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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535048	A. BUILDING ______ B. WING ______	08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WORLAND HEALTHCARE AND REHABILITATION CENTER	1901 HOWELL AVENUE WORLAND, WY 82401

(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 LPN: Licensed Practical Nurse MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual.	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by:	F 155	F 155 The facility will comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Admin (X6) DATE: 9/10/2015

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
SEP 14 2015
Healthcare Licensing

Changes made per phone call with Kristen Scheveleman, Adm on 9/28/15 @ 4:17pm. POC = 10/5/15. POC accepted. Janice Co[illegible] 10/2/15

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F 155	Continued From page 1 Based on observation, staff interview, medical record review, and policy and procedure review the facility failed to ensure residents have the right to refuse treatment for 1 of 12 sample residents (#32) and 1 non-sample resident (#24) receiving medications. The findings were: 1. Observation of medication administration for resident #32 on 8/18/15 at 11:50 AM showed the nurse prepared quetiapine (anti-psychotic) 50 mg by crushing 1 tablet and mixing it in hot cocoa. The following concerns were identified: a. Continued observation on 8/18/15 at 11:50 AM showed the nurse gave the hot cocoa to the resident and did not tell the resident the hot cocoa had medication in it. b. Interview with LPN #1 on 8/18/15 at 11:50 AM revealed the nurse had to "be sneaky with it [the medication] otherwise [s/he] won't take it." c. Observation on 8/18/15 at 12:46 PM showed resident #32 was sleeping at the lunch table and approximately 25% of the hot cocoa with the medication in it had not been consumed. CNA #1 and CNA #2 attempted to talk to the resident and ask if s/he would like to lie down. The resident responded with slurred speech and was difficult to comprehend. The remainder of the hot cocoa with medication in it was discarded. d. Review of the physician orders dated 8/1/15 through 8/31/15 showed the resident did not have an order to mask (hide) medication in food or drink for administration. 2. Observation of medication administration for resident #24 on 8/18/15 at 12:17 PM showed the nurse prepared acetaminophen (an analgesic) 325 mg by crushing 2 tablets and mixing them in hot cocoa and coffee. The following concerns were identified:	F 155	Corrective Action: 1. Resident #32 now has knowledge and receives her medications in such a way that the resident has the right to refuse them. On or before date of compliance the Director of Nursing/Designee will re-educate the nurse(s) responsible for "masking" the resident's medications in such a manner that the resident was unable to refuse them if she wanted to. 2. Resident #24 now has knowledge and receives his medications in such a way that the resident has the right to refuse them. On or before date of compliance the Director of Nursing/Designee will re-educate the nurse(s) responsible for "masking" the resident's medications in such a manner that the resident was unable to refuse them if he wanted to. Identification: Residents residing in the facility have the potential to be affected by this practice. Systemic changes: Beginning September 10, 2015 and continuing up until the allegation of compliance the Nurses employed at Worland Healthcare have been in-serviced by the Director of Nursing/Designee on medication administration to include ensuring all medications are completely consumed and not "masked" in such a manner that the resident does not have the right to	~~11/20/15~~ 10/5/15 ~~11/20/15~~

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F 155	Continued From page 2 a. Continued observation on 8/18/15 at 12:17 PM showed the nurse gave the mixture to the resident and did not tell the resident the drink had medication in it. b. Interview with LPN #1 8/18/15 at 12:17 PM revealed she mixed the resident's medication in a drink so the resident would not refuse the medication. c. Review of the physician orders dated 8/1/15 through 8/31/15 showed the resident did not have an order to mask (hide) medication in food or drink for administration. 3. Interview with the DON on 8/20/15 at 11:15 AM confirmed the nurse would be unable to determine the amount of medication consumed if the resident did not finish the food or drink medication was concealed in, and further confirmed residents should have a physician's order to mask medications, or the residents should be notified they are consuming medications. 4. Review of the facility policy "Medication Management Guidelines" dated 5/28/15 showed the facility should "ensure that residents receive medications and treatments per physician orders...ensure that medications and treatments are administered according to state/federal regulations and nursing standards of practice..."	F 155	refuse them. An attendance sheet will be utilized and reconciled with the current active staff roster. Nursing staff unable to attend will be provided with one on one in-servicing. In-service education will become part on new hire orientation for licensed nursing staff and will be provided annually and prn. Monitoring: Nursing management Staff will perform medication pass reviews on random nurses weekly for one month then annually and prn. Medication pass reviews will be part of new employee orientation and annual evaluations of licensed staff, Issues identified will be trended and reviewed and presented by the Director of Nursing/Designee in the Quality Assessment and Assurance Committee for three months and then prn to ensure plan is implemented, sustained, and evaluated for its effectiveness.	
F 221 SS=D	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.	F 221	F221 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.	

