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

PRINTED: 03/10/2016
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
	535038	A. BUILDING ______ B. WING ______	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

(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 In addition to the recertification survey, a complaint survey was conducted by Healthcare Licensing and Surveys on 2/22/16 through 2/25/16. The survey was prompted by complaint intake WY00002194. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the complaint investigation. The following common abbreviations are used throughout this document: ADON- Assistance Director of Nursing DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set mg- milligrams RN- registered nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and medical record review, the facility failed to ensure an assessment was completed for safe self-administration of medications for 1 of	F 176	An assessment was completed for self-administration of medications for resident #36 on 3/1/16. The IDT team determined there were other residents that desire to self-administer medications. Assessments were completed on these residents on 3/1/16. All residents will be reassessed quarterly to ensure, if they desire to self-administer medications, that they are safe to do so. Any concerns will be reported to the QA committee.	3/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE ADMINISTRATOR (X6) DATE 3/19/16

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 accepted. Call to Nancy Burt, NHA on 4/12/16 @ 3:10pm. Janelle Cal 10x2c

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F 176	Continued From page 1 9 sample residents (#36). The findings were: Review of the 12/17/15 quarterly MDS assessment showed resident #36 was cognitively intact with a BIMS (Brief Interview for Mental Status) score of 14/15. Observation on 2/22/16 at 6 PM showed the resident was eating in his/her room and had a medication cup containing multiple pills located on the meal tray. Interview with the resident at that time revealed the nurse had left the medications, and the resident wondered if his/her pain medication was included. Interview with LPN #1 on 2/22/16 at 6:05 PM verified the medications had been left with the resident, and the pain medication was included. She then verified she should have stayed and ensured the resident took the medications. Interview with the DON on 2/24/16 at 10:45 AM verified nurses were expected to watch residents take medications, and there was no assessment completed for the resident related to self-administration.	F 176		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225		

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F 225	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on review of policies and procedures, and facility investigation documentation, and staff interview, the facility failed to ensure resident safety during the investigation for 1 of 3 allegations of staff to resident abuse reviewed (resident #34). The findings were: 1. Review of facility investigation documentation showed an allegation of "mistreatment" involving resident #34 occurred on 6/9/15. An LPN was accused of "jerking the resident up in bed" and hurting his/her arm. Review of the facility's documentation showed staff were told to always	F 225	Effective immediately, Administrator and DON will ensure any staff member mentioned in an investigation involving abuse/mistreatment will be suspended until the investigation is complete. Administrator will conduct monthly review of investigations to ensure appropriate action is taken. Any concerns will be reported to QA committee.	3/1/16

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F 225	Continued From page 3 have a second staff person present when caring for resident #34. There lacked evidence the facility protected other residents from potential abuse by the LPN during the investigation. The results of the investigation were dated 6/12/15; the facility determined the allegation was unsubstantiated. 2. During an interview on 2/25/16 at 8:16 AM, the administrator stated the LPN was not suspended or removed from direct resident contact during the investigation. She stated she did not do that because the assessment of the resident after the incident did not reveal any injuries to the arm. 3. Review of the facility's policy "Abuse-Prevention, Investigating and Reporting" (#2001, revised 6/2009) revealed "...Protection...If the complaint alleges abuse by a staff member, that staff member will be suspended or removed from direct patient care (whichever is appropriate to protect the resident) until an investigation has been completed..."	F 225		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility, This REQUIREMENT is not met as evidenced by: Based on review of resident group meeting minutes, and staff and resident interview, the	F 244		

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F 244	Continued From page 4 facility failed to ensure grievances from the resident group were acted upon to resolve repeated issues for 3 of 3 months (December 2015, January 2016, February 2016) reviewed. The findings were: Review of the resident council meeting minutes for December 2015, and January and February 2016 showed there were issues that were unresolved. These issues included the need for more staff to answer call lights timely, the need for added assistance/coverage in the dining room for the evening meal, and to have nurses stay in the room to ensure residents took their medications. Confidential interview with a group of residents on 2/23/16 revealed of the 9 residents who attended the group interview, 7 felt these issues had not improved. Interview with the resident advocate on 2/24/16 at 9:50 AM revealed the process for addressing resident council grievances/issues was for the administrator to respond in e-mail. The advocate received the e-mail and then relayed the information to the residents at the next meeting. The advocate confirmed the process was not always effective, and repeat issues had been brought up.	F 244	The topic of acting on resident council concerns was discussed with the resident council on 3/1/16 and with the QA committee on 3/2/16. The resident council would like to invite department managers to the meeting when there is a concern in their department. After voicing the concern, the department manager will come up with a resolution and will return to the next month's resident council to discuss the resolution and ensure it is acceptable to the council. Department managers will be expected to address orally and in writing any concerns voiced by the resident council. Resident Advocate will review monthly minutes of the resident council and if an issue is brought for more than three consecutive months, a written grievance process will be initiated until the issue is resolved.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure handrails were maintained	F 253	Administrator will conduct monthly review of resident council minutes for four months to ensure concerns are being addressed appropriately. Resident Advocate and/or Administrator will monitor follow-up on resident council concerns and will bring issues to QA committee.	3/2/16

