings:</p> <p>Record review from 8/31/15 to 9/3/15 of Resident #1's "Admission Face Sheet," dated 12/15/14, and "History and Physical," dated 12/11/14, revealed the Resident was unable to care for herself at home, and had a history of falls, urinary tract infection (UTI), and progressive dementia.</p> <p>Record review from 8/31/15 to 9/3/15 revealed Resident #1 had an initial comprehensive assessment completed on 12/18/14, and quarterly assessments completed on 3/20/15 and 6/15/15.</p> <p>Weight Loss:</p> <p>Record review from 8/31/15 to 9/3/15 of the weight flowsheet log, found in the Resident's medical record, revealed the Resident was admitted on 12/11/14 with a weight of 182 pounds (lbs.). On 3/17/15, the Resident weighed 160.9</p>	F 274	<p>a) Corrective action:</p> <p>A Significant Change report for this resident has been filed.</p> <p>Review with Team members as well as record review indicates that all the needs of the residents were carefully met.</p> <p>-Unintended weight loss: Dietician consulted and her ideal body weight was recorded to be 110lbs +/-10%, she had stabilized in the 150's after her two UTI's, and nutritional supplements.</p> <p>-ADL Change: She did have changes and these were thought to be related to the expected progression of her Dementia. The appropriate care was provided to ensure that she was safely accommodated.</p> <p>-Behavioral Changes: the notation of the increase in the number of Ativan doses was related to a change in the MD's order indicating that she could have more frequent doses during the day. She had, for a prolonged period, indicated numerous combative episodes that could not be alleviated until she was allowed to have her Ativan doses earlier in the day, and since then, her disposition has improved with nearly no combative episodes.</p>	

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F 274	<p>Continued From page 4</p> <p>lbs. This resulted in a unintended weight loss of 11.6% over 97 days.</p> <p>Further review of the Resident's "Quarterly Progress Note," dated 3/31/15, indicated "[Resident #1's] appetite is very poor. [S/he] has had a weight loss of 20 lbs. since admission ..."</p> <p>Increased need for Activities of Daily Living (ADLs) Assistance:</p> <p>Record review of the Resident's initial MOS (Minimum data set) assessment, dated 12/18/14, and Quarterly assessment, dated 3/20/15, when compared side by side, indicated an increased need for AQL assistance in the areas of bed mobility, walking in room, locomotion on the unit, dressing, eating, toilet use, personal hygiene, and bathing.</p> <p>Further review of the Resident's "Quarterly Progress Note," dated 3/31/15, indicated "[Resident #1] has experienced a decline in ambulation this past quarter. Modifications to care plan reflect use of 4 wheeled walker instead of front-wheeled walker, gait belt, and contact guard assist... [S/he] has experience[d] 2 supported falls without injury this past quarter. [Resident #1] requires one person assistance with transfers/ambulation, bathing, grooming/hygiene tasks, toileting, dressing, and eating. [S/he] is able to feed herself at times, but needs to be fed by staff when she is not motivated to initiate eating herself."</p> <p>Change in Behavior:</p>	F 274	<p>b) Who else can be affected: Any Resident in the Nursing home can be affected.</p> <p>c) Measure to address deficiency: MDS RN researched and consulted with National MDS expert to obtain clarity and to gain better understanding of what may be interpreted as criteria that would constitute Significant Change for a report to be filed. MDS RN will review the RAI Reference Guide.</p> <p>d) How to assure this is working: At the Quarterly IDT's for each resident, the IDT will evaluate together if there are significant changes that need to be reported. Discussion during resident rounds in the weekly LTC/UR Management Team meetings will address changes that may constitute criteria for filing the Significant Change reports for all residents (declines or improvements). A report by MDS nurse to verify that a Significant Change Report has been filed. LTC Administrator, will monitor this more closely.</p> <p>e) Date of completion: 10/1/2015</p> <p>f) Signature: </p>	

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F 274	<p>Continued From page 5</p> <p>During an initial tour interview on 8/31/15 between the hours of 9:00 am and 10:00 am, the MOS Nurse indicated that Resident #1 can get agitated at times, had struck out at staff before, and can be resistant to care.</p> <p>Record review of the "Medication Administration Record" revealed the Resident's use of the medication lorazepam (Ativan), was given for treating "Agitation/Anxiety." Further review revealed that the Resident received Ativan for a number of reasons, such as, anxiousness, restlessness and increased agitation.</p> <p>Record review from 8/31/15 to 9/31/15 of the "Monthly Utilization Review - June 2015," revealed Resident's use of Ativan had increased from 12 doses in January, to 28 doses in February, and 39 doses in March. The number of doses the Resident was receiving more than doubled in the month of February (compared to the previous month) indicating an increase in the medication's target behaviors of "agitation/anxiety." Additionally, the resident used 11 more doses of Ativan in March than in February.</p> <p>During an interview on 9/21/15 at 2:45 pm, the MOS Nurse acknowledged the Resident's weight loss since admission, as well as, an increased need for activities of daily living (ADL) assistance, and change in behavior interventions. The MOS Nurse further stated that, in hindsight, a significant change evaluation may have been warranted given the changes to Resident #1's behaviors and ADLs during the same time as the Resident's weight loss.</p> <p>During an interview on 9/21/15, the Resident's</p>	F 274			

