10/30/12

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

PRINTED: 10/10/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	538019	A. BUILDING _____ B. WING _____	09/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CNA Certified Nurse Aide DON Director of Nursing IDT Interdisciplinary Team LPN Licensed Practical Nurse MDS Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. 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. 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. 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. The facility must keep confidential all information contained in the resident's records, regardless of	F 164	**This facility will ensure personal privacy and will keep confidential information contained in the resident's record.** A. Social Services will visit with resident #21 to ensure resident understands her right to privacy and empowers this resident to ask staff to pull curtains and close doors if that hasn't been done for her prior to staff providing cares. Resident's primary care aide and CNA #1 will be instructed that privacy should be considered immediately upon arriving in resident #21 room and always prior to providing any care.	

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.

X Accepted by [signature] 10/30/12

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F 164	Continued From page 1 the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, the facility failed to ensure visual privacy was provided during care for 1 of 9 sample residents (#21). In addition, the facility failed to ensure confidentiality for 12 residents whose names were associated with the past survey results. These results were posted and available for residents and the public to read. The findings were: 1. Observation on 9/25/12 at 8:15 AM showed resident #21 was assisted in the bathroom by CNA #1. The CNA helped the resident to transfer off of the toilet. While the care was being provided, the door to the bathroom was open, as were the curtains on the window by the resident's bed. The window faced the facility parking lot and road, and the bathroom with the resident and CNA was clearly visible to anyone who may be passing by. Interview with the resident on 9/25/12 at 8:20 AM revealed s/he was bothered by the lack of privacy, and stated it "feels like people from the highway can see in...it's a clear shot right into the bathroom." Interview with CNA #2 on 9/26/12 at 3:15 PM revealed they were taught to be aware and close windows and doors to protect the privacy of residents when care was being provided. 2. Observation on 9/26/12 at 11:30 AM showed	F 164	Confidential Resident information was immediately removed from binder which contained posted survey results. Social Service was inserviced by Administrator regarding posted survey should never include Confidential resident information. **B.** Social Services will inservice all residents at a resident council meeting regarding their rights to privacy and their ability right to ask staff for privacy consideration at any time and to take their concerns to Social Services or Administration at any time. Administrator will review all posted documents to ensure no personal confidential information is available to the public. Any confidential information identified will be immediately removed by Administrator. **C.**All staff will be inserviced by Social Service Director regarding the need to provide privacy during cares for all residents. Staff will be inserviced that privacy curtains and window curtains should be drawn, corridor doors and bathroom doors should be shut. Staff should consider privacy prior to beginning any resident care.	

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F 164	Continued From page 2 the binder that contained the posted survey results from the previous years survey included confidential resident information. Included with the public survey results was a "Confidential-For Facility Use Only- Do Not Post" resident sample list. This list showed the names of 12 residents some of whom still resided at the facility. The resident names were listed for the facility's use in identifying the resident by number which was how they were referred to for confidential measures in the survey report. Interview with the administrator on 9/26/12 at 5:55 PM revealed she was unaware the confidential information had been included as part of the public information and she immediately removed it.	F 164	Social Service was immediately inserviced by Administrator regarding posted survey should never include Confidential resident information. D. Monitored by Director of Nursing and Social Services through quarterly Quality Assurance reporting.	11/21/12
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 resident and staff interview the facility failed to provide dignity and respect related to personal property for 1 of 9 sample residents (#21). In addition, the facility failed to ensure staff treated residents with respect based on confidential interview with 1 sample resident and 9 non-sample residents. The findings were: 1. Interview with resident #21 on 9/26/12 at 8:20 AM revealed s/he was upset because staff had come into his/her room that morning and removed the personal mattress that was on the	F 241	**This facility will ensure that it maintains an environment that enhances dignity and respect of all residents.** A.1) Social Services will visit with resident #21 regarding her concerns about the mattress being removed from her room. Social Service will assist the resident in completing a Grievance Form and Grievance Form will be reviewed by Care Plan Team and Administrator to ensure resident's concerns are addressed and care planned as appropriate. 11/21/12	