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F 221	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and policy and procedure review the facility failed to ensure 1 of 2 sample residents (#32) with restraints were assessed for safety and appropriateness of use. The findings were: 1. Review of the 7/31/15 quarterly MDS assessment showed resident #32 was severely cognitively impaired with a brief interview for mental status (BIMS) score of 8/15, and diagnoses that included anxiety disorder and non-Alzheimer's dementia. Observation on 8/18/15 at 10:28 AM showed a wedge was placed between the mattress and the bed frame on the open side of the resident's bed and the other side of the bed was against the wall. The following concerns were identified: a. The device raised the mattress significantly higher on the outside of the bed, making positioning difficult for the resident and was in place while the resident was in bed. Review of the medical record revealed the device had not been assessed for safety and potential risk of injury from fall. b. Interview with CNA #2 on 8/18.15 at 12:46 PM revealed the wedge was used to keep the resident from "throwing [him/herself] on the floor." c. Review of the physician orders dated 8/1/15 to 8/31/15 showed there was no physician's order for use of the device. d. Review of the resident's care plan showed the resident was at risk for falls and the wedge should be used "in bed for positioning." e. Review of the facility policy titled "Restraint Management Program" dated 10/22/11 showed	F 221	Corrective Action: For Resident #32 the wedge cushion currently utilized under her mattress has been reviewed by the Interdisciplinary Team and the Physical Restraint/Bed Safety Risk review was completed. Based on the review the resident is utilizing the least restrictive device. An order was obtained from doctor and a signed consent was obtained from the resident responsible party. The Care Plan was updated to reflect the use of the bed safety device. Identification A review of records for resident's currently utilizing Restraints (including Wedge cushions) was conducted by the Interdisciplinary Team prior to the allegation of compliance date. Issues identified concerning appropriate assessment of the restraint and/or the documentation to support the continued use of the Restraint will be corrected at that time. Systemic Changes Each resident is reviewed on admission, quarterly, annually, and with significant change for the use of physical restraints (hip belts, lap buddy, merry walkers, wedge cushions and/ or chairs that prevent rising). For residents who are currently using physical restraints, clinical record documentation will be reviewed to ensure documentation	~~11/20/15~~ 10/5/15

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F 221	Continued From page 4 "...A physical restraint is defined as any: Manual method, physical or mechanical device, or material or equipment, that is attached or adjacent to the resident's body (that the individual cannot easily remove), which restricts freedom of movement or normal access to one's body." Further review showed "...4.1 Risk Review Requirements...1. Risk Review: Prior to utilizing physical restraints, the following risk review will be completed by a designated healthcare professional in conjunction with the resident and/or family to identify the least restrictive devices to be used. Physical Restraint Safety Risk Review [CL-RS-0105.F1] is completed for a resident on: Admission/readmission, Significant change, Change in restraint device type, Quarterly when a restraint device is indicated and used..." f. Review of the facility policy titled "Bed-Safety Guidelines" dated 10/24/11 showed "...4. Assistive Device: Any device whose primary purpose is to maximize the independence and the maintenance of health of an individual who is limited by physical injury or illness, psychological dysfunction, mental illness, developmental or learning disability, the aging process, cognitive impairment or an adverse environmental condition. 5. Bed-Safety Devices ["Bed -Safety Devices"]: Devices (including Half Bed-Safety Rails) that attach to either side of the bed to provide the resident with assistance in repositioning themselves while in bed, as well as an aid to enter and leave the bed in an effort to maximize the independence of the resident..." g. Interview with DON on 8/20/15 at 11:15 AM revealed the device had not been assessed for safety, the device would prevent normal movement for the resident, and confirmed there was a risk for injury because of the device.	F 221	includes; Restraint assessment, Restraint consent, care plans addressing restraint use and quarterly restraint reviews that reflect the specific condition, indication for restraint use, and evaluation to evaluate continued use. If a resident is utilizing a restraint, the Restraint Consent Form will be completed and signed by the resident and/or the resident's legal representative. The continued restraint use will be evaluated quarterly by the Interdisciplinary Team. On or prior to the allegation of compliance the Director of Nursing/Designee will reeducated the Nurses and Interdisciplinary Team on this process. Monitoring: Quarterly, residents utilizing restraints are reviewed to evaluate the appropriateness of the restraint as well as evaluation of supporting documentation for continued use of the restraint. Potential reduction attempts will be evaluated at that time if indicated. The restraint documentation audit will be conducted quarterly on resident's utilizing restraints to ensure the restraint is being monitored per facility policy and other required documentation is in place. The reviews will be presented in Quality Assessment & Assurance Committee by the Director of Nursing/Designee to ensure the plan is implemented, sustained and evaluated for its effectiveness.	

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F 225 SS=E	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 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.	F 225	F225 The facility will 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 will 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. The facility will have evidence that all alleged violations are thoroughly investigated, and will prevent further potential abuse while the investigation is in progress. The results of all investigations will be reported to the administrator or his designated representative and to other officials in accordance with State law within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	

