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

4/13/15

PRINTED: 03/11/2015
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
	535029	A. BUILDING _____ B. WING _____	02/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	713 OAK STREET SUNDANCE, WY 82729

(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 The following common abbreviations are used throughout this document: CNA - Certified Nurse Aide DON - Director of Nursing MDS - Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000	Crook County Medical Services District (CCMSD) Long Term Care (LTC) strives to ensure that our residents have the least restrictive method possible to treat their medical symptoms. Residents #6 and #26 had safety assessments conducted, restraint release schedules implemented and care plans updated to reflect treatment of their targeted medical symptoms.	4/10/2015
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview and policy and procedure review, the facility failed to assess physical restraints to ensure they were the least restrictive method to treat medical symptoms for 2 of 2 sample residents (#6, #26) who used restraining devices. The findings were: 1. Review of the 2/12/15 quarterly MDS assessment showed resident #26 required extensive assistance for bed mobility, ambulation, and transfers. Review of physician's orders showed the resident had an order dated 10/1/13 for a lap buddy while up in wheelchair as needed related to Alzheimer's disease. The following concerns were identified: a. Observation on 2/24/15 at 9:15 AM showed	F 221	All the residents that require the use of restraints will have a safety assessment conducted, a release schedule implemented and the care plan will reflect the goals and interventions for that restraint. Education will be provided to LTC staff regarding assessment, documentation and safe use of restraints. All restraints will be monitored by Assistant Director of Nursing (ADON) / Director of Nursing (DON) using an audit tool, weekly for six weeks to ensure appropriate assessments were done, release schedules were followed and care plans are updated to reflect the interventions and goals for that resident. Any deviations will be corrected immediately and education provided at the time of occurrence. Will be reported quarterly to Quality assurance	

changed w/ NHA 4/13/15 on JB

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

CEO 3-20-2015

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.

RECEIVED
WY Dept of Health
MAR 20 2015
Healthcare Licensing and Surveys

Accepted w/ changes pg 1 + 4
spoke w/ Jeff Mengenhausen Regarding changes on 4/13/15 @ 1:30pm
DOC: 4/10/15

RR 4/3/15

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F 221	Continued From page 1 the resident was up in his/her wheelchair near the nurse's station with a lap buddy in place. An activity was being conducted a short distance away. The resident was not assisted or offered to participate in the activity, but remained near the nurse's station with the lap buddy in place throughout the time of the activity. b. Observation on 2/24/15 at 10:06 AM showed the resident was assisted to the restroom and the lap buddy was removed. Continued observation showed that upon completion of personal care, the resident was placed back in the wheelchair and the lap buddy was re-applied. c. Observation on 2/24/15 at 10:39 AM showed the resident was propelling him/herself in the wheelchair, with the lap buddy in place, near his/her room and was redirected by another resident. d. A nurse's note written on 2/24/15 stated the resident required a lap buddy for poor safety awareness and to prevent falls, however, no indication of a safety assessment, release schedule, or care plan was identified in the medical record. e. Interview with CNA #1 at 2/25/15 PM at 1:55 PM revealed the resident was unable to remove the lap buddy. f. Interview with the DON and unit manager on 2/26/15 at 9:04 AM revealed the lap buddy was to prevent the resident from falling, the resident could not remove it on demand, and the facility did not have a "good assessment for lap buddies". Further interview at that time revealed the facility had not determined when to release the lap buddy. 2. Review of the 12/2/14 quarterly MDS assessment showed resident #6 required extensive assistance for bed mobility, ambulation,	F 221	Please see page 1 for plan of correction.	