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F 241	Continued From page 3 bed. The resident stated s/he was seated in the recliner in the room as the staff were working, and they would not answer him/her as to why they needed to remove the mattress and change it out, or where they were moving it to. Interview with the resident later that day at 2:05 PM revealed the resident talked to DON #1 about the issue, and found out why the mattress was changed and where the mattress was moved to. The resident stated s/he now understood why it was changed; however, the resident felt the staff in the morning were "disrespectful not telling [him/her] what they were doing with [his/her] things." Interview with DON #1 on 9/27/12 at 9:20 AM verified the resident had voiced his/her concern and after the DON explained the situation the resident expressed understanding. The DON stated the resident had also expressed to her, feeling disrespected and upset at how s/he had been treated by the staff. 2. Confidential interview with 10 residents (1 sample and 9 non- sample) during the survey from 9/24/12 to 9/27/12 revealed they felt that sometimes aides were "disrespectful" further stating it was based on "their tone of voice and the way they talk to you." Interview with DON #1 on 9/27/12 at 9:20 AM verified she had small inservice meeting with staff as needed to discuss issues such as respect and dignity.	F 241	2) Social Services will address all residents in Resident Council meeting. She will address the issue of respect and dignity and empower all residents to know that they may voice their specific concerns to Social Services or Administration at any time. A Grievance Form will be started and concerns addressed through Care Plan Team and Administrator. **B.** Social Services will inservice all residents at a resident council meeting regarding their rights to dignity and respect. Any concerns identified during resident council meeting will have Grievance Form started immediately and Grievance will be addressed by Care Plan Team and Administrator for appropriate intervention. **C.** Social Service and Administrator will inservice all staff regarding protecting the dignity of a resident and showing respect to all residents at all times.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279	**This facility will ensure accurate and appropriate care plans are developed to meet a resident's medical, nursing, mental and psychosocial needs as identified in a comprehensive assessment.**	

F241 Continued

Social Service will develop a new facility policy related to Grievance Procedures. Grievance Forms will be filled out with each resident complaint and policy followed through to appropriate intervention.

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D. Monitored by Social Services through quarterly quality assurance reporting of grievances. 11/21/12

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F 279	Continued From page 4 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure care plans were developed for 2 of 10 sample residents (#15, #21). The findings were: 1. Review of the 7/8/12 significant change MDS assessment for resident #21 showed several areas triggered for further assessment. The areas for nutrition status and dehydration/fluid maintenance were assessed and a decision was made to care plan these areas; however, review of the 7/30/12 care plan showed these areas were not addressed. Interview with DON #1 on 9/27/12 at 9:20 AM verified there were interventions in place, but the areas were not addressed in the residents care plan. 2. Review of the 7/9/12 quarterly MDS assessment for resident #15 revealed s/he had	F 279	**A.** Resident #21 will have comprehensive assessment reviewed by DON #1. All areas triggered for further assessment will have further assessment performed. Assessments will result in appropriate interventions care planned. Resident #15 will have bladder assessment review done by DON #2 and further assessment performed as appropriate. Bladder assessment will result in appropriate interventions care planned for this resident. **B.** Care Plan Team will review all comprehensive assessments. Any assessment noted to require further assessment will have additional assessments performed by appropriate discipline. Results of assessment will be evaluated for appropriate interventions and inclusion in care plan. **C.** Care Plan Team will use assessment process as an inservice tool to ensure all comprehensive assessments result in further detailed assessment as necessary and all identified interventions care planned. **D.** Monitored by DON through quarterly QA reporting of care plan review.	11/21/12

