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

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WY Dept of Health
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Healthcare Licensing

PRINTED: 09/02/2015
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
	535026	A. BUILDING _____ B. WING _____	C 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN MANOR	1851 BIG HORN AVE SHERIDAN, WY 82801

(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 On 8/17/15 through 8/20/15 a recertification survey was condcuted at Sheridan Manor. In addition, a complaint investigation was done prompted by complaint intakes WY00001891 and WY00001996. The following common abbreviations are used throughout this document: DON- Director of Nursing MAR- medication Administration Record mg- Milligrams	F 000	F225 Corrective Action: An investigation was conducted by the NHA, the investigation was started on 2/19/15 and completed on 2/23/15. The completed report was submitted to the State Survey Agency on 2/23/15 by the NHA. The NHA failed to contact the state on 2/19/15.	
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).	F 225	An investigation was conducted by the NHA, the investigation was started on 6/10/15 it was completed and a report was submitted to the State Survey Agency on 6/15/15 by the NHA.The NHA failed to contact the state within the first 24 hours of the incident. Identification of Others: The NHA has reviewed all investigations of legal abuse for the past 6 months for timeliness of reporting to State Survey Agency. No additional concerns were identified. System Measure: The SDC or designee will educate staff on abuse guideline by 10/2/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bruce Allen — TITLE: Administrator — (X6) DATE: 9/11/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation. POC accptd. Called to Bruce Allen, NHA on 9/30/15 @ 11:26a.m.

Janice Cox 10/2/15

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F 225	Continued From page 1 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 review of facility abuse investigation documentation and staff interview, the facility failed to ensure 2 of 2 allegations of abuse or injuries of unknown origin were reported immediately to the State survey and certification agency. The findings were: 1. Review of facility investigation documentation revealed the following: a. An allegation of sexual assault involving resident #90 occurred on 6/1/15 but was not reported to the State survey and certification agency until 8/5/15. b. An injury of unknown origin involving resident #91 occurred on 1/31/15 but was not reported to the State survey and certification agency until 2/3/15. 2. During an interview on 8/19/15 at 4:50 PM the administrator stated he called the State survey and certification agency and thought he was told he just needed to send in his written investigation	F 225	Monitoring: Administrator will monitor for compliance. Data obtained by the way an audit will be analyzed for patterns and trends reported monthly to facility QAPI committee. QAPI committee will evaluate based on trends identified and interventions as needed for continued compliance for 3 months..	10/2/15

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F 225	Continued From page 2 in 5 days. He stated he would now immediately report allegations.	F 225		
F 253 SS=D	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 1 of 3 resident shower room floors were clean and in good repair. The findings were: 1. Observation on 8/19/15 at 3 PM in the Rock Creek shower room showed the floor had over 700 2 x 2 inch ceramic tiles which were cracked and darkened with dirt and debris which created a surface that could not be adequately cleaned. 2. Interview with the maintenance director on 8/19/15 at 3:30 PM verified the shower floor was in need of repair. However, the facility failed to have a plan with a specific time frame to address these concerns.	F 253	F253 Corrective Action: Tiles on the Rock Creek Shower floor are cracked and the grout between the tiles is missing, the tile and the grout will be replaced. Replacing tiles will make the floor a cleanable surface. The NHA will obtain a bid for the work by Wyoming Interiors on September 16,2015. The work will be completed as soon as it can be scheduled by the vendor. Identification of Others: The facility Maintenance Director and the NHA have inspected all of the facility showers rooms on 9/10/15 no additional concerns were identified.	10/2/15
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	System Measures: An audit of the shower room floor will be conducted weekly by the Director of Maintenance and the NHA until the identified issue is corrected.	

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F 309	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of standing orders, and staff interview, the facility failed to ensure interventions were implemented for constipation for 3 of 15 sample residents (#36, #84, #85). The findings were: 1. Review of physician's orders showed resident #84 had an order for Peri-Colace 8.6 mg-50 mg tablet twice per day as needed (PRN) for constipation. Review of the bowel movement (BM) documentation showed no documented BM on 7/8/15-7/12/15 (5 days) and 7/23/15-7/26/15 (4 days). Review of the MAR and nursing notes showed no evidence interventions were implemented during those timeframes to address constipation. 2. Review of the BM documentation for resident #85 revealed no BMs on 7/19/15-7/22/15 (4 days) and 8/10/15-8/14/15 (5 days). Review of the MAR and nursing notes showed no evidence interventions were implemented during those timeframes to address constipation. 3. Review of the August 2015 Physician Order Sheet revealed resident #36 had orders for "Miralax 17 gram/dose Powder" and "Dulcolax 10 mg Suppository" as needed (PRN) for constipation. Review of the bowel tracking documentation for the resident showed s/he did not have a bowel movement from 8/6/15-8/10/15, a period of four days. Review of the August 2015 MAR showed no evidence interventions were implemented during that time frame to address constipation.	F 309	Monitoring: Maintenance Director/designee will monitor for compliance. Data obtained by the way of preventative maintenance audits will be analyzed for patterns and trends reported monthly to facility QAPI committee. QAPI committee will evaluate based on trends indentified and interventions as needed to ensure continued compliance for 3 months.	10/2/15