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F 221	Continued From page 2 and transfers. Review of the 8/12/14 wheelchair seating assessment showed the resident used a "lap buddy" cushion on the wheelchair to keep the resident from sliding out of the wheelchair. The assessment also showed the resident was able to remove the lap buddy cushion. The following concerns were identified: a. The 6/3/14 revised care plan related to falls and safety awareness showed a "lap buddy" was to be used in the wheelchair for positioning. "[The resident's name] frequently falls asleep in the wheelchair and slides out." b. Observation on 2/23/15 at 10:35 AM showed the resident was not utilizing the lap buddy and was transferred from the wheelchair into the bathroom with the assist of one staff member. Review of the care plan dated 6/3/14 showed the resident had behaviors which included "hollering and trying to get up." Interventions included an alarm attached to the resident to alert staff at attempts to rise. c. Interview with CNA #2 on 2/24/15 at 10:35 revealed the lap buddy in the resident's room was used when needed to keep the resident in the wheelchair. d. Observation with CNA #3 and CNA #4 on 2/25/15 at 11:45 AM showed the resident was unable to remove the lap buddy when applied to the wheelchair. Interview with these staff members at that time revealed the lap restraint was used for the resident as needed to keep him/her in the chair. 3. Review of the facility policy entitled, "Use of Restraints," revised February 2014, showed "Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. The policy further defined	F 221	Please see page 1 for plan of correction.	

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F 221	Continued From page 3 restraints as "any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body." 4. Interview with the unit manager, DON, and the MDS coordinator on 2/26/15 at 9:10 AM revealed they had discussed the use of the lap buddy devices for these residents and had not considered them restraints. They also verified, although these residents were not safe to do so, both residents were able to stand if the device was not in place.	F 221	Please see page 1 for plan of correction.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the	F 225	CCMSD strives to provide a safe environment free of abuse, neglect and maltreatment, including bruises of unknown origin. An investigation will be done on residents #26 and #28 and results will be reported to that Wyoming State Licensing Division. Staff will be educated on how to identify, document and report suspected signs of abuse, neglect and maltreatment. All alleged incident involving mistreatment, neglect or abuse, including injuries of unknowns source are reported to the administrator of the facility and to other officials in accordance with WY State law and Federal law, an investigation will be conducted with results reported to the WY State Licensing Division. Correction action is done immediately. (Continued on next page "5")	4/10/2015

Changes for WHH on 4/13/15

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F 225	Continued From page 4 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, incident report review, staff interview, and policy and procedure review the facility failed to ensure injuries of unknown origin were identified, reported, and investigated for 2 of 2 sample residents (#26, #28) with injuries of unknown origin. The findings were: 1. Medical record review showed resident #26 had a head to toe skin assessment dated 1/30/15 that revealed the resident "has bruises on [his/her] right hand near thumb and right medial wrist, they appear to have been there for a couple days." Review of facility incident reports failed to show any report or investigation of this injury. Interview with the DON on 2/26/15 at 9:04 AM revealed the facility was to fill out incident reports on bruises of unknown origin and confirmed no report was completed for this injury.	F 225	(Continued from page "4") Alleged abuse or neglect incidents will be tracked using a log which will be discussed weekly at out Inter-Disciplinary Team (IDT) meetings, which are reported quarterly to the Quality Assurance and Performance Improvement (QAPI) Committee, with follow-up to be determined by the QAPI Committee.	

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F 225	Continued From page 5 2. Review of a nursing note dated 1/24/15 showed resident #28 had a "large bruise on left ribs, unsure how bruise happened." Review of facility incident reports failed to show any report or investigation of this injury. Interview with the DON on 2/26/15 at 9:04 AM revealed the facility was to fill out incident reports on bruises of unknown origin and confirmed no report was completed for this injury. 3. Review of the facility policy entitled "Abuse Investigations," revised February 2014, showed "All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management."	F 225		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure maintenance services were implemented to repair walls in 3 of 3 resident areas (2 resident hallways, dining room). The findings were: Observation on 2/25/15 at 2:30 PM showed the following walls in need of repair: a. Resident room 210 showed a hole in the wall near the bed and window. The hole was 6.5 inches long by 4 inches wide. Additionally, under the window there was a scrape on the wall which was 10 inches in length.	F 253	CCMSD strives to provide a sanitary, orderly and comfortable interior for our residents. Repairs will be made to room 210 walls, outside of room 217 and the walls surrounding the dinning room and across from the bathing room. Monthly facility inspections will be done using an audit tool by LTC staff and will have the appropriate follow up done by maintenance to ensure proper upkeep. This will be reported to the QAPI Committee quarterly with the appropriate follow-up to be determined by the QAPI Committee.	4/10/2015