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F 279	Continued From page 5 occasional urinary incontinence and required extensive assistance with toileting. From 1:34 PM until 4:40 PM on 9/26/12, the resident was observed in the dining room, visiting with family and sitting in the lobby. During the observation (a time period of over three hours) staff did not check, change or offer toileting assistance. At 4:40 PM, CNA #2 assisted the resident to the bathroom and removed his/her urine soiled disposable brief. During an interview at that time, the CNA stated staff reminded the resident to go to the bathroom at various times during the day, but there was no scheduled intervals. Interview on 9/27/12 at 9:35 AM with DON #2 revealed staff should be aware of prolonged periods without toileting for this resident because s/he received twice daily doses of Lasix (a diuretic). She also stated the resident's toileting needs should have been addressed in the care plan, but it had not been done.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280	**This facility will ensure care plans are revised to reflect a resident's current status.** A. Resident #35 will have comprehensive assessments reviewed by DON #1 with special attention made to swallowing evaluation and assessment. DON will determine appropriate interventions and additions to the care plan.	

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F 280	Continued From page 6 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, medical record review and staff interview, the facility failed to ensure care plans were revised to reflect the current status of 2 of 10 sample residents (#25, #35). The findings were: 1. Review of the 2011 and 2012 MDS assessments for resident #35 revealed s/he did not have swallowing difficulties until June 2012. Review of the 6/18/12 nursing assessment and 9/10/12 significant change MDS revealed the resident had episodes of coughing/choking during meals and when swallowing medications. According to the nursing documentation in the medical record, the resident had a choking episode in the dining room on 9/16/12 at 8 AM. Review of the June to September 2012 IDT documentation showed the swallowing difficulties were not addressed by the team. Review of the care plan showed only one intervention that addressed safety concerns related to swallowing problems was developed in the three months after the problem was first identified. Further review showed the one intervention which was "assess while swallows pills for safety", was not added to the care plan until 9/11/12. An interview with DON #1 on 9/27/12 at 8:45 AM revealed staff had discussed implementing safety measures like positioning, using a suction machine, providing	F 280	Resident #25 will have comprehensive assessments reviewed by DON #1 with special attention made to toileting needs of this resident. DON will determine appropriate interventions and care plan will be updated to reflect resident toileting needs. B. DON will review all resident's comprehensive assessments. Any assessment identified as triggering a need will have further assessment done by appropriate discipline. Care Plan Team will review all assessments and appropriate interventions will be determined and care plan updated as appropriate. C. DON's will use the process of comprehensive assessment review through to appropriate care planning as an education tool to ensure all residents have an appropriate care plan in place to lead all staff in best care for all residents. D. Monitored by Director of Nursing through quarterly Quality Assurance reporting of comprehensive assessment and care plan review.	11/21/12

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F 280	Continued From page 7 close supervision at meal time, and staff education. At that time she stated some of these measures were implemented at various time, but none of the measures had been incorporated into the care plan to provide a uniform, consistent, and systematic approach for staff. 2. Review of the medical record for resident #25 showed s/he was transported to the hospital on 12/31/12 after s/he fell and fractured his/her femur. Further review showed s/he had surgery and was readmitted to the facility on 1/11/12. Review of the January 2012 to April 2012 nurses notes revealed the resident was readmitted with a urinary catheter that was discontinued on 4/24/12. Review of the June 2012 to September 2012 nurses notes showed staff found the resident on the floor on 6/21/12 and 8/22/12. This review also showed no serious injuries were sustained from either incident. Interview with the resident's family member on 9/27/12 at 10:45 AM revealed each time the resident fell it was during an attempt to go to the bathroom without staff assistance. This family member also stated the resident only attempted this when s/he observed the opened bathroom door. Review of the 8/22/12 nurses notes showed when staff found the resident on the floor, the bathroom door was open. Periodic observations on 9/26/12 and 9/27/12 revealed a sign posted on the bathroom door directing staff to keep the bathroom door closed at all times. Review of the 7/2/12 quarterly MDS showed the resident had moderate cognitive impairment, required extensive assistance with toileting, and was frequently incontinent. Review of the care plan, revised on 7/31/12, showed interventions for toileting were not addressed and information	F 280		