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F 253 SS=D	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 1 of 3 resident shower room floors were clean and in good repair. The findings were: 1. Observation on 8/19/15 at 3 PM in the Rock Creek shower room showed the floor had over 700 2 x 2 inch ceramic tiles which were cracked and darkened with dirt and debris which created a surface that could not be adequately cleaned. 2. Interview with the maintenance director on 8/19/15 at 3:30 PM verified the shower floor was in need of repair. However, the facility failed to have a plan with a specific time frame to address these concerns.	F 253	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Corrective Action: Resident #64 constipation orders were updated on 9/9/15. Peri-colace 8.6mg-50mg tablet: Give 1 tablet po bid after 3 days without bowel movement. If no BM results after peri-colace, give dulcolax suppository 10mg per rectum AM of 5th day, if no BM results by noon Give fleets enema per rectum. Notify MD if no BM from fleets enema. Resident #36 was discharged from the facility on 8/25/15. Resident #85 constipation orders were updated on 9/9/15. Miralax order was discontinued. Orders are as follows:	10/2/15
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	Peri-colace 8.6mg-50mg tablet: Give 1 tablet po bid after 3 days without bowel movement. If no BM results after peri-colace, give dulcolax suppository 10mg per rectum AM of 5th day, if no BM results by noon Give fleets enema per rectum. Notify MD if no BM from fleets enema.	

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F 309	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of standing orders, and staff interview, the facility failed to ensure interventions were implemented for constipation for 3 of 15 sample residents (#36, #64, #85). The findings were: 1. Review of physician's orders showed resident #64 had an order for Peri-Colace 8.6 mg-50 mg tablet twice per day as needed (PRN) for constipation. Review of the bowel movement (BM) documentation showed no documented BM on 7/8/15-7/12/15 (5 days) and 7/23/15-7/28/15 (4 days). Review of the MAR and nursing notes showed no evidence interventions were implemented during those timeframes to address constipation. 2. Review of the BM documentation for resident #85 revealed no BMs on 7/19/15-7/22/15 (4 days) and 8/10/15-8/14/15 (5 days). Review of the MAR and nursing notes showed no evidence interventions were implemented during those timeframes to address constipation. 3. Review of the August 2015 Physician Order Sheet revealed resident #36 had orders for "Miralax 17 gram/dose Powder" and "Dulcolax 10 mg Suppository" as needed (PRN) for constipation. Review of the bowel tracking documentation for the resident showed s/he did not have a bowel movement from 8/8/15-8/10/15, a period of four days. Review of the August 2015 MAR showed no evidence interventions were implemented during that time frame to address constipation.	F 309	Identification of Others: An audit was completed by the Director of Nursing/Designee to identify any resident's with constipation and ensure constipation orders were received from the physician and were initiated. An audit of physician orders was completed by the Director of Nursing Designee to ensure that constipation orders contained parameters for initiation. Any orders that did not contain parameters were clarified with the physician and updated to reflect initiation parameters. The standing orders were updated and signed by the physicians to reflect the following bowel protocol for each resident residing in and admitted to the facility with constipation as follows: Peri-colace 8.6mg-50mg tablet: Give 1 tablet po bid after 3 days without bowel movement. If no BM results after peri-colace, give dulcolax suppository 10mg per rectum AM of 5th day, if no BM results by noon Give fleets enema per rectum. Notify MD if no BM from fleets enema. Systemic Changes: Standing orders for the facility were updated to reflect the following bowel protocol: Peri-colace 8.6mg-50mg tablet: Give 1 tablet po bid after 3 days without bowel movement. If no BM results after peri-colace, give dulcolax suppository 10mg per rectum AM of 5th day, if no BM	10/2/15 10/2/15