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F 253	Continued From page 6 b. Outside of the doorway of resident room 217 there was an area on each side of the doorway where the paint was peeled away. Each damaged area measured 20 inches in length. c. Along the bottom part of the white wall in the dining room there were six areas where the paint was scraped off. Additionally, the red-colored wall in the dining room had areas with scraped paint near the beverage area. These areas were 3 inches long and 1 to 2 inches wide. d. The wall across the hallway from the resident "bath" room had an area 20 inches long and 2 inches wide which was scraped. e. Interview with The DON on 2/26/15 at 9:45 AM revealed the maintenance director resigned in January 2014. The current staff that were available to complete maintenance projects such as painting were back-logged with work orders.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	F 278	CCMSD Strives to ensure all care plans and MDS's accurately reflect the needs of our residents. Resident #26 will have their care plans updated to reflect the need, use and goals of restraint usage. All Resident requiring restraint use will have accurately coded MDS and a care plan in place that will reflect the need, use and goals of the restraint.	4/10/2015

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F 278	Continued From page 7 subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure the MDS assessment was accurate for 1 of 9 sample residents (#26). The findings were: Review of the 2/12/15 quarterly MDS assessment showed resident #26 had diagnoses that included hip fracture, Alzheimer's disease, and anxiety disorder. Medical record review showed the resident had a physician's order dated 10/1/13 for a lap buddy while up in wheelchair as needed related to Alzheimer's disease. The following concerns were identified: a. Observation on 2/24/15 at 9:15 AM showed the resident was up in his/her wheelchair near the nurses' station with a lap buddy in place. Observation on 2/24/15 at 10:06 AM showed the resident was assisted to the restroom and the lap buddy removed. Continued observation showed that upon completion of personal care, the resident was placed back in the wheelchair and the lap buddy was re-applied. Observation on 2/24/15 at 10:39 AM showed the resident was propelling him/herself in the wheelchair, with the lap buddy in place, near his/her room and was	F 278	The MDS coordinator will receive education on restraint use, definitions, and coding requirements using the RAI Manual. MDS's will be audited monthly for three months by DON/ADON using and audit tool to ensure accurate coding of restraint use. Any deviances will be corrected immediately and education provided. Results will be reported to the QAPI Committee quarterly, with follow-up to be determined by the QAPI Committee.	4/10/2015

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F 278	Continued From page 8 redirected by another resident. b. Review of the quarterly MDS assessment showed the resident was not coded as having a restraint. c. Interview with CNA #1 on 2/25/15 at 1:55 PM revealed the resident was unable to remove the lap buddy. d. Interview with the DON and Unit Manager on 2/26/15 at 9:04 AM revealed the lap buddy was to prevent the resident from falling and the resident could not remove it on demand.	F 278		
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 observation, staff interview and medical record review, the facility failed to ensure enabler bars were assessed for safety for 3 of 3 sample residents (#6, #24, #26) who used enabler bars, and failed to ensure gait belts were used during 3 of 3 manual transfers for 1 non-sample resident (#3) and 1 sample resident (#16). The findings were: 1. Review of the 12/2/14 quarterly MDS assessment showed resident #6 was cognitively impaired with a brief interview for mental status (BIMS) score of 3/15. The resident was confused	F 323	CCMSD strives to ensure that our facility environment is free of accident hazards and our resident receive adequate supervision and assistive devices to prevent accidents. Residents #6, #24 and #26 had safety assessments completed to ensure appropriateness of assistive devices. Resident #3 and #16 had transfer assessments completed. All residents will have safety assessments completed prior to the use of assistive devices, appropriate for the intended device. Care plans will be updated to reflect individual interventions that are appropriate. All LTC staff will receive education on the proper use of gait belts and enabler bars used for assistance with transfers and positioning. Weekly monitoring will be done by the DON/ ADON, using an audit tool for six weeks to ensure appropriate use and documentation of assistive devices. Any deviances will be corrected immediately and education provided.	4/10/2015