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F 225	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on review of medical record, facility incident logs, State agency logs, and facility policy and procedure, and staff interview the facility failed to thoroughly investigate 3 of 5 incidents reviewed (involving residents #26, #28, #32, #33) involving potential or alleged abuse. Further, the facility failed to report 3 of 5 allegations of abuse (involving residents #26, #32) to the State survey and certification agency. The findings were: Regarding the failure to thoroughly investigate incidents involving potential or alleged abuse: 1. Review of a facility incident report dated 6/9/15 showed resident #28 and resident #33 were involved in a resident-to-resident altercation. Review of the nurse's note for resident #28 dated 6/9/15, timed 5:15 AM, showed s/he was found lying naked on another resident with a blanket between them, and the resident under the blanket was complaining of pain and pinching the arms of the other resident and attempting to push him/her off. The following concerns were identified: a. Review of the medical record for resident #33 showed there was no documentation to indicate a nursing assessment had been completed on resident #33 following the incident. Review of the social services notes showed the social services director had conducted a basic assessment of resident #33 on 6/9/15 and a basic assessment of resident #28 on 6/14/15 (5 days after the incident); however neither of these assessments referenced anything specific to the incident that took place on 6/9/15. Further review showed that neither assessment thoroughly evaluated the residents' mental status in regards to the incident.	F 225	Corrective Action: The Interdisciplinary Team was in-serviced on 9/10/15 by the Regional Director of Health Services regarding Company Policy on "Abuse and Investigations." - To ensure that all appropriate staff know and understand what type of incident under the Abuse Prevention Policy requires an investigation. - To ensure that all appropriate staff know and understands what is required during the course of an investigation - To ensure that all appropriate staff knows and understands what constitutes a complete investigation. - To ensure that all appropriate staff knows and understands the steps that should occur after an investigation is completed. Identification: Residents who reside at facility are at potential risk. There have been no further allegations of abuse that were not reported. Systemic changes: Beginning September 10, 2015 and continuing up until the date of compliance the Staff employed at Worland Healthcare have been in-serviced regarding the timely and accurate reporting of all abuse allegations	~~11/20/15~~ 10/5/15

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F 225	Continued From page 7 b. Record review and interview with the DON on 8/20/15 at 11:20 AM revealed a standard skin assessment was conducted on resident #28 and on resident #33 on 6/11/15 (2 days after the incident), but no nursing assessment was conducted at the time of the incident. Further interview with the DON and the social services director on 8/20/15 at 2:15 PM confirmed no assessment that evaluated the resident's mental state was completed following the incident. 2. Review of a social service note for resident #28 dated 8/18/15 and timed 2 PM showed the resident had verbalized an allegation to a CNA that s/he had been assaulted. The note stated "...it appears [s/he] was confused about what was happening during cares." The following concerns were identified: a. Interview with the DON and social worker on 8/20/15 at 2:20 PM revealed the social worker had interviewed the resident after the allegation was made, and determined the resident was upset that staff had removed his/her urine-soaked pants from the room, and the social worker felt confident that no assault had occurred. However, further interview confirmed that no further investigation of the allegation was completed, and no medical assessment of the resident was conducted. 3. Review of a nurses' note dated 8/12/15, timed 8 AM, showed resident #32 was taken to the breakfast table where s/he grabbed a tablemate's arm and started to hit the tablemate. The following concerns were identified: a. Review of facility incident reports showed an incident report was not completed. b. Interview with the DON on 8/20/15 at 1:05 PM revealed she was unaware of the incident	F 225	to the Interdisciplinary Team. Facility supervisors will immediately correct and intervene in reported or identified situations in which abuse, neglect, or misappropriation of resident property is at risk for occurring including conducting an investigation of an alleged abuse/neglect, misappropriation of resident property, and reporting to appropriate agencies in accordance with state law. The investigation will include interviews of other residents as well as staff members. The facility will investigate all patterns, trends, or incidents that suggest the possible presence of abuse, neglect to include bruises of unknown origin or misappropriation of property, identified through analysis conducted by the Quality Assurance and Assessment Committee, with intervention, reporting or policy/procedure modification conducted as appropriate. Monitoring; The nurse management team will monitor effectiveness of the system through review of the 24 hour report in the morning stand up meeting, and through investigation of incidents for patterns or trends that may indicate the presence of possible abuse. The Director of Nursing/Designee will review incident/accident reports and grievances monthly for three months then quarterly thereafter to ensure any incident/grievance that may indicate	

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F 225	Continued From page 8 involving resident #32 that occurred on 8/12/15 and stated staff should have contacted her. 4. Review of the facility's policy titled "Incident/Accident Investigation Process" dated 11/14/05, page 2 of 6, showed: "The following reportable allegations and/or events are considered serious in nature and require a prompt investigation: ....abuse allegations (verbal, physical, psychological, sexual ....resident to resident abuse etc) .... Resident to resident abuse incidents/allegations resulting in actual physical or psychological harm ...Resident to resident sexual activity when either, or both residents are declared not consenting ..." Further review showed "3.0 Procedure: 1. Upon discovery of a reportable incident accident event ...the Nursing/RSD manager on duty will immediately initiate an investigation and notify the Administrator/Executive Director and Director of Nursing/RSD. First, the responding party should: (a) assess the condition of the individual or resident involved in the incident in order to secure his or her safety and well-being. 2. The Nursing/RSD manager on duty will immediately: Evaluate the situation, Implement a solution to promote safety and well-being of those involved, Assess the condition of the individual(s) involved in the event ... " Regarding the failure to report allegations of abuse to the State survey and certification agency: 1. Review of a nurse's note for resident #32 dated 7/24/15 and timed 5:30 PM showed the resident took his/her "2 handle cup" and hit another resident across the right cheek. Review of the facility incident reports showed an incident report	F 225	abuse has been investigated and appropriately reported if indicated. Issues identified will be reviewed by the quality improvement team to ensure the system has been implemented, sustained and evaluated for its effectiveness.	