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F 280	Continued From page 8 regarding the posted sign on the bathroom door was lacking. During an interview on 9/27/12 at 8:45 AM, DON #1 verified the signage on the bathroom door was a reminder for the resident to call staff for assistance with toileting. The DON further stated the care plan should have been revised to include interventions that addressed the resident's toileting needs.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to provide care to promote continence for 1 of 5 sample residents (#15) who had urinary incontinence. The findings were: Review of the 7/9/12 quarterly MDS for resident #15 revealed s/he had occasional urinary incontinence and required extensive assistance with toileting. Continuous observations on 9/26/12 from 1:34 PM to 4:40 PM showed staff did not offer assistance or direct the resident to the bathroom during that time. At 4:40 AM, CNA #2	F 315	**This facility will ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.** **A.** Resident #15 will have comprehensive bladder assessment done by DON. Comprehensive assessment will result in further assessment to determine most appropriate interventions for this resident. Interventions will be care planned. **B.** DON will review all resident's comprehensive bladder assessments. Any identified to have triggered concern in the area of bladder continence will have further assessment done by DON to determine most appropriate interventions for each resident. Interventions will be added to care plans.	

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F 315	Continued From page 9 removed the urine soiled disposable brief when she assisted the resident to the bathroom. At that time, the CNA verified the resident had not received toileting assistance since before 1:34 PM (three hours time elapsed). The CNA further stated staff reminded the resident to go to the bathroom at various times during the day, but there was no scheduled intervals. Interview on 9/27/12 at 9:35 AM with DON #2 revealed staff should be aware of prolonged periods without toileting for this resident because s/he received twice daily doses of Lasix (a diuretic). She also stated the resident's toileting needs should have been addressed in the care plan, but it had not been done.	F 315	C. DON will use comprehensive assessment review as training tool for developing appropriate care plan based on resident need. DON will inservice certified nursing assistants regarding the need to always toilet a resident known to be incontinent frequently. D. Monitored by DON through quarterly Quality Assurance reporting of assessment and care plan review.	11/21/12
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 record review and staff interview, the facility failed to complete post fall evaluations for 3 of 3 sample residents (#18, #25, #31) who had recurrent falls. The findings were: Interview on 9/26/12 at 4:55 PM with the risk manager revealed the facility did not have a system for evaluating each fall to determine effective measures to prevent recurring incidents.	F 323	**This facility will ensure that the resident environment remains free of accident hazards.** A.Risk Manager will complete post fall evaluations for resident #18, #25, and #31. Residents #18, #25 and #31 will be evaluated for continued falls and new plans of care developed with new interventions if previous interventions have proven ineffective.	

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F 323	Continued From page 10 The risk manager further stated the policy regarding falls required staff to follow up each incident with a physical assessment, but did not include directions to review medications, environment or other factors that might or might not have contributed to the incident. During an interview on 9/28/12 at 11:25 AM, the social services director verified the lack of a system. Review of the medical record for resident #25, showed s/he fell and fractured his/her femur on 12/31/12. Further review showed s/he fell again on 6/21/12 and 8/22/12, but no injuries were sustained. Review of the medical record for resident #18 showed s/he had sustained minor injures when s/he fell on 6/25/12, 7/22/12, and again on 9/9/12. According to nursing documentation for resident #31, s/he fell on 7/29/12 and again on 08/28/12. Review of the annual January to August 2012 management reports of falls and incidents showed six to fourteen residents had fallen each month and one or more of these resulted in injury. Review of these reports also showed no evidence of a system for evaluating each incident to determine contributing factors and identifying measures to prevent repeated falls.	F 323	**B.** All residents will be reviewed for falls in the past 6 months by Risk Manager. Any resident identified as having a fall in the past 6 months will have a post fall evaluation completed. These same residents will be evaluated for continued fall risk and new plans of care developed with new interventions if previous interventions have proven ineffective. **C.** Risk Manager will develop a new post fall evaluation policy which will include evaluating each fall to determine effective measures and post fall tracking to ensure minimized risk of recurring incident. Post fall evaluation will include physical assessment, medication review, environmental review at a minimum. Policy will include incremental follow-up post fall tracking reviews to determine effectiveness of last intervention.	
F 371 SS=L	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**This facility will ensure food is stored, prepared, distributed and served under sanitary conditions.** **A.**Upon identification of low rinse temps in the dishwasher, Administrator put an immediate Action Plan in place which included:	