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F 323	Continued From page 9 and had diagnoses including dementia. Observation on 2/24/15 at 10:35 AM showed an enabler bar was attached to the open side of the resident's bed, and the other side of the bed was against the wall. The device was designed to have gaps between the bars. The gaps were measured, and there were two gaps between bars that were 4 inches by 10 inches in size. Interview with CNA #2 on 2/24/15 at 10:35 AM revealed the device was used to help the resident get in and out of bed. Review of the "side-rail use assessment form" showed it was completed on 9/22/14. The assessment showed the siderail was used as an enabler to promote independence. Further, the assessment showed the "resident expressed a desire to have the side rails raised while in bed for safety and/or comfort." The assessment failed to address the potential for limb entrapment. Additionally, the use of the enabler bar was not addressed in the resident's care plan. 2. Review of the 1/7/15 significant change MDS assessment showed resident #24 was cognitively impaired with short term and long term memory problems. Observation on 2/24/15 at 9:22 AM showed the resident's bed had two enabler bars attached to one side of the bed, and one enabler bar attached to the other side. The devices were designed to have gaps between the bars. The gaps were measured, and there were two gaps between bars that were 4 inches by 10 inches in size. Review of the "side-rail use assessment form," dated 9/22/14, showed the enabler bars were used for positioning or support. Further, the assessment showed the "resident expressed a desire to have the side rails raised while in bed for safety and/or comfort." The assessment failed to address the potential for limb entrapment.	F 323	Results will be reported to the QAPI Committee quarterly with appropriate follow-up to be determined by the QAPI Committee.	4/10/2015

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F 323	Continued From page 10 Additionally, the use of the enabler bars was not addressed in the resident's care plan. 3. Review of 2/12/15 quarterly MDS assessment showed resident #26 was severely cognitively impaired with short term and long term memory problems. The resident was confused and had a diagnosis of Alzheimer's disease. Observation on 2/23/15 at 4:12 PM showed an enabler bar in place on the outside of the bed, and the other side of the bed was against the wall while the resident was in bed. Observation on 2/25/15 at 1:55 PM showed the resident lying in bed with an enabler bar in place on the outside of the bed, and the other side of the bed against the wall. The enabler bar was designed to have gaps between the bars. The gaps were measured, and there were two gaps between bars that were 4 inches by 10 inches in size. Interview with CNA #1 on 2/25/15 at 1:55 PM revealed the resident used the enabler bar when s/he sat up on the side of the bed. Interview with the Unit Manager on 2/26/15 at 9:04 AM revealed she was unsure if the enabler bar was appropriate for the resident. Additionally, the use of the enabler bar was not addressed in the resident's care plan. 4. Interview with the DON on 2/26/15 at 8:58 AM verified the gaps between the rails posed a safety risk and they had not evaluated the enabler devices related to safety. 5. Review of the quarterly MDS dated 2/4/15 showed resident #16 required the extensive assistance of 2 or more persons with transfers. Observation of a transfer on 2/24/15 at 3 PM showed CNA #5 and CNA #6 transferred the resident from a recliner to wheelchair using an underarm lift technique. No gait belt or other	F 323	Please see page 10 for plan of correction.	

4/13/15

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	535029	A. BUILDING _____ B. WING _____	02/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK CO MEDICAL SERVICE DISTRICT LONG TERM CARE	713 OAK STREET SUNDANCE, WY 82729

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F 323	Continued From page 11 assistive device was utilized. Observation of another transfer on 2/25/15 at 2:25 PM showed CNA #5 and CNA #3 transferred the resident from a recliner to wheelchair using an underarm lift technique. No gait belt or other assistive device was utilized. 6. Review of the care plan for resident #3 revealed the resident required extensive assistance with transfers. Observation of a transfer on 2/25/15 at 4:55 PM showed CNA #5 and CNA #3 attempted to transfer the resident from a recliner to his/her wheelchair using a manual underarm lift technique. At that time, no gait belt or other assistive device was used. During the transfer the resident hollered and verbalized pain. The CNAs sat the resident on the edge of the recliner and allowed the resident to lay back into the recliner with his/her head on the back of the recliner and arm rest. One CNA remained with the resident as the other obtained a mechanical lift. The transfer was then completed using the mechanical lift. 7. Interview with the Unit Manager on 2/26/15 at 10:55 AM revealed a gait belt was supposed to be used with all two-person manual lifts for resident safety.	F 323	Please see page 10 for plan of correction.	
F 371 SS=F	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	CCMSD strives to store, prepare, distribute and serve food under sanitary conditions. The areas underneath the electric slicer and microwave, the two fans and their covers and the oven were cleaned. The celery, four cucumbers, pimentos, sliced strawberries and the shredded cheese were disposed of. (Continued on next page)	4/10/2015

