PRINTED: 03/15/2017
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 |
|---|---|---|---|
| | 535023 | A. BUILDING _____ B. WING _____ | 02/09/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WESTON COUNTY HEALTH SERVICES | 1124 WASHINGTON BLVD NEWCASTLE, WY 82701 |

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| F 000 | INITIAL COMMENTS<br><br>A recertification survey was conducted by Healthcare Licensing and Surveys on 2/6/17 through 2/9/17. Complaint WY000002265 was also reviewed in the course of this survey.<br><br>The following common abbreviations are used throughout this document:<br><br>ADLs: Activities of Daily Living<br>CNA: Certified Nurse Aide<br>DON: Director of Nursing<br>MDS: Minimum Data Set<br>RN: Registered Nurse<br><br>Less commonly used abbreviations will be annotated in each deficiency. | F 000 | | |
| F 253 SS=E | 483.10(l)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure 6 of 7 resident areas (100 hall, 200 hall, 300 hall, 400 hall, common area, activities room) were clean and in good repair. The findings were:<br><br>1. Concerns identified on the 100 hall:<br>a. Observation on 2/7/17 at 10:05 AM showed 2 ceiling tiles outside of room #1 had a rectangle-shaped cover in the center of the tile that had water damage.<br>b. Observation on 2/7/17 at 10:06 AM showed a 2-inch by 2-inch plaster repair on the wall | F 253 | F253 - WCHS Maintenance staff is responsible for the following repairs and concerns.<br>1. Concerns identified on hall 100.<br>a. Ceiling tiles outside of room 1 will be painted with an oil based sealer.<br>b. The 2 inch by 2 inch plaster repair will be fixed and painted to match between room 3 and 4. | 04/09/2017 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: NHA | (X6) DATE: 3/29/17

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.

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| F 253 | Continued From page 1<br>between room #3 and #4 that could not be cleaned effectively.<br><br>2. Concerns identified on the 200 hall:<br>a. Observation on 2/7/17 at 10:20 AM showed a crack in the wall, 12 inches in length, that ran down from the ceiling beam on the left side of the door frame of the shower room.<br>b. Observation on 2/7/17 at 10:24 AM showed a 19-inch by 7-inch plaster patch in the wall by room #27 that could not be cleaned effectively. In addition, there was water damage to 3 ceiling tiles between room #27 and room #22.<br>c. Observation on 2/7/17 at 10:25 AM outside of room #23 showed a 1-inch by 1/2-inch section of wall which was damaged and exposed the underlying material. Further, the wall outside of room #24 had 2 damaged areas which measured 1-inch by 1/4-inch, and 3/4-inch by 1/2-inch. The wall to the left of the door to room #25 had a damaged area measuring 2 inches by 1/2-inch that could not be cleaned effectively.<br><br>3. Concerns identified on the 300 hall:<br>a. Observation on 2/9/17 at 9:45 AM showed a section of floor in room #9 had a 4-foot by 1/2-inch long seam under the foot of the bed that was not properly secured. A section of floor by the sink had a 41-inch by 14-inch rippled and torn area that could not be cleaned effectively.<br><br>4. Concerns identified on the 400 hall:<br>a. Observation on 2/7/17 at 10:40 AM showed part of the push rail on the exit door by room #29 was missing a cover, which exposed the wiring and caused a safety hazard for the residents.<br><br>5. Concerns identified in the Common area:<br>a. Observation on 2/7/17 at 10:10 AM showed | F 253 | 2. Concerns identified on hall 200.<br>a. Crack in wall approximately 12 inches in length from the ceiling on the left side of shower room will be repaired and painted to match.<br>b. The 19 inch x 7 inch plaster patch by room 27 will be repaired and painted to match along with the 3 ceiling tiles between room 27 and 22 will be painted with oil base sealer.<br>c. Outside room 23 the 1 inch by 1/2 inch section of wall will be repaired. The wall outside of room 24 had 2 damaged areas that will be repaired approximately 1 inch by ¼ inch and ¾ inch by ½ inch. The wall left of room 25 2 inches by ½ inch will be repaired to match for cleaning purposes.<br>3. Concerns on hall 300.<br>a. The entire flooring in room 9 will be replaced including the restroom.<br>4. Concerns on hall 400.<br>a. Part of the push rail on the exit door by room 29 was under repair of our current contractors this is completed and cover replaced.<br>5. Concerns in common area.<br>a. The 4 water damaged ceiling tiles located next to 2nd light fixture will be painted with oil base sealer. | |