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F 309	Continued From page 4 4. Review of the physician's standing orders provided by the facility showed the following orders for constipation: 1 ounce (oz) of constipation cocktail twice per day for chronic constipation; Milk of Magnesia or equivalent 30 milliliters (ml); use either dulcolax, fleets, or TWE [tap water enema] if no relief with M.O.M. The standing orders did not specify a timeframe to implement the interventions, i.e. use M.O.M. if no BM after 3 days. 5. During an interview on 8/19/15 at 5:17 PM the DON stated the facility did not have a policy to address interventions for constipation. She further stated the standing orders did not define constipation, nor gave timeframes to implement the interventions. She further stated her expectation was that after 3 days of no bowel movements the nurses would implement interventions to address constipation.	F 309	results by noon Give fleets enema per rectum. Notify MD if no BM from fleets enema. Nurses will be in-serviced regarding monitoring bowel movements daily using the Care Alert Report and initiation of constipation interventions according to the updated bowel protocol after 3 days of no bowel movement. The Unit Managers will be in-serviced regarding monitoring of bowel movements using the Care Alert Report and initiating interventions according to the updated bowel protocol. Unit Managers will review the Care Alert Report daily Monday thru Friday identifying resident's who have not had a BM in 3 days and follow up with the charge nurse to ensure the bowel protocol has been initiated per parameters on the physician orders. The Director of Nursing/Designee will monitor weekly bowel movement reports to ensure compliance. New orders will be reviewed Monday thru Friday by the DON/Designee in the morning IDT meeting. Any orders for constipation that are noted to be PRN and without parameters will be given to the Unit	10/2/15
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of resident council minutes, the facility failed to ensure food was maintained at a temperature considered palatable. The census was 86. The findings were:	F 364		

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F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of resident council minutes, the facility failed to ensure food was maintained at a temperature considered palatable. The census was 86. The findings were:	F 364		

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F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of resident council minutes, the facility failed to ensure food was maintained at a temperature considered palatable. The census was 86. The findings were:	F 364		

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F 364	Continued From page 5 1. Review of the resident council minutes showed food temperature was brought up as a concern for the months of May and June 2015. During a group interview of 10 residents on 8/18/15 at 1:15 PM, the residents revealed the temperature of the food served was still too cold for their liking. 2. Interview with resident #8 on 8/19/15 at 9:45 AM revealed the potatoes served for breakfast that morning were cold. 3. Observation on 8/19/15 of the lunch meal preparation and service showed the menu included liver and onions and mashed potatoes. Prior to the start of the meal service at 11:57 AM, cook #2 was making final preparations before beginning service from the main steam table. No food temperature was taken and was requested at that time. When measured, the internal temperature of the liver was observed to be 110 degrees Fahrenheit (F) and the mashed potatoes were observed to be 90 degrees F. The temperatures from the portable steam table were also taken at this time, revealing an internal temperature of 130 degrees F for the liver and 100 degrees F for the potatoes. 4. Interview with the registered dietitian on 8/20/15 at 8:10 AM revealed he was unaware of the resident council complaints regarding food temperatures.	F 364	A plan has been implemented for temperature management during meal services. Staff will take the food temperatures of the prepared food on the tray line within 15 minutes of serving as well as at the end of the meal service to assure temperatures have remained appropriate and palatable. by dietary staff. T he Daily Service Checklist will be filled out during and after every meal. A mandatory in-service was conducted on 8/27/15 for all dietary staff to educate them to this new process. Monitoring: Dietary Manager/ designee will monitor for compliance. Data obtained by the way of food temperature audits will be analyzed for patterns and trends reported monthly to facility QAPI committee. QAPI committee will evaluate based on trends indentified and interventions as needed to ensure continued compliance for 3 months.	
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	F 371		10/2/15