QR 4/13/15

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F 371	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a sanitary environment in the kitchen. The findings were: 1. Observation on 2/23/15 at 4:05 PM showed the counter underneath the electric slicer and under the microwave oven were soiled with food spills and crumbs. Both pieces of equipment were not in use at that time. Observation on 2/25/15 at 3:05 PM showed the areas remained uncleaned. 2. Observation on 2/23/15 at 4:05 PM showed the two fans and covers which were part of the condenser unit located in the walk-in refrigerator were soiled with black dust and grease. On 1/25/15 at 3:05 PM the area was observed to be in the same uncleaned condition. 3. Observation on 2/23/15 at 4:05 PM and on 2/25/15 at 3:05 PM showed the "Vulcan" oven had spilled food burned onto the bottom of the oven. 4. Observation on 2/23/15 at 4:05 PM and on 2/25/15 at 3:05 PM showed storage of raw celery and raw cucumbers which were in poor condition. The celery was wilted and 4 cucumbers were soft, shriveled and 2 had areas of spoilage/mold. 5. Observation on 2/23/15 at 3:05 PM showed there were containers labeled "pimentos 2/2/15," "sliced strawberries taken out 2/12/15," and a container of shredded cheese dated "2/10" stored	F 371	(Continued from page "12") The dietary staff were educated about the cleaning schedule and perishable food use, storage and labeling. All refrigerated, Ready-to-eat, perishable foods will be labeled to indicate the date by which the food will be consumed or discarded. An audit will be conducted weekly, by the dietary manager, for six weeks using an audit tool to ensure cleaning is done appropriately and foods are labeled correctly and disposed of in a timely manner if needed. Results will be reported to the QAPI Committee quarterly. Further follow-up will be determined by the QAPI Committee.	

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F 371	Continued From page 13 in the refrigerator available for use. 6. Interview with the dietary manager on 2/25/15 at 4:45 PM verified the areas of the kitchen identified needed to be cleaned on a regular basis. She further verified the produce that was in poor condition should have been discarded and not available for use. 7. According to Food Code 2013, U.S. Public Health Service 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. "...(C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris." 8. According to Food Code 2013, U.S. Public Health Service 3-501.17 " (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under§ 3-502.12, and except as specified in ¶¶ (E) and (F) of this section, refrigerated, READY-TO -EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days."	F 371	Please see pages 12 & 13 for plan of correction.	
F 441 SS=D	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	F 441	CCMSD strives to establish and maintain a safe, sanitary and comfortable environment for all our residents.	

4/13/15

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F 441	Continued From page 14 to help prevent the development and transmission of disease and infection. (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, medical record review, and staff interview the facility failed to ensure staff followed acceptable infection control practices	F 441	Resident #4's oxygen tubing was replaced. Staff received education on proper infection control measures in regards to oxygen tubing. Random observation rounds, using an audit tool will be conducted weekly by the DON/ ADON, for six weeks to ensure the infection control practices are being followed. Any deviances found will be corrected immediately and education will be provided. Results will be reported to the QAPI Committee quarterly with further follow-up actions to be determined by the QAPI Committee.	4/10/2015

SB 4/13/15

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F 441	Continued From page 15 related to oxygen tubing for 1 non-sample resident (#4) during 1 random observation. The findings were: Medical record review showed resident #4 had a physician order dated 2/24/15 for supplemental oxygen at 2 liters per minute continuously. Observation on 2/25/15 at 1:18 PM showed the resident was seated at a dining room table with an oxygen concentrator on the floor next to him/her. The nasal cannula of the oxygen tubing was lying on the floor under the table. The floor was visibly soiled with fallen food. CNA #4 obtained the cannula from the floor and placed it directly into the resident's nares without cleaning, sanitizing, or replacing it. Interview with the infection control nurse on 2/26/15 at 9:30 AM revealed that the nasal cannula should have been changed prior to putting it in the resident's nose.	F 441	Please see page 15 for plan of correction.	