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APR 17 2017
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4/18/17 3:36 pm POC Accepted & agreed Chang
Spoke with JoAnn Farnsworth, Admin.
~~1 word~~ me, 4/9/17 Date of Compliance

Rene Cruz. State Surveyor

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| F 253 | Continued From page 2<br>4 water-damaged ceiling tiles located next to the 2nd light fixture.<br>b. Observation on 2/7/17 at 10:50 AM showed the small common area outside the solarium had 2 water-damaged ceiling tiles in front of the exit door. In addition, in the corner of the room where the recliners and the bird cage were located was a section of wall which measured 6 inches by 6 inches that was damaged and exposed underlying material.<br><br>6. Concerns identified in the Activities area:<br>a. Observation on 2/7/17 at 12:55 PM showed the Activities room had 2 large ceiling tiles with water damage.<br><br>7. Interview with maintenance assistant on 2/9/17 at 11:15 AM verified the identified areas were in need of repair, with no time frame in place for repairs. | F 253 | b. The 2 ceiling tiles in the small common area outside of the solarium will be replced. In addition, the section of wall in the corner of the room 6X6 inches will be patched and painted to match.<br><br>6. Activities Room concerns will be repaired: a. the 2 ceiling tiles showing water damage will be replaced by maintenance.<br>b. Maintenance team will do a walk through of the facility to identify any other issues to be ~~prepared.~~ repaired. 4/18/17 3:36 PM ME<br>c. Maintenance will monitor these concerns via monthly walk-throughs and report monthly to QA | |
| F 309 SS=G | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>483.24 Quality of life<br>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care.<br><br>483.25<br>(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, | F 309 | | |

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| F 309 | Continued From page 3<br>the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, medical record review, and policy and procedure review, the facility failed to promptly assess 1 of 6 sample residents (#51) who had a change of condition. This failure resulted in a delay in treatment and actual harm to the resident. In addition, the facility failed to perform neurological assessment for 1 of 6 sample residents (#16) with falls. The findings were:<br><br>1. Review of a "Health Status Note" dated 11/19/16 and timed 4:16 PM showed resident #51 was scheduled to go out with his/her family; however, the trip was canceled because the resident stated s/he did not "...feel well enough to go..." Further review of the medical record failed to show any evidence a nursing assessment was completed when the resident complained of feeling unwell.<br><br>2. Review of a "Change of Condition" late entry note dated 11/20/16 and timed 8 AM showed resident #51 was unresponsive when the nurse attempted to wake him/her up for breakfast. The resident was noted to have had complaints of an upset stomach the previous day. Further, the note indicated the change "...Appeared to have started on: 11/19/16..." and the resident was transferred | F 309 | F309 The facility will ensure that residents who experience a change in condition will be assessed timely.<br><br>Resident #51 is no longer a resident in the facility.<br><br>1. All other residents will be monitored by all staff for changes in condition and the "Assessing for change in condition" process will be implemented.<br><br>2 Director of Nursing or designee will conduct an in-service to the nursing staff & IDT members on the Change of Condition Process to include; completing the SBAR Assessments, nursing assessment, vital signs, family notification, physician notification, and adding resident to the alert charting.<br><br>3 Director of Nursing or designee will do daily audit 5 days a week to ensure that the IDT members are conducting a morning meeting to include IDT members and are reviewing notes/orders/alerts in PointClickCare ensuring that change of conditions via SBAR Assessments have been completed, vital signs, family | 04/09/2017 |