F323 Continued

D. Monitored by Risk Manager through quarterly Quality Assurance reporting of fall evaluation and tracking results. 11/21/12

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BONNIE BLUEJACKET MEMORIAL NURSING HOME	398 SOUTH US HWY 20 BASIN, WY 82410

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F 371	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility procedures and service records, the facility failed to implement a system that ensured dietary staff were knowledgeable regarding the importance of taking action to correct inadequate final rinse temperatures of the dish machine and implementing alternatives to ensure resident dinnerware and utensils were effectively sanitized to minimize the potential for food-borne illness. When tested during the survey it was determined the temperature of the dish machine rinse water was not sufficient to sanitize. Review of the rinse temperature logs showed the recorded hot rinse temperatures had been inadequate for six months; however, the problem was not resolved nor were there any alternative sanitation methods used during those times. Therefore this resulted in immediate jeopardy for all residents of the facility. The census was 33. The findings were: Review of the September 2012 dish machine log showed the hot water rinse temperature was recorded 3 times most days and as of 9/24/12 sixty-two of the recorded temperatures were less than the required 180 degrees F to sanitize the dishes and utensils, 39 of those times, the temperatures were less than or equal to 160 degrees F. Interview with the certified dietary manager (CDM) at 4:20 PM on 9/24/12 revealed she was aware of the low hot water temperatures on the log, and reported it had been a problem for the last six months. Continued interview with the CDM revealed the recorded temperatures were taken by looking at a temperature gauge located	F 371	1) All dishes used at the last meal were washed using 3 sink washing/sanitizing system. Dietary staff inserviced regarding proper sanitizing procedures for 3 wash sink sterilization and resident/ patient dinnerware use. 2) Dish machine service was called for dish machine repair and intervention. 3) Dish machine service determined best action was to install sanitizing rinse injector to the dishwasher. 4) Quality assurance monitoring study put in place to ensure proper sanitation. Dishwashing machine was repaired September 24, 2012 (sanitizing rinse injector added to machine). **B.** Dishwashing machine will be tested 3x daily by dietary staff. Infection Control Coordinator will do chemical testing once per week to ensure same test results are being obtained by dietary staff and Infection Control.	