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F 225	Continued From page 9 was completed. The following concerns were identified: a. Review of the State survey agency logs showed the incident was not reported to that agency. 2. Review of a nurse's note for resident #32 dated 8/12/15 and timed 8 AM showed the resident was taken to the breakfast table where s/he grabbed a tablemate's arm and started to hit the tablemate. The following concerns were identified: a. Review of facility incident reports showed an incident report was not completed. b. Review of the State survey agency logs showed the incident was not reported to that agency. 3. Interview with the DON on 8/20/15 at 1:05 PM revealed she was unaware of the incident involving resident #32 that occurred on 8/12/15 and stated staff should have contacted her. 4. Review of a social service note for resident #26 dated 8/18/15 and timed 2 PM showed the resident had verbalized an allegation to a CNA that s/he had been assaulted. The note stated "...it appears [s/he] was confused about what was happening during cares." The following concerns were identified: a. Review of the State survey agency logs showed the incident was not reported to that agency. b. Interview with the DON and social services director on 8/20/15 at 2:20 PM confirmed that this incident was not reported to the State survey agency. c. Additional review of the facility incident reports verified no incident report was completed regarding this incident.	F 225		

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WORLAND HEALTHCARE AND REHABILITATION CENTER	1901 HOWELL AVENUE WORLAND, WY 82401

(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 225	Continued From page 10 5. Review of the facility's policy on Incident/Accident Investigation Process dated 11/14/05, page 2 of 6, showed: "The following reportable allegations and/or events are considered serious in nature and require a prompt investigation:....abuse allegations (verbal, physical, psychological, sexual....resident to resident abuse etc)....Resident to resident abuse incidents/allegations resulting in actual physical or psychological harm...Resident to resident sexual activity when either, or both residents are declared not consenting..."	F 225		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, activity calendar review and staff interview the facility failed to offer activity programming before 2 PM or after 6 PM for 1 of 2 activity programs (secure unit - SCU). The findings were: 1. Observation on 8/18/15 from 9:58 AM to 1:11 PM showed there were no activities performed with or for the residents residing in the secure unit. 2. Observation on 8/19/15 from 6:40 PM to 7:40 PM showed there were no activities performed	F 248	F248 The facility will provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interest and the physical, mental, and psychosocial well-being of each resident. Corrective Action: Activities are being provided in the Secure Unit throughout the day according to the Activity Calendar. Identification: Residents residing on the Secure Unit are at risk. Systemic Changes: Residents are reviewed on admission, quarterly, annually, and with significant changes in status to identify their activity interests and /or preferences. The review includes interview of residents and or family members as well as reviewing admission documentation that comes with	11/20/15 10/5/15

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F 248	Continued From page 11 with or for the residents residing in the secure unit. The television was playing a series titled "The Middle" and residents were not engaged in the program. Further observation at that time showed all residents were assisted to bed by 7:40 PM. 3. Review of the SCU Activities calendar showed there was an activity titled "Baking Club" scheduled for 9:30 AM on 8/18/15 and "Music Time" scheduled for 6:30 PM on 8/19/15. The same activities were scheduled at the same times for the rest of the facility. 4. Interview with CNA #1 on 8/20/15 PM at 11:30 AM revealed activities didn't get done in the unit during the day because CNAs were expected to do them and they were busy providing care. Further interview at that time revealed activities were done outside of the unit and residents from the unit could attend, however, they didn't do well out of the unit and their behaviors were disruptive. 6. Interview with the activities director on 8/20/15 at 2:10 PM revealed there was an activities assistant for the secure unit that came in between 2 PM and 6 PM. Further interview at that time revealed there were no set secure unit activities except between 2 PM and 6 PM. Continued interview confirmed the residents from the SCU could attend activities outside of the unit, but their behaviors were often disruptive.	F 248	resident. Activities will be provided on the Secure Unit throughout the day. The Secure Unit staff will provide individual, small, or large group programs that are meaningful to individuals with Dementia. Five different programs will be utilized to interact with the remaining abilities of the residents. The Five programs are Programs of Daily Living, Sensorial Experience, Cognitive Stimulation, Motor programs, and Group programs. Programs will be determined on an individual basis and by what successfully engages the resident for whatever time they allow. On or before the date of compliance the staff member assigned to the Secure Unit have be in-serviced by the Director of Nursing/Designee on this process Monitoring: The facility will review residents activity plan quarterly, annually, and with significant changes in status to ensure plan is individual and includes resident preferences. Changes will be made at that time if indicated. Facility will also monitor through feedback from Resident Council, Resident, and Family feedback and through feedback from the Ombudsman. Issues identified will be corrected immediately, trended, and reviewed in Quality Assessment and Assurance Meeting monthly to ensure plan has been implemented, sustained, and evaluated for its effectiveness.	
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.	F 253		