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F 253	Continued From page 5 in 3 of 3 resident hallways (100 hallway, 200 hallway, 300 hallway). In addition, the facility failed to ensure resident floors were maintained to ensure adequate cleaning for the television area (connected to the main dining area) and 3 of 3 hallways (100 hallway, 200 hallway, 300 hallway). The findings were: 1. Observation on 2/25/16 at 10 AM showed the following handrails had various scratches and scrapes: a. In the hallway by room #103. b. In the hallway by room #104. c. In the hallway by room #105. d. In the hallway between rooms #300 and #302. e. In the hallway across from the nursing station by room #200. f. In the hallway across from the nursing station by the beauty shop. g. In the hallway across from the nursing station by the custodial closet. 2. Observation on 2/25/16 from 8:15 AM through 9 AM showed the following concerns with damaged floors that created a surface inadequate for cleaning: a. The floor between the doorway of room #100 and the hallway had a noticeable gap 42 inches in length which was darkened with dirt and debris. b. The floor at the front of room #106 had 2 tiles that measured 12 by 12 inches with a 6 inch noticeable crack that was darkened with dirt. c. The floor between the doorway of room #106 and the hallway had a noticeable gap 42 inches in length which was darkened with dirt and debris. d. The floor between the doorway of room	F 253	The handrails were refinished for the following hallway by room 103, hallway by room 104, hallway by room 105, hallway between rooms 300 and 302, hallway across from nursing station by room 200, hallway across from nursing station by beauty shop, hallway across from nursing station by custodial closet. The refinishing will be completed on 4/9/16. The tile flooring was replaced in the following areas: doorway of room 100, doorway of room 105, doorway of room 106, doorway of room 107, doorway of room 110, doorway of room 200, doorway of room 201, doorway of room 202, doorway of room 203, doorway of room 205, sitting room (204) entry, front of room 208, front of room 210, hallway near clean utility room across from nursing station, outside exit door in day room (TV room). The floor projects will be completed on 4/9/16. The maintenance supervisor or designee will inspect handrails monthly to ensure they are not showing excessive amounts of ware. Any that show excessive ware will be refinished. The maintenance supervisor or designee will inspect tile flooring monthly to ensure it is not showing signs of cracking. Any that show cracking will be replaced. Any concerns regarding flooring or handrails will be brought to the QA committee.	4/9/16

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F 253	Continued From page 6 #107 and the hallway had a noticeable gap 32 inches in length which was darkened with dirt and debris. e. The floor between the doorway of room #110 and the hallway had a noticeable gap 42 inches in length which was darkened with dirt and debris. f. The floor at the front of room #200 had 1 tile that measured 12 by 12 inches with a 6 inch noticeable crack that was darkened with dirt. g. The floor between the doorway of room #201 and the hallway had a noticeable gap 32 inches in length which was darkened with dirt and debris. h. The floor at the front of room #202 had a noticeable crack which measured 36 inches in length and was darkened with dirt. i. The floor at the front of room #203 had a noticeable crack which measured 24 inches in length and were darkened with dirt. j. The floor at the front of room #205 had multiple cracks which measured 30 inches in length and were darkened with dirt. k. The floor at the front of room #204 (the sitting room) had multiple cracks which measured 66 inches in length and were darkened with dirt. l. The floor at the front of room #208 had multiple cracks which measured 38 inches in length and were darkened with dirt. m. The floor at the front of room #210 had 2 torn tiles which measured 22 inches in length and were darkened with dirt. n. The hallway floor by the clean utility room across from the nursing station had a gap between 2 tiles which measured 12 inches by 12 inches each with an accumulation of dirt and debris. o. The outside exit door in the television room connected to the main dining area had multiple	F 253		

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F 253	Continued From page 7 cracks on the floor which measured 32 inches in length and collected dirt and debris. 3. Interview with the maintenance director on 2/25/16 at 9:50 AM confirmed he was aware of the issues with the handrails and floors. He "touched-up" the handrails at intervals, but confirmed there was no schedule with a timeframe to address the handrails. He stated the facility planned to place new flooring in the building. However, he confirmed the facility did not have a plan with a timeframe to address the floor issues.	F 253		
F 309 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on medical record and staff interview, the facility failed to ensure 1 of 1 sample resident (#13) who had a fall with a head injury received neurological checks (neuro-checks). The findings were: Medical record review for resident #13 showed s/he had a fall on 2/8/16 at 2:30 PM. Review of the corresponding post-fall assessment showed the following under the team meeting notes, "Per nurse resident lost [his/her] balance and fell in	F 309		