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F 371	Continued From page 12 on the outside of the dish machine. The manager then verified an internal temperature was not taken to her knowledge in the past six months, neither by using a temperature strip indicator or a holding thermometer. She further revealed there was no alternative used to sanitize the dishes when the machine was known not to be working properly. She stated she "hoped" it was a problem with the temperature gauge. The manager also stated there were a couple of times when the maintenance director worked on the machine and was not successful in getting the water to maintain a sufficient temperature (180 degrees F) to sanitize. However, she did not know of anything else that was done to fix the problem. Review of the past six months of temperature logs showed the following number of times the dish machine rise temperature was recorded as 160 degrees F or lower: a. 10 times ineffective temperatures were recorded in April 2012. With low temperatures ranging from 145 degrees to 160 degrees F. b. 6 times the temperatures were low in May 2012 with the low temperatures ranging from 155 degrees to 160 degrees F. c. 12 times the temperature was recorded to be too low in June 2012 with the temperatures ranging from 150 to 160 degrees F. d. 25 times in July 2012 with the temperatures ranging from 120 to 160 degrees F. e. 42 times in August 2012 with the temperatures ranging from 120 to 160 degrees F. f. 39 times as of September 24, 2012 with the temperatures ranging from 115 to 160 degrees F. A test of the internal dish machine hot water temperature was done on 9/24/12 at 5:20 PM by the surveyor and witnessed by the CDM. The test	F 371	If at any time, testing results prove to be less than adequate for sanitization of dishes, dietary manager will immediately put process in place, including using paper dishes, implementing 3-sink sanitization procedure, notifying Administrator, notifying dishwasher vendor, to ensure the safety of all residents/patients. Registered Dietician will review results of sanitization testing weekly and will note results in Dietician report. C. A new policy has been developed by Administrator to ensure appropriate testing of dish machine and to ensure appropriate actions taken if machine fails to meet sanitization requirements. Infection Control Coordinator will inservice all dietary staff to include Registered Dietician regarding the need to identify and report any and all sanitation concerns to Administrator immediately and to immediately implement actions to ensure resident/patient safety. Infection Control Coordinator will evaluate all processes within the facility which have the potential to spread disease or infection and will implement appropriate procedures as necessary.	

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F 371	Continued From page 13 was performed using indicator stickers (thermolabels) designed to turn black when the dish surface reaches 160 degrees F when run through the dish machine cycle (160 degrees F at the rack level/dish surface reflects 180 degrees F at the manifold, which is the area just before the final rinse nozzle where the temperature of the dish machine is measured). During two tests of the dish surface temperature, the thermolabels failed to turn black. According to Food Code 2009, U.S. Public Health Service: 4-501.112 "(A) Except as specified in ¶ (B) of this section, in a mechanical operation, the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be more than 90oC (194oF), or less than... (2) For all other machines, 82oC (180oF)." The following additional concerns were noted related to a lack of action taken to the known problem with the dish machine and the susceptibility of the population being served: According to Food Code 2009, U.S. Public Health Service: "Highly susceptible population means PERSONS who are more likely than other people in the general population to experience foodborne disease because they are: (1) Immunocompromised...or older adults; and (2) Obtaining FOOD at a facility that provides services such as...health care, or assisted living...adult day care center, kidney dialysis center, hospital or nursing home..." 1. Interview with cook #1 on 9/24/12 at 6:20 PM revealed she used the dish machine most days and the rinse temperature was usually between 142 and 160 degrees F. She stated she used the external temperature gauge to read the	F 371	D. Monitored by Dietary Manager and Infection Control Coordinator through monthly Quality Assurance reporting of dishwasher sanitization results for one quarter and then quarterly if it is determined by QA Committee that appropriate changes and appropriate sanitization has occurred.	10/11/12

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F 371	Continued From page 14 temperature and would record it on the sheet. She further verified the dish machine continued to be used even when ineffective temperatures were being seen. She stated she reported the problem many times and the maintenance director tried to make adjustments; however, the temperatures remained a problem. 2. Review of the facility's chemical supply company orders/invoices showed the supplier would sometimes test the condition of equipment when checking inventory levels. Review of these order/invoices on 9/14/12, 6/19/12, and 4/10/12 showed the dish machine was checked on these dates and the final rinse temperature was recorded respectively as 170, 160, and 170 degrees F. Further review of these reports showed although the temperatures were not adequate to sanitize, there was nothing documented in the comments or results section to recommend any changes or further action to be taken. Additionally it did not indicate how the temperatures were taken. 3. Interview with the consultant registered dietitian (RD) on 9/26/12 at 9:20 AM revealed he sometimes checked the equipment when he was on-site. He stated if a problem was noticed or brought to his attention, he would document the concern or recommendations in his report, or sometimes just discuss it with the dietary manager. He verified he was not aware of the length of time the dish machine temperatures had been problematic. Review of the RD monthly reports from April to September 2012 showed no mention of this sanitation problem except on September 5, 2012. In this report the RD recognized the final rinse temperature of the dish	F 371		