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F 248	Continued From page 11 with or for the residents residing in the secure unit. The television was playing a series titled "The Middle" and residents were not engaged in the program. Further observation at that time showed all residents were assisted to bed by 7:40 PM. 3. Review of the SCU Activities calendar showed there was an activity titled "Baking Club" scheduled for 9:30 AM on 8/18/15 and "Music Time" scheduled for 6:30 PM on 8/19/15. The same activities were scheduled at the same times for the rest of the facility. 4. Interview with CNA #1 on 8/20/15 PM at 11:30 AM revealed activities didn't get done in the unit during the day because CNAs were expected to do them and they were busy providing care. Further interview at that time revealed activities were done outside of the unit and residents from the unit could attend, however, they didn't do well out of the unit and their behaviors were disruptive. 5. Interview with the activities director on 8/20/15 at 2:10 PM revealed there was an activities assistant for the secure unit that came in between 2 PM and 6 PM. Further interview at that time revealed there were no set secure unit activities except between 2 PM and 6 PM. Continued interview confirmed the residents from the SCU could attend activities outside of the unit, but their behaviors were often disruptive.	F 248		
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.	F 253	F253 The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	

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F 253	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide a sanitary and well-maintained environment in 3 of 4 units in the building. The findings were: 1. Observation of room 112 on 8/20/15 at 11:57 AM showed a wall to the right of the doorway with a gouge measuring 6 inches by 1/2 inch wide, 11 inches from the floor, that penetrated the drywall. Continued observation at that time showed another area that measured 22 inches by 1 inch, that was 22 inches up from the floor and exposed the underlying drywall. 2. Observation of room 205 on 8/20/15 at 12:05 PM showed several damaged tiles below the window including 1 cracked tile that measured 12 inches by 12 inches, 1 cracked tiled that measured 6 inches by 12 inches, 1 cracked tile that measured 6 inches by 10 inches and a gap between the tiles that measured 1 inch by 20 inches long. 3. Observation of the exit door in the secure unit on 8/20/15 at 12:07 PM showed 7 tiles measuring 12 inches by 12 inches that were cracked. 4. Observation of the fire door on unit 1 and 2 on 8/20/15 at 12:10 PM showed a broken kick plate that measured 11 inches by 1 1/2 inches that had sharp edges and exposed underlying wood. 5. Observation of the shower room in the 100 hallway on 8/20/15 at 12:12 PM showed 100 tiles measuring 1 inch by 1 inch that were cracked,	F 253	Corrective Action: 1. Damaged drywall areas in Room 112 were repaired on 9/2/15. 2. Damaged tiles in Room 205 were replaced. 3. Exit door in secure unit: broken tiles will be replaced. 4. Fire door kick plate on hall 1 and 2: A new kick plate was ordered on 9/9/15 and will be installed upon delivery. 5. Hall 1 Shower Area: Maintenance Supervisor will replace cracked/broken tiles and Pest Control will spray for ants. 6. Said carpet area was cleaned on 8/19/15 7. Said carpet area was cleaned on 8/19/15 8. Said carpet area was cleaned on 8/19/15 9. The main entrance outside concrete: bid will be acquired for sealing of cracked/uneven concrete. 10. Carpet: all carpet in facility will be shampooed on or before date of compliance and a weekly shampooing schedule will be followed. Identification: Housekeeping and Maintenance Director conducted visual rounds at the time of	~~11/20/15~~ ~~11/20/15~~ ~~11/20/15~~ ~~11/20/15~~ ~~11/20/15~~ ~~11/20/15~~ ~~11/20/15~~ ~~11/20/15~~ ~~11/20/15~~ ~~11/20/15~~ 10/5/15

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F 253	Continued From page 13 chipped or missing, as well as two areas of the shower wall measuring 1/2 inch each that were covered in ants. 6. Observation of the carpet outside of room 408 on 8/20/15 at 12:15 PM showed a stain measuring 24 inches by 20 inches. 7. Observation of the carpet outside of the nurses' station between the 100 and 200 hallway on 8/2/15 at 12:20 PM showed three stains: area #1 measured 14 inches by 12 inches, area #2 measured 12 inches by 12 inches, and area #3 measured 8 inches by 6 inches. 8. Observation of the carpet outside room 106 on 8/20/15 at 12:25 PM showed a stain that measured 12 inches by 8 inches. 9. Observation of the concrete outside the main entrance on 8/20/15 at 12:30 PM showed the concrete had cracks and chips that spanned the entire length of the area where visitors and residents enter and exit the facility as well as in the area designated for residents to smoke. 10. Interview with the maintenance director on 8/20/15 at 12:28 PM confirmed the identified areas were damaged and because of the damage the facility would not be able to effectively clean the tiles or the damaged wall. Further interview revealed the facility carpets were cleaned once a week but the carpeting is almost twenty-five years old and there is no current plan to replace this carpeting. Continued interview at that time revealed the areas of damaged concrete had not been previously identified and a work order had not been made.	F 253	survey to identify other potential issues. No other issues were identified Residents residing at the facility are potentially affected. Systemic Changes: Housekeeping and Maintenance Director and facility management team will conduct visual rounds to ensure that items are stored properly, and that rooms, common areas, and equipment are cleaned and maintained on a regular basis. Starting 9/9/15 and up to the date of compliance the Administrator/designee will in-service facility staff on communication of maintenance and housekeeping concerns issues via work orders located throughout the facility and on the nursing 24-hour report. On or before the date of compliance the Nursing Home Administrator/designee will in-service housekeeping staff on the importance of cleanliness of the facility. The Nursing Home Administrator will provide oversight to ensure identified issues have been resolved. Monitoring: The Maintenance Director, Housekeeping Director, and Nursing Home Administrator/designee, will conduct monthly environmental rounds in order to identify outstanding housekeeping and maintenance issues with overall oversight provided by the Nursing Home Administrator/designee. Findings will be	