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F 309	Continued From page 8 [his/her] room. Blood sugar 93. Slightly raised area to right posterior cranium." Review of the entire medical record showed no documentation of any neuro-checks after the resident's fall. Interview with the DON on 2/24/16 at 5:30 PM confirmed the facility failed to perform neuro-checks on the resident after the 2/8/16 fall. She further confirmed her expectation was for facility staff to perform neuro-checks any time a resident has an injury to his or her head. According to Lippincott Nursing Procedures, Seventh Edition 2014 by Wolters Kluwer; after a fall, "Determine whether the patient experienced a head trauma, which requires further diagnostic evaluation to rule out subdural hematoma...Even if the patient shows no signs of distress or has sustained only minor injuries, monitor his vital signs and assess his neurological status frequently until his condition stabilizes. Notify the practitioner if you note any change from the baseline."	F 309	A head to toe assessment with neuro check was completed for resident #13 on 3/2/16. No concerns were identified. Memo provided to nursing staff on 2/25/16 and 3/3/16 regarding neuro-checks needing to be done anytime a resident has an injury to his/her head. Neuro checks post fall added to weekly audit checklist. DON or designee will ensure neuro-checks are initiated when a resident sustains injury to head. Any concerns will be reported to the QA committee.	3/3/16
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced	F 315		

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F 315	Continued From page 9 by: Based on observation, medical record review, and staff interview, the facility failed to an indwelling the catheter was clinically necessary for 1 of 2 sample residents (#29) with indwelling catheters. The findings were: Observation on 2/22/16 at 4:44 PM revealed resident #29 was in bed, with a catheter drainage bag attached to the side of the bed. Review of the 10/28/15 admission and 1/28/16 quarterly MDS assessments revealed the resident had an indwelling catheter. Review of the Care Area Assessment (CAA) associated with the admission MDS assessment showed the resident had a catheter "related to impaired mobility and incontinence as evidenced by need for foley catheter to prevent skin breakdown." Review of physician progress notes showed no medical justification for the catheter; in fact, the catheter was not mentioned at all. During an interview on 2/24/16 at 4:45 PM, the ADON stated "If residents are admitted to the facility with it [catheter] in, we can leave it in." On 2/24/16 at 5:30 PM the DON stated they didn't evaluate catheters for appropriate use if they were present upon admission.	F 315	Resident #29 was seen by his/her attending physician on 3/3/16. Resident was diagnosed with neuromuscular dysfunction of the bladder. Physician reported catheter is clinically necessary. Catheter will remain in place for resident #29 and will be reviewed with quarterly assessment. Any resident having a catheter in place (whether on admit or otherwise) will be reviewed weekly by DON or designee for appropriateness to ensure clinical necessity. Any found to lack clinical necessity will be reviewed by physician and addressed per physician recommendation. Any concerns identified will be brought to the QA committee.	3/3/16
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure food and food service equipment was stored/prepared under sanitary conditions in 2 of 2 kitchens (activity room kitchen, main kitchen). The findings were: 1. Observations of the activity room kitchen on 9/23/16 at 9:10 AM showed the oven, microwave, and small refrigerator were in need of cleaning. The equipment was soiled with food debris on the interior and exterior surfaces. In addition, the small refrigerator with containers of pudding in it was not equipped with a thermometer. Further, the large refrigerator in this kitchen contained food items which were not dated to show when they were to be discarded. These items included buns, a partial bag of shredded lettuce, two shell eggs, and an opened bag of shredded cheese. Observation on 2/24/16 at 3:35 PM showed the condition of the equipment remained soiled, and some of the undated food items had been removed. According to Food Code 2013, U.S. Public Health Service: 3-501.17 "(A)...refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days.	F 371	Activity room appliances (oven, microwave, and small fridge) were cleaned on 2/25/16. Activity staff was in-serviced on 2/25/16 regarding cleaning of appliances. The appliances will be placed on a cleaning schedule to be cleaned weekly. Activity staff was in-serviced on 2/25/16 regarding dates on open items. Activity director or designee will inspect the appliances and the food items to ensure compliance with the cleaning schedule and labeling requirements on a weekly basis. Any concerns will be reported to the QA committee. The 6 beverage pitchers in the main kitchen were discarded on 3/18/16. The cutting boards were discarded on 3/18/16 and replaced with new ones. The white cutting board surface of the steam table will be replaced on/before 4/9/16. The lids used to cover plates will be discarded and replaced with new ones on/before 4/9/16. The ceiling vents were cleaned on 3/14/16. The dietary manager or designee will inspect all kitchen equipment once per month to ensure there are no issues with un-cleanable surfaces and to ensure items are in proper working order without signs of wear. Kitchen vents will be placed on a bi-weekly cleaning schedule and will be inspected monthly for cleanliness by dietary manger or designee. Any issues identified will be reported to the QA committee.	4/9/16