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F 371	Continued From page 15 machine was a problem noting it was low at 150 degrees F. His note recommended re-checking the temp 2-3 more times and referring to the sanitation regulations or the manufacture recommendations. However, interview with the administrator on 9/26/12 at 4 PM verified there was no follow-up to this report to show if corrective measures where implemented. On 9/24/12 at 6:50 PM, the administrator was notified of the immediate jeopardy. The facility's action plan included immediate changes to include: a. Use of a 3 compartment manual method to sanitize dishes/utensils, and use of disposable items for meal services for all meals for the next 48 hours. b. Education to all nursing and dietary staff related to the disposable service ware, and manual dish washing/sanitizing method for all dietary staff. c. Service call to the equipment manufacture to repair the dish machine. d. A quality assurance monitoring study was put into practice related to the manual sanitation of the dishes. The action plan was accepted on 9/26/12 at 5:20 PM, and the immediate jeopardy was removed at 5:30 PM.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	**This facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection.**	

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F 441	Continued From page 16 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and label information the facility failed to ensure staff effectively disinfected the point-of-care glucometer for 2 of 2 observations of resident testing. The findings were:	F 441	A. Resident #1 and resident #15 will have new single patient use glucometers purchased and new glucometer will be used only on the individual resident. B. DON will identify all residents needing glucometer testing. Each resident needing testing will have new single patient use glucometer purchased and new glucometer will be used only on an individual resident. Each glucometer will be labeled. C. Infection Control Coordinator will develop a new policy regarding glucometer use and disinfecting. All nursing staff will be inserviced by Infection Control Coordinator regarding new policy and appropriate use and disinfecting of the glucometer. D. Monitored by Infection Control Coordinator through quarterly Quality Assurance reporting of glucometer use and disinfecting review.	11/21/12

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F 441	Continued From page 17 Observation on 9/26/12 at 3:50 PM showed LPN #1 cleansed the glucometer with alcohol after obtaining blood glucose results for resident #1. Continuous observation revealed the LPN used the same alcohol cleansed glucometer to obtain blood glucose results for resident #15 at 4:15 PM. Interview with the LPN at that time revealed cleansing the glucometer with alcohol wipes between resident use was the accepted standard of practice for the facility. Interview with DON #1 on 9/27/12 at 9:25 AM revealed she had received information about about effective disinfectants like PDI Sani-Cloths but she had not had an opportunity to share this information with other staff . Review of the manufacturer's recommendation revealed the device should be cleaned to remove blood or solid from the the surface and disinfected to destroy infectious agents on the surface after each use. According to recently released guidance by the Food and Drug Administration (FDA) at www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/InVitroDiagnostics/ucm227935.htm (accessed 10/4/12) for cleaning and disinfecting of blood glucose meters,"...The disinfection solvent you choose should be effective against HIV, Hepatitis C, and Hepatitis B virus.: Further, "Please note the 70% ethanol solutions are not effective against viral blood borne pathogens."	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520	**This facility will maintain a quality assessment and assurance committee to identify and correct quality deficiencies.**	

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F 520	Continued From page 18 facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of quality assurance program information, the facility failed to ensure identified sanitation issues in the dietary department were monitored and corrected. The findings were: Review of the September 2012 dish machine log showed the hot water rinse temperature was recorded 3 times most days and as of 9/24/12 sixty-two of the recorded temperatures were less than the required 180 degrees F to sanitize the dishes and utensils. Interview with the CDM at 4:20 PM on 9/24/12 revealed she was aware of the low hot water temperatures on the log, and stated it had been a problem for the last six	F 520	**A.** Dietary Manager will ensure daily testing of dish machine is done during dish washing at each meal. Dietary Manager will report results of testing to Quality Assurance Committee monthly x3 months and then quarterly if it is determined that sanitization and reporting is being maintained appropriately. **B.** Quality Assurance Committee will develop a schedule with each department to identify possible processes which may result in resident/patient infection/ disease risk. For any risk identified, the department manager will develop a quality monitoring tool and will monitor and report results to Quality Assurance Committee quarterly. **C.** Quality Assurance Coordinator will be inserviced by Administrator regarding Quality Assurance process to include identification of facility quality issues; study of the identified issues; resulting in developing and implementing appropriate action plans to improve quality; and continued study for effectiveness of interventions.	