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F 282 F 282 SS=D	Continued From page 14 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to follow the care plan for 1 of 10 sample residents (#46) with incontinence. The findings were: Review of 8/1/15 annual MDS assessment showed resident #46 required the extensive assistance of two persons for toilet use, and was always incontinent of urine. Review of resident's care plan for urinary incontinence, last updated on 2/1/15, indicated that a check and change should be done before and after meals, at bedtime, as needed and with nightly rounding. Additionally, the care plan noted the risk of skin breakdown and infections related to incontinence. The following concerns were identified: a. Continuous observation on 8/18/15 beginning at 10:20 AM showed the resident was up in his/her wheelchair in the activity area, participating in a cooking discussion. At 11:07 AM the resident was taken from the activity to an area in front of the nurses' station, until being taken to the dining room at 11:17 AM. After completing the meal, the resident was taken back to the nurses' station area until 2:53 PM when he/she was taken to his/her room for check and change of his/her incontinence protection brief. Interview on 8/18/15 at 3:18 PM with CNA #3 confirmed the resident's	F 282 F 282	F282 The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. Corrective action: Resident #46 is being toileted per her Plan of Care. Identification: Residents who require assistance with toileting are at risk. The facility will do a record review of those residents residing at facility to identify residents who require assistance with toileting. The residents identified will be evaluated to ensure an effective toileting program is in place, including toileting times and that the care plan has been communicated to the C.N.A staff via the C.N.A assignment sheets. System: On or before the allegation of compliance the Staff Development coordinator/designee will in-service C.N.A staff on the importance of timely toileting according to the Plan of Care. Monitoring: Licensed staff will monitor that residents are being toileted per the plan of care via random reviews of the CNAs providing ADL assistance. Director of Nursing and/or designee with monitor the licensed	11/20/15 10/5/15

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F 282	Continued From page 15 brief was wet when s/he was changed. b. Interview with DON on 8/20/15 beginning at 1:05 PM confirmed that the resident should have been checked and changed according to the care plan.	F 282	staff and CNAs by frequently reviewing daily C.N.A worksheets/checklists, CNA charting, and random observations, 3 times weekly for a month then weekly for a month, and then pm. Identified issues will be reviewed in Quality Assessment and Assurance Meeting by the Director of Nursing/Designee to ensure plan is implemented, sustained, and evaluated for its effectiveness.	
F 323 SS=D	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 review of medical record and policy and procedure, the facility failed to ensure bed rails were assessed for safety for 1 of 1 sample residents (#28) who used bed rails. The findings were: 1. Review of the 6/14/15 admission MDS assessment showed resident #28 was severely impaired with daily decisions and had diagnoses that included Alzheimer's disease, anxiety, insomnia, and a history of urinary tract infection. Observation on 8/20/15 at 11:15 AM showed the resident had a bed rail placed on the open side of the bed with the other side of the bed against the wall. The device was designed to have a gap that measured 5 inches by 2 1/2 inches. The following concerns were identified: a. Review of the medical record showed that a safety assessment was not completed. The	F 323		

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

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F 282	Continued From page 15 brief was wet when s/he was changed. b. Interview with DON on 8/20/15 beginning at 1:05 PM confirmed that the resident should have been checked and changed according to the care plan.	F 282		
F 323 SS=D	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 review of medical record and policy and procedure, the facility failed to ensure bed rails were assessed for safety for 1 of 1 sample residents (#28) who used bed rails. The findings were: 1. Review of the 6/14/15 admission MDS assessment showed resident #28 was severely impaired with daily decisions and had diagnoses that included Alzheimer's disease, anxiety, insomnia, and a history of urinary tract infection. Observation on 8/20/15 at 11:15 AM showed the resident had a bed rail placed on the open side of the bed with the other side of the bed against the wall. The device was designed to have a gap that measured 5 inches by 2 1/2 inches. The following concerns were identified: a. Review of the medical record showed that a safety assessment was not completed. The	F 323	F323 The facility will ensure that the resident environment remains as free of accident hazards as is possible; and each resident received adequate supervision and assistance devices to prevent accidents. Corrective Action: For Resident #28 - the assist rail attached to his bed, utilized by the resident, has been reviewed by the Interdisciplinary Team and the Physical Restraint/Bed Safety Risk review was completed. Based on the review, the resident is utilizing the least restrictive bed safety device. The Care Plan was updated to reflect the use of the bed safety device. Identification: A review of records for resident's currently utilizing assist rails was conducted by the Interdisciplinary Team prior to the allegation of compliance. Issues identified concerning appropriate assessment of the assist and/or the documentation to support the continued use of the assist rails to be corrected at that time.	~~11/20/15~~ 10/5/15