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F 274	<p>Continued From page 6</p> <p>family member stated a noticeable decline in the residents overall condition during the past year. The family member indicated that the Resident's decline, both physically and mentally, began while the Resident was living alone at home, as s/he had several falls. The Resident's family member further stated the Resident's decline continued to progress after admission to the hospital, and eventually the long term care (LTC) unit.</p> <p>The Surveyor noted three areas of decline at the time of Resident #1's 3/20/15 Quarterly MOS assessment, they are: the Resident's significant unplanned weight loss of 11.6%; an increased need for AOL assistance; and increased usage of PRN medication to treat the target behaviors of agitation and anxiety. The changes noted above meet the criterion necessary to inflate a Comprehensive MOS assessment.</p> <p>Record review of the facility's "MOS Plan of Care Assessments" policy, effective date 2/11/15, states "A Comprehensive MOS assessment is completed on all new resident admissions and annually as well as if a significant change occurs in a resident's condition or on return from a stay in an acute care hospital."</p>	F 274	<p>F 371 a) Corrective Action: The 3 frozen pizza, 7 Marie Calendar's meatballs frozen meals, 4 bell peppers, 2 groups celery stacks and 2 cucumbers were discarded.</p> <p>b) Who else can be affected: All occupants of the Nursing home and others who would partake of foods cooked in the kitchen could have been exposed to food-borne illnesses.</p>	
F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p>			

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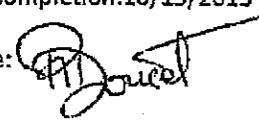
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F 371	<p>Continued From page 7</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview the facility failed to ensure frozen foods were stored per manufactures instructions and vegetables were discard appropriately due to condition. This created a potential for food-borne illness in a vulnerable population (based on 9 residents who received food from the kitchen). Findings:</p> <p>During an observation of the central kitchen on 8/31/15 at 9:00 am revealed:</p> <ul style="list-style-type: none"> 3 frozen pizzas thawed in the refrigerator, manufactures instructions indicated to keep frozen until ready to cook; 7 frozen Marie Calendars meat balls in the refrigerator, manufactures instructions indicated to keep frozen until ready to cook; 4 red peppers that were soft to the touch and had black spots; 2 groups of celery stalks with fuzzy coating; and 2 cucumbers with fuzzy coating. <p>During an interview on 8/31/15 at 9:20 am the Dietary Manager stated the staff usually kept frozen foods in the freezer as opposed to placing in the refrigerator. In addition, the Dietary Manager stated the vegetables that were soft to the touch, containing black spots and fuzzy</p>	F 371	<p>c) Measure to address deficiency:</p> <p>i) Under the supervision of the RD, Dietary Supervisor and/or Director of Support Service dietary will purchase produce bi-weekly to ensure wholesomeness and freshness. Dietary staff will ensure new shipment of produce is put into clean sanitized bins/trays. Each produce bins/trays will be labeled with a use-by date following the USDA food storage chart located in department.</p> <p>ii) Dietary will continue to follow protocol: daily AM cook to do a walk through coolers, freezers, reach in cooler & dry storage room to complete a hands on visible 360 degree inspections especially as it relates to produce to ensure wholesomeness and freshness, chart and discard any foods' out of date or questionable. Department will add to protocol, that the PM cook do a walk through as described above as well.</p> <p>iii) With a menu change the Registered Dietician, Dietary Supervisor, and/or Director of Support Services will do the following: Develop an action plan that addresses: reviews proposed changes to ensure foods meet nutritional needs to all patients & resident's diet needs by reviewing nutrition labels and review manufactures thawing and cooking directions.</p>	

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F 371	Continued From page 8 coating should have been removed.	F 371	Training to be completed by RD or CDM to all dietary staff regarding the change in the menu and the action plan that addresses the above items. In service for staff on new process & competency to be reviewed with staff and re-visited annually. (See attached competency and policy). d) How to assure this is working: Dietary Supervisor will ensure that processes are followed by the staff, through set inspection protocols and Dietary Supervisor will be in-charge of identifying change of processes if needed. She will consult the Dietician. Dietician will provide guidance or recommendations, with a visit to audit for compliance quarterly or if requested by the Director of Support Services. e) Date of completion: 10/15/2015 f) Signature: 	
F 431 SS-E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			