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F 520	Continued From page 19 months. Continued interview with the CDM revealed the recorded temperatures were taken by looking at a temperature gauge located on the outside of the dish machine. The manager further revealed there was no alternative used to acquire a temperature or to sanitize the dishes when the machine was known not to be working properly. She stated she "hoped" it was a problem with the temperature gauge. The manager also stated there were a couple of times when the maintenance director worked on the machine at her request and was not successful in getting the water to maintain a sufficient temperature (180 degrees F) to sanitize. She further revealed she did not know of any other actions taken to fix the problem. Interview with the administrator and the quality assurance (QA) coordinator on 9/26/12 at 5:30 PM verified the dietary department participated in the QA program. However, there was not any specific measure identified, being tracked, or being reported related to kitchen sanitation issues. Review of the QA program information showed the information being collected and reported was on nutrition screening and other medical nutrition topics. Further, the administrator verified the issue of the dish machine was something that should have been reported on and sanitation issues such as that should be routinely monitored and incorporated into the QA program. The following additional concerns were noted related to a lack of action taken to the known problem with the dish machine: 1. Interview with cook #1 on 9/24/12 at 6:20 PM revealed she used the dish machine most days	F 520	Quality Assurance Committee will be inserviced by Infection Control Coordinator regarding the need to be aware of any processes within the facility that may cause risk of spread of disease or infection. Identification of potential risks will result in department monitoring and reporting. Any substandard results will result in immediate intervention to remedy the risk. Infection Control Coordinator will work with departments to develop a list of appropriate reporting. D. Monitored by Infection Control Coordinator through monthly Quality Assurance Committee reporting of infection/disease process review. Dietary Manager and Infection Control Coordinator will review all cleaning and sanitizing process in the dietary department and Dietary Manager will monitor all identified processes and report to Quality Assurance Committee quarterly. All departments will report disease and/or infection risk processes to Quality Assurance Committee	11/21/12

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F 520	Continued From page 20 and the rinse temperature was usually between 142 and 160 degrees F. She stated she used the external temperature gauge to read the temperature and would record it on the sheet. She further verified the dish machine continued to be used even when ineffective temperatures were being seen. She stated she reported the problem many times and the maintenance director tried to make adjustments; however, the temperatures remained a problem. 2. Review of the facility's chemical supply company orders/invoices showed the supplier would sometimes test the condition of equipment when checking inventory levels. Review of these order/invoices on 9/14/12, 6/19/12, and 4/10/12 showed the dish machine was checked on these dates and the final rinse temperature was recorded respectively as 170, 160, and 170 degrees F. Further review of these reports showed although the temperatures were not adequate to sanitize, there was nothing documented in the comments or results section to recommend any changes or further action to be taken. Additionally it did not indicate how the temperatures were taken. 3. Review of the registered dietitian (RD) monthly reports from April to September 2012 showed no mention of this sanitation problem except on September 5, 2012. In this report the RD recognized the final rinse temperature of the dish machine was a problem noting it was low at 150 degrees F. His note recommended re-checking the temp 2-3 more times and referring to the sanitation regulations or the manufacture recommendations. However, interview with the administrator on 9/26/12 at 4 PM verified there	F 520		

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F 520	Continued From page 21 was no follow-up to this report to show if corrective measures where implemented.	F 520		