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F 371	Continued From page 6 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 food was maintained at required temperatures for safety for one of one meal observed. In addition, the facility failed to ensure a sanitary environment in the kitchen related to food handling and food containers. The findings were: 1. Observation of the lunch preparation and service on 8/19/15 from 10:35 AM to 1 PM showed the menu included liver and onions, mashed potatoes, and cake with strawberry topping. The following concerns were noted: a. At 10:40 AM, cook #1 placed 5 trays of frozen liver slices in the ovens, with one tray left on food preparation table uncovered. It remained uncovered on the table until 11:11 AM (31 minutes later), when it was placed in the oven. According to Food Code 2013, U.S. Public Health Service 3-305.14 Food Preparation, "During preparation, unPACKAGED FOOD shall be protected from environmental sources of contamination." b. Observation beginning at 10:47 AM showed cook #2 dished out cake slices using gloved hands and a spatula onto small plates, then topping them with strawberry puree and	F 371	F371 Corrective Action: 1:1 education has been conducted with all cook about food being kept in the stem table until it is ready to be served. All food needs to be covered once it is served or taken from stem table. All staff has been educated by DM regarding the use of gloves and hand washing while serving food. An in-service was conducted on 8/24/15. All staff were required to attend. All staff have been educated by the DM . Grill will be cleaned after each meal and during meals if needed. An in-service was conducted on 8/24 15. The policy was reviewed with all dietary staff. All staff attended an in-service on 8/24/15 and were educated on how and when to take food temperatures. Temperature will be taken within 15 minutes of serving the food. The temperature will also be taken 15 minutes after the last plate has been served to see if the temperature has been maintained throughout the meal.	

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	535026	A. BUILDING _____ B. WING _____	C 08/20/2015

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F 371	Continued From page 7 whipped topping. Throughout this process, he was observed touching the handles of the 3 compartment refrigerators multiple times to remove items from inside, then returned to dishing up the cake with the same gloves and no hand washing. He answered the telephone and returned to dishing up the cake with the same gloves and no hand washing. He lifted up the lid to the large trash can in the center of the room, then returned to dishing up the cake continuing to wear the soiled gloves and no hand washing. 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 to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands;" According to Food Code 2013, U.S. Public Health Service, 3-304.15 Gloves, Use Limitation "(A) If used, SINGLE-USE gloves shall be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation..." c. Observation at 11:07 AM showed the griddle top was visibly dirty with pancake pieces and burnt pancake batter. Observation at 11:28 AM showed cook #1 put oil and fresh onions on the griddle without cleaning off the burnt material. Continued observation showed cook #2 stirring the onions, with blackened food particles sticking to the onions.	F 371	Identification of Others: A complete kitchen sanitation audit was completed on 8/24/15 by the Dietary Manager and the registered Dietitian. Corrective action was tken. A weekly sanitation will be conducted to assure that sanitation conditions and guidelines are maintained. Systems/Measures: The Dietary Manager, with the assistance from the Registered Dietitian or designee will complete the daily sanitation audit kitchen walkthrough/ check to assure sanitary conditions are followed. This will also include observation of proper food storage, glove use, temperature and cleaning logs. Un-cleanable equipment like plastic food containers have been replaced Wall surfaces will be cleaned and chipped paint will be repaired behind the three compartment sink. Correction actions will be taken immediately and recorded on the log. This will be completed by 10/2/15 A mandatory in-service for all dietary staff was held on 8/27/15, the above issues were discussed and addressed with all staff.	

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F 371	Continued From page 8 According to Food Code 2013, U.S. Public Health Service, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood- Contact Surfaces, and Utensils, (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..." d. Prior to the start of the meal service at 11:57 AM, cook #2 was making final preparations before beginning service from the main steam table. No food temperature was taken and was requested at that time. When measured, the internal temperature of the liver was observed to be 110 degrees Fahrenheit (F) and the mashed potatoes were observed to be 90 degrees F. The temperatures from the portable steam table were also taken at this time, revealing an internal temperature of 130 degrees F for the liver and 100 degrees F for the potatoes. Interview with cook #2 at that time revealed he does not take the food temperature before service to ensure it is maintained at a safe temperature. Interview with the registered dietitian on 8/20/15 at 8:10 AM revealed he did not have formal documentation of education provided to the kitchen staff regarding food temperatures. He stated his expectation for taking food temperatures was it needed to be done when the food was taken out of the oven, but did not need to be taken again to ensure the food was maintained at a safe temperature. According to Food Code 2013, U.S. Public Health Service: 3-501.16 "(A) Except during preparation,	F 371	Monitoring: Dietary Manager/ Registered Dietitian or designee will monitor for compliance. Data obtained by the way of the Daily Sanitation Audit will be analyzed for patterns and trends reported monthly to facility QAPI committee will evaluate based on trends identified and interventions as needed to ensure continued compliance month X3.	10/2/15

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	535028	A. BUILDING _____ B. WING _____	C 08/20/2015