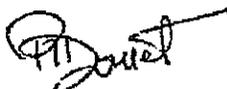
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 9</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview the facility failed to ensure the package integrity of controlled medications were preserved and free from compromises for 2 sampled residents (#1 and #3) out of 3 sampled residents and 1 non-sampled resident (#6). This created a risk for compromised medication stability and had the potential to affect all residents receiving controlled medications (based on a census of 9). Findings:</p> <p>Observation on 8/31/15 at 12:00 pm of the locked drawer on the medication cart revealed compromised tramadol bubble packs for Resident #1. Additional observation revealed compromised tramadol and Norco bubble packs for Resident #3. Further observation revealed a compromised tramadol bubble pack for Resident #8. The bubble packs' integrity was compromised by means of being punctured, ripped and/or taped over.</p>	F 431	<p>a) Corrective action: All controlled unit dose medications that had compromised packaging were appropriately discarded and accounted for by Pharmacist, as per policy for "Scheduled Control Substances-Accounting Procedures". (Attached: Polycystat ID 1227966) In order to protect the integrity of the packages until a new locked cupboard was acquired, they were placed in individual sleeves for protection to mitigate any further inadvertent puncturing of the compartments.</p> <p>b) Who else can be affected: All residents in the Facility who depend on the integrity and efficacy of these medications when they need them.</p> <p>c) Measure to address deficiency: Team Leaders were educated and reminded of the critical nature of ensuring the integrity of the medication, as well as the sensitivities around the management of controlled substances. (Staff Meeting completed 10/1/15) A new locked cupboard for non controlled meds was acquired (9/28/15) to allow for more room for the large number of individual controlled bubble packages to be housed safely, without more incidences of inadvertent puncturing and compromise to the bubble packaging.</p>	

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

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F 431	Continued From page 10 During an interview on 8/31/15 at 12:10 pm LN (Licensed Nurse) #1 stated that if a medication was refused, they would return the pill by first taping the dispensing flap in order to secure it until ready to dispense. In addition the LN stated that because the facility had to pack so many of the individual dosed bubble cards into one drawer, which potentially could have caused physical damage to the seals protecting the medications. During an interview on 8/31/15 the Pharmacist stated he was aware of this ongoing issue and confirmed the packages were crowded into the locked storage drawer. The Pharmacist acknowledged the facility had a problem with available controlled medication storage space. In addition, the Pharmacist stated he did not condone the medications being taped over.	F 431	d) How to assure this is working: Pharmacist will be performing random weekly and monthly checks of the medications to ensure that there is no further compromise in the practices and preservation of integrity of the controlled medication. Report at Pharmacy & Therapeutics and Quality Management Committee meeting that there is no further compromise of medications in their packaging in the LTC. e) Date of completion: 10/1/2015 f) Signature: 	
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF- EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interview and observation the facility failed to ensure staff had sufficient knowledge and skills to respond to a fire emergency in the central kitchen for 2 of 2 kitchen staff interviewed. Failure to ensure staff could respond to a fire emergency placed residents at risk for injury and/or exposure to a smoke and fire environment. Findings:	F 518	a) Corrective action: Re-education of the Dietary staff on Emergency procedures during a Fire; where to access the pull stations, the availability of the hood fire suppression system, and the purpose of the different types of fire extinguishers. b) Who else can be affected: All occupants of the facility could be affected by the exposure to unsuppressed smoke and fire originating from the kitchen.	

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F 518	<p>Continued From page 11</p> <p>During an interview and observation on 9/2/15 at 2:15 pm Cook #1 was asked if the kitchen had a fire extinguisher. In response, the Cook stated the kitchen had a red one. The Cook was asked to show the Surveyor the location of the extinguisher. Cook #1 walked around the kitchen and pointed to the fire extinguisher on the wall and stated the canister was silver and not red. When asked what the extinguisher was intended to do, the Cook was not able to verbalize its intended use for grease fires. Additional interview revealed the Cook was not aware the hood suppression system could be activated manually.</p> <p>During an interview on 9/2/15 at 2:16 pm the Dietary Manager was not able to verbalize an appropriate method to manually activate the hood suppression system. In addition, the Dietary Manger was not able to verbalize the correct use of the silver K-extinguisher located in the kitchen.</p> <p>Observation on 9/2/15 from 2:15 to 2:16 pm revealed the kitchen contained a silver K-extinguisher that was intended to be used for ordinary combustibles and grease fires.</p>	F 518	<p>c) Measure to address deficiency: Review of Ansul R-120 kitchen hood fire suppression system training video Updates made to monthly dietary department safety checks that include areas noted as above. (See Attached: competency : Response to a fire within Dietary Department, and Monthly Department Safety Checklist)</p> <p>d) How to assure this is working: Designated Safety personnel will perform the monthly Safety checks- quizzing staff and performing on- going training as needed.</p> <p>e) Date of completion: 10/15/15</p> <p>f) Signature: </p>	