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

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F 323	Continued From page 16 facility failed to address the safety of the bed rail use or potential for limb entrapment. Additionally, the use of the bed rail was not addressed in the resident's care plan. b. Review of the facility policy titled "Bed-Safety Guidelines" dated 10/24/11 showed "...4. Assistive Device: Any device whose primary purpose is to maximize the independence and the maintenance of health of an individual who is limited by physical injury or illness, psychological dysfunction, mental illness, developmental or learning disability, the aging process, cognitive impairment or an adverse environmental condition. 5. Bed-Safety Devices ["Bed -Safety Devices"]: Devices (including Half Bed-Safety Rails) that attach to either side of the bed to provide the resident with assistance in repositioning themselves while in bed, as well as an aid to enter and leave the bed in an effort to maximize the independence of the resident..." Continued review showed "...1. Risk Review...a. Nursing: The Data Review Tool, MDS assessment (bed mobility score), and physical restraint/bed Safety Risk Review (if indicated) is to be completed for each resident on admission, re-admission, annually and when a change in status is indicated by a designated healthcare professional to determine if there are risk factors that may lead to serious injury to the resident. c. Interview with DON on 8/20/15 at 11:15 AM revealed the bed rail had not been assessed for safety and confirmed there was a risk for resident injury because of the bed rail.	F 323	Systemic Changes: Each resident's functional status including bed mobility and transfers is reviewed on admission, quarterly, annually, and with significant change. For residents who are currently using assist rails on their beds to assist them with bed mobility and/or transfers: clinical record documentation will be reviewed to ensure; Bed/Safety device assessment was completed by the Interdisciplinary Team, care plans addressing the assist rail use, signed family/resident consent, and quarterly bed safety device reviews that reflect the specific condition, indication for the use of the assist rail, and evaluation to evaluate continued use. The continued use of the assist rail use will be evaluated quarterly by the Interdisciplinary Team on or prior to the allegation of compliance date. The Director of Nursing/Designee will re-educate the Nurses and Interdisciplinary Team on this process. Monitoring Quarterly residents utilizing assist rails are reviewed to evaluate the appropriateness of the assist rail as well as evaluation of supporting documentation for continued use of the assist rails. The assist rail documentation audit will be conducted quarterly on resident's utilizing assist rails to ensure the assist rail is being assessed per facility policy and other required documentation	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		

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F 323	Continued From page 16 facility failed to address the safety of the bed rail use or potential for limb entrapment. Additionally, the use of the bed rail was not addressed in the resident's care plan. b. Review of the facility policy titled "Bed-Safety Guidelines" dated 10/24/11 showed "...4. Assistive Device: Any device whose primary purpose is to maximize the independence and the maintenance of health of an individual who is limited by physical injury or illness, psychological dysfunction, mental illness, developmental or learning disability, the aging process, cognitive impairment or an adverse environmental condition. 5. Bed-Safety Devices ["Bed -Safety Devices"]: Devices (including Half Bed-Safety Rails) that attach to either side of the bed to provide the resident with assistance in repositioning themselves while in bed, as well as an aid to enter and leave the bed in an effort to maximize the independence of the resident..." Continued review showed "...1. Risk Review...a. Nursing: The Data Review Tool, MDS assessment (bed mobility score), and physical restraint/bed Safety Risk Review (if indicated) is to be completed for each resident on admission, re-admission, annually and when a change in status is indicated by a designated healthcare professional to determine if there are risk factors that may lead to serious injury to the resident. c. Interview with DON on 8/20/15 at 11:15 AM revealed the bed rail had not been assessed for safety and confirmed there was a risk for resident injury because of the bed rail.	F 323	is in place. The reviews will be presented in Quality Assessment and Assurance Committee by the Director of Nursing/Designee to ensure the plan is implemented, sustained, and evaluated for its effectiveness.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	F332 The facility will ensure that it is free of medication error rates of five percent or greater.	

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	535048	A. BUILDING _____ B. WING _____	08/20/2015

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F 332	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure a medication error rate of less than 5%. Errors were identified in 3 observations (residents #15, #31, #32) of 31 total observations, resulting in an error rate of 9.68%. The findings were: 1. Observation on 8/19/15 at 5:11 PM showed resident #15 was administered phenytoin EX (an anti-convulsant) 100 mg, 1 capsule by mouth. Review of the August 2015 signed physician order recapitulation showed the resident was ordered 4 ml of phenytoin, 100 mg per 4 ml suspension. 2. Observation of medication administration for resident #32 on 8/18/15 at 11:50 AM showed the nurse prepared quetiapine (anti-psychotic) 50 mg by crushing 1 tablet and mixing it in hot cocoa. The following concerns were identified: a. Continued observation showed the nurse gave the hot cocoa to the resident and did not tell the resident the cocoa had medication in it. b. Interview with LPN #1 on 8/18/15 at 11:50 AM revealed the nurse had to "be sneaky with it [the medication] otherwise [s/he] won't take it." c. Observation on 8/18/15 at 12:46 PM showed the resident was sleeping at the lunch table and approximately 25% of the hot cocoa with the medication in it had not been consumed. CNA #1 and CNA #2 attempted to talk to the resident and ask if s/he would like to lie down. The resident responded with slurred speech and was difficult to comprehend. The remainder of the	F 332	Corrective Action: On or before the date of compliance the Nurses employed at Worland Healthcare will have been in-serviced on medication administration to include ensuring all medications are completely consumed. Identification: Residents residing at facility are at risk. Systemic Changes: Beginning September 10, 2015 and continuing up until the allegation of compliance the Nurses employed at Worland Healthcare have been in-serviced by the Director of Nursing/Designee on medication administration to include ensuring all medications are completely consumed and that the physician order for the medication type and correct dose is followed. An attendance sheet will be utilized and reconciled with the current active staff roster. Nursing staff unable to attend will be provided with one on one in-servicing. In-service education will become part of new hire orientation for licensed nursing staff and will be provided annually and prn. Monitoring: Nursing management staff will perform medication pass reviews on random nurses weekly for one month then annually and prn. Medication pass reviews will be part of new employee	~~11/20/15~~ 10/5/15