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| F 309 | Continued From page 4<br>to the hospital on 11/20/16.<br><br>3. Review of the "ER Note" dictated on 11/21/16 at 1:13 AM showed resident #51 was admitted on 11/20/16 and the family member stated the resident "did not feel well yesterday and canceled a family outing that had been planned and reports that [s/he] was complaining of nausea and may have had some vomiting also..." The note indicated the resident had not been "seen" since 7:30 PM on 11/19/16, 12 1/2 hours prior to being found unresponsive. During the physical examination the resident's blood glucose was determined to be "less than 20" and 2 amps (ampoules) of D 50 (dextrose 50%) was given. The resident's blood sugars improved; however, the resident remained unresponsive. Further, the physician was notified by the laboratory that the resident's lactic acid was elevated and the physician determined the resident was in septic shock, administered vancomycin (an antibiotic) 1 gram IV (intravenous), and transported the resident "by air" to a higher level of care. The diagnosis was septic shock with organ failure.<br><br>4. Interview with the DON on 2/9/17 at 10:10 AM confirmed a nursing assessment was not completed when the resident complained of feeling unwell on 11/19/16, and further revealed the resident was not placed on change of condition monitoring but should have been.<br><br>5. Review of the policy titled "Change in a Resident's Condition or Status" last revised 04/2014 showed "...1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been:...d. a significant change in the resident's physical/emotional/mental | F 309 | notification, physician notification and resident is added to the alert charting.<br><br>4.Director of Nursing or designee will bring the audit results to the QAPI monthly meeting for review and corrective actions taken where necessary<br><br>5. Resident #16 and all residents will be monitored with neurological assessments after all unwitnessed falls and falls with head injury.<br><br>6. Director of Nursing or designee to conduct in-service to the nursing staff & IDT members on the fall protocol to include; completing the Incident Report, SBAR Assessments, nursing assessment, vital signs, family notification, physician notification, and adding resident to the alert charting as well as the neurological assessments forms.<br><br>7. Director of Nursing or designee will complete 100% chart audit of the residents' progress notes and SBARS for the past 60 days to identify residents who have had an unwitnessed fall without neurological assessments forms being completed. | |

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| F 309 | Continued From page 5<br>condition;...2. A "significant change" of condition is a decline or improvement in the resident's status that:...d. Ultimately is based on the judgement of the clinical staff and the guidelines outlined in the Resident Assessment Instrument and 42 CFR 483.20 (b)(ii)..."<br><br>6. Review of the 1/25/17 annual MDS assessment showed resident #16 had diagnoses that included Parkinson's disease and fibromyalgia. The resident had a BIMS score of 13 (cognitively intact) and required the extensive assistance of 1 person for bed mobility and transfers. The following concerns were identified:<br>a. Review of an "Incident Note" dated 11/14/16 and timed 2:55 PM showed the resident was found on the floor next to his/her bed. The resident denied hitting his/her head and stated, "I didn't fall." The note further indicated the resident had activated the call light but was unable to remember why and "...does become confused and delusional at times..."<br>b. Review of the progress notes between 11/14/16 and 11/17/16 showed no evidence of follow-up documentation or neurological assessments.<br>c. Review of a "Change of Condition" note dated 1/3/17 and 2:30 PM showed the resident slid off his/her bed to get closer to the wheelchair. There was no documentation to show if the event was witnessed or unwitnessed.<br>d. Review of the progress notes between 1/3/17 and 1/6/17 showed no evidence neurological assessments were performed.<br>e. Interview with the DON on 2/9/17 at 10:10 AM revealed neurological assessments were not completed for either of the falls because there was no evidence of a head injury; however, she confirmed that without a neurological | F 309 | 8. Director of Nursing or designee will complete 100% chart audit of the residents' progress notes and SBARS for the past 60 days to identify residents who have had an unwitnessed fall without neurological assessments forms being completed.<br><br>9. Director of Nursing or designee will bring the audit results to the QAPI monthly meeting for review and corrective actions taken where necessary until resolved. | |