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/10/2016
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
	535038	A. BUILDING _____ B. WING _____	C 02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - EVANSTON	475 YELLOW CREEK ROAD EVANSTON, WY 82930

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F 371	Continued From page 11 According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." According to Food Code 2013, U.S. Public Health Service: 4-204.112 " ... (B) Except as specified in ¶ (C) of this section, cold or hot holding EQUIPMENT used for TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be designed to include and shall be equipped with at least one integral or permanently affixed TEMPERATURE MEASURING DEVICE that is located to allow easy viewing of the device's temperature display. " 2. Observation of the main kitchen on 2/24/16 at 11:15 AM showed 6 beverage pitchers which had an un-cleanable outer surface due to accumulation of adhesive labels, and 2 white cutting-boards which were stored on a rack were discolored and scored from use. The white cutting-board surface of the steam table was discolored and scored from use. The lids used to cover plates of food were visibly stained and the outer plastic material was worn, creating a non-cleanable surface. Further, there were 3 ceiling vents above the food preparation and serving tables with visible dust on the outer surface and surrounding ceiling tiles. According to Food Code 2013, U.S. Public Health Service: 4-201.11 "EQUIPMENT and UTENSILS shall be designed and constructed to be durable and to retain their characteristic qualities under normal use conditions.	F 371		

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F 371	Continued From page 12 3. Interview with the dietary manager on 2/24/16 at 3:35 PM verified the above mentioned equipment needed to be cleaned and or replaced in the main kitchen. Also she confirmed the activity room kitchen was in need of monitoring to ensure items were dated and labeled and that the equipment was cleaned.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431		

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F 431	Continued From page 13 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medications available for use were not available past the expiration date in 2 of 3 storage areas (Group I medication cart, Group II medication cart). The findings were: 1. Observation on 2/25/16 at 9:25 AM with RN #1 showed the Group I medication cart had 24 tablets of Phenergan 25 mg (anti-emetic) with an expiration date of 9/15/15 that was available for use for resident #31. At that time RN #1 confirmed the medication was expired and available for use. 2. Observation on 2/25/16 at 9:40 AM with LPN #2 showed the Group II medication cart had 21 tablets of Zofran 8 mg (anti-emetic) with an expiration date of 1/2/16 that was available for use for resident #8. At that time LPN #2 confirmed the medication was expired and available for use. According to Clinical Nursing Skills 7th edition by Smith, Duell, and Martin; the six rights of medication administration includes the right medication, "Compare drug container label to the medication sheet (MAR) three times. Note expiration date..."	F 431	The expired medications that were found were removed from use and properly destroyed on 2/25/16. The DON or designee will conduct weekly audit of medications to ensure expired medications are not available for use. Any concerns will be brought to the QA committee.	2/25/16
F 465	483.70(h)	F 465		

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F 465 SS=D	Continued From page 14 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe and sanitary environment in 1 of 1 dish rooms. The findings were: Observation of the dish room on 2/24/16 at 11:15 AM showed the wall behind the sprayer had black grime which covered an area approximately 2 feet long by 6 inches in height. In addition, the dish room ceiling vents had visible dust on and around them, and the partition wall between the dirty and clean side of the room was soiled with food debris and had a corner piece missing. Interview with the dietary manager and the maintenance director on 2/24/16 at 4:50 PM verified these areas needed to be cleaned and/or repaired.	F 465	The sections of wall covering identified in the dish room were thoroughly cleaned by dietary staff member on 3/18/16. If the wall covering does not clean adequately (after discussion with the consultant dietician) the sections of wall covering will be replaced on/before 4/9/16. The ceiling vents in the dish room were cleaned on 3/14/16. The vents were placed on a bi-weekly cleaning schedule. The wall covering and corner pieces on the partition wall in the dish room were replaced with new wall covering and new corner pieces on 3/10/16. In-service conducted with dietary staff regarding cleaning techniques and requirements on 2/25/16. Dietary manager or designee will inspect dish room and kitchen areas for cleanliness once per month. Extra cleaning will be done if issues are identified. Any issues identified will be reported to the QA committee.	3/25/16