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F 332	Continued From page 18 hot cocoa was discarded. 3. Observation of medication administration for resident #31 on 8/18/15 at 12:05 PM showed LPN #1 prepared calcium 600 mg + Vitamin D 200 international units (IU) and administered 1 tablet to the resident by mouth with a shake. Review of the August 2015 physician order recapitulation showed the resident was ordered calcium 600 mg + Vitamin D 400 IU by mouth three times per day. 4. Interview with the DON on 8/20/15 at 11:15 AM confirmed the nurse would be unable to determine the amount of medication consumed if the resident did not finish the food or drink their medication was concealed in, and the resident should have a physician's order to mask medications or the residents should be notified they are consuming medications. 5. Interview with the DON on 8/20/15 at 1:05 PM confirmed a clarification should be obtained from the physician when the form or dosage of medication available differs from the physician orders. 6. Review of the facility policy "Medication Management Guidelines" dated 5/28/15 showed the facility should "ensure that residents receive medications and treatments per physician orders...ensure that medications and treatments are administered according to state/federal regulations and nursing standards of practice..."	F 332	orientation and annual evaluations of licensed staff. Issues identified will be trended and reviewed and presented by the Director of Nursing/Designee in Quality Assessment and Assurance Committee meeting for three months and then prn to ensure plan is implemented, sustained, and evaluated for its effectiveness.	
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371	F371 The facility will procure food from sources approved or considered	

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F 371	Continued From page 19 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure a sanitary environment was maintained in 1 of 1 food preparation areas (kitchen). The findings were: 1. Observation 8/19/15 at 6 PM showed cook #1 left the serving line while wearing gloves and opened the microwave, opened the walk-in cooler, returned and opened the microwave again, and then returned to the tray line to serve food. Without changing gloves the cook handled plates and buns that were served to the residents. According to Food Code 2013, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... "(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands..." 2. Observation on 8/19/15 at 5:00 PM showed 5 water carafes on resident tables that were noted to have fissures and cracks throughout the plastic which would prevent effective cleaning and sanitizing. All 5 of the water carafes were used by the residents during the evening meal. According to Food Code 2013, U.S. Public Health Service	F 371	satisfactory by Federal, State, or local authorities; and store, prepare, distribute, and serve food under sanitary conditions. Corrective action: No specific resident was identified. The slicer has been cleaned; the cracked water pitchers were discarded and replaced, the cracked water glass was discarded and replaced, the Bologna dated 08/11/15 was discarded. The staff member who wore gloves after touching microwave and then served food without changing gloves was re-educated. Identification: Residents that reside at the facility are at potential risk. Systemic Changes: A cleaning schedule will be implemented to ensure kitchen items are kept clean and will be monitored by the Dietary Manager and/or designee. The Dietary Manager/Designee will ensure Kitchen Sanitation rounds are conducted weekly to ensure sanitary conditions are being followed. On or before the date of compliance, the Dietician/Designee will in-service the dietary staff on this process. A sign in sheet will be utilized and those dietary staff unable to attend the in-servicing will be provided with 1:1 education.	~~11/20/15~~ 10/5/15

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F 371	Continued From page 20 4-101.11 " Materials that are used in construction of UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT may not be allowed the migration of deleterious substances or impart colors, odors, or tastes to FOOD and under normal use conditions shall be:(A) Safe;(B) Durable, CORROSION-RESISTANT, and nonabsorbent(C) Sufficient in weight and thickness to withstand repeated WAREWASHING;(D) Finished to have a SMOOTH, EASILY CLEANABLE surface; and(E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. " 3. Observation on 8/17/15 at 7:15 PM and 8/19/15 at 4:40 PM showed the meat slicer in the kitchen had dried food on the guide. According to Food Code 2009, U.S. Public Health Service: 4-601.11 " (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 4. Observation on 8/17/15 at 7:15 PM and again on 8/20/15 at 10:40 AM showed there was a package of bologna in the walk-in cooler dated 8/11/15. 5. Interview with the dietary manager on 8/20/15 at 10:40 AM confirmed the cook should have changed gloves before handling resident food, the water carafes should have been removed from use, and the meat slicer should have been	F 371	Monitoring: The Dietary Manager/Designee will monitor compliance through daily and prn rounds in all areas of the kitchen to ensure that sanitary conditions are maintained. Rounds will be trended and will be presented by the Dietary Manager/designee to be reviewed at Quality Assessment and Assurance Committee Meeting to ensure plan has been implemented, sustained and evaluated for effectiveness.	

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F 371	Continued From page 21 cleaned. Continued interview at that time revealed the bologna should have been removed after 7 days.	F 371		