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F 371	Continued From page 9 cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, potentially hazardous food time/temperature control for safety food) shall be maintained: (1) At 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54°C (130°F) or above; or (2) At 5°C (41°F) or less." 2. Observation on 8/17/15 at 3:55 PM and 8/20/15 at 8:30 AM showed the wall behind the three compartment sink was splattered with food and had chipped, peeling paint. Further observation showed plastic food containers available on a wire rack. Seven of these containers were visibly soiled with white, crusted matter and a white film over the surface. 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." 3. Interview with the dietary manager on 8/20/15 beginning at 8:53 AM confirmed gloves need to be changed when switching between tasks. He also confirmed the tray of liver on the table should have been covered to prevent possible contamination from other sources. Additionally, he confirmed the griddle should have been cleaned after breakfast, and the onions should not have been cooked on a soiled cooking	F 371		

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F 371	Continued From page 10 surface. He acknowledged the soiled plastic ware was available but was no longer appropriate for food and would be discarded.	F 371		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, review of the 2567 and resident council minutes, and staff and resident interview, the facility failed to have an effective quality assessment and assurance (QAA)	F 520	Corrective Action: The NHA will facilitate weekly QAPI meetings re: F225, F253, F309, and F371 to ensure progress is being made in regards to the correction of the current deficiencies. Identification of Others: A monthly review of Resident Council minutes and the Resident Food Committee meeting will be conducted, all department heads that are mentioned will involved in the solution of the issue. The NHA or designee will conduct a thorough QAPI committee meeting to identify any additional concerns and take corrective actions as needed. Systems/Measures:	

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F 520	Continued From page 11 program to implement corrective actions for identified problem areas. The findings were: Review of the 7/10/14 CMS-2567 for the previous year's survey showed F371 was written related to not maintaining appropriate food temperatures for safety. This same issue was identified during this survey as evidenced by: a. Review of the resident council minutes showed food temperature was brought up as a concern for the months of May and June 2015. b. During a group interview of 10 residents on 8/18/15 at 1:15 PM, the residents revealed the temperature of the food served was still too cold for their liking. c. Observation on 8/19/15 of the lunch meal preparation and service showed the menu included liver and onions and mashed potatoes. Prior to the start of the meal service at 11:57 AM, cook #2 was making final preparations before beginning service from the main steam table. No food temperature was taken and was requested at that time. When measured, the internal temperature of the liver was observed to be 110 degrees Fahrenheit (F) and the mashed potatoes were observed to be 90 degrees F. The temperatures from the portable steam table were also taken at this time, revealing an internal temperature of 130 degrees F for the liver and 100 degrees F for the potatoes. During an interview on 8/20/15 at 8:50 AM the administrator and DON stated the issue of food temperatures was looked at in QAA after last year's survey, but acknowledged that the issue was not adequately addressed. They further stated that resident council minutes were brought to QAA, and acknowledged that the issue of food temperatures had not been corrected.	F 520	A plan has been implemented for temperature management during meal services. Staff will take the food temperatures of the prepared food on the tray line within 15 minutes of serving as well as at the end of the meal service to assure temperatures have remained appropriate and palatable. by dietary staff. T he Daily Service Checklist will be filled out during and after every meal. A mandatory in-service was conducted on 8/27/15 for all dietary staff to educate them to this new process. they will be turned into the Administrator for his signature, the Administrator will also follow up with the Recreation Director to see if concerns have been addressed. Once they have been addressed they will be filed in our concern log. The Dietary Manager will conduct a monthly food meeting. This meeting is for all residents to discuss the food issues as well as to have a say with food choices. There is a resident choice meal offered on Fridays. When issues are discussed in this meeting the same process as above will be followed as above.	

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			Monthly Resident Council Meetings will be held. The Recreation Director will conduct the meeting, at this time concerns and complaints will be addressed. The Recreation Director will review the concerns and then pass them on to our Customer Service Coordinator; she will then review all of the concerns and pass them on to the appropriate department heads. Once they have addressed the issues We have a system set up for all concerns that residents and family members have. All concerns will be turned into the Customer Service Coordinator. She will review each concern and will make sure the appropriate department heads receives the concern. When concerns have addressed it is then given to the administrator for review and his signature. When this it complete the concern is returned to the Customer Service Coordinator to file in our concern log.	

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			Monitoring: Recreation Director, Dietary Manager and the Customer Service Coordinator will monitor for compliance. Data obtained will be analyzed for patterns and trends reported monthly to the facility QAPI committee. QAPI committee will evaluate based on trends identified and interventions as needed to ensure compliance month X3.	10/2/15