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| F 309 | Continued From page 6<br>assessment, the facility could not be sure there was not a head injury.<br><br>7. Review of the policy titled "Performing Neurological Assessments" last revised on 11/2013 showed "...Accurate neurological assessments will be performed immediately on any resident with a suspected head injury (including after falls), after physician orders, and/or as deemed necessary by the nurse on duty..." | F 309 | | |
| F 323 SS=E | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are | F 323 | F323 The facility will ensure the safety of residents #16, #34, #35, #37, #41 and all residents. This will be accomplished by:<br><br>1. Resident #35: Enabler / Transfer Bar / Pre-Restraint Assessment completed on 2/9/2017. The use of the transfer bar was in care plan created on 6/6/2016. The safety of the use of the transfer bar added to the care plan 3/6/2017.<br>2. Resident #16: Enabler / Transfer Bar / Pre-Restraint Assessment completed on 2/9/2017. The use of the transfer bar was in care plan | 04/09/2017 |

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| F 323 | Continued From page 7<br>appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure safety for 5 of 7 sample residents (#16, #34, #35, #37, #41) with positioning devices. The findings were:<br><br>1. Review of the 1/18/17 significant change MDS assessment showed resident #35 had diagnoses that included non-Alzheimer's dementia, Parkinson's disease, and muscle weakness, and the resident had a BIMS (brief interview for mental status) score of 9 (moderately impaired). Further, the resident required the extensive assistance of 2 people for bed mobility and transfers and was not coded as having physical restraints while in bed. The following concerns were identified:<br>a. Observation on 2/6/17 at 7:25 PM showed the resident had an enabler applied to one side of the bed and the other side of the bed was placed against the wall.<br>b. Observation on 2/9/17 at 9 AM showed the enabler was designed to have a gap between the bars which was large enough for the the resident to place a limb through. The gaps measured 4 1/2 inches by 4 inches.<br>c. Review of the resident's medical record showed no evidence that a safety assessment of the enabler was completed.<br><br>2. Review of the 1/26/17 annual MDS assessment showed resident #16 had diagnoses that included Parkinson's disease and fibromyalgia. The resident had a BIMS score of 13 (cognitively intact) and required the extensive assistance of 1 person for bed mobility and | F 323 | created on 7/10/2015. The safety of the use of the transfer bar added to the care plan 3/6/2017.<br>3. Resident #37: Enabler / Transfer Bar / Pre-Restraint Assessment completed on 2/9/2017. The use of the transfer bar was in care plan created on 1/30/2017. The safety of the use of the transfer bar added to the care plan 3/6/2017.<br>4. Resident #34: Enabler / Transfer Bar / Pre-Restraint Assessment completed on 2/9/2017. The use of the transfer bar was in care plan created on 3/6/2017. The safety of the use of the transfer bar added to the care plan 3/6/2017.<br>5. Resident #41: Enabler / Transfer Bar / Pre-Restraint Assessment completed on 2/9/2017. The use of the noodle was in care plan created on 11/1/2016. The safety of the use of the noodle added to the care plan 3/6/2017.<br>6. Director of Nursing or designee to conduct in-service to the nursing staff & IDT | |

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| F 323 | Continued From page 8<br>transfers. Further, the resident was not coded as having physical restraints in bed. The following concerns were identified:<br>a. Observation on 2/6/17 at 7:15 PM showed the resident had an enabler applied to one side of the bed and the other side of the bed was placed against the wall.<br>b. Observation on 2/9/17 at 9:15 AM showed the enabler was designed to have 2 gaps between the bars which were large enough for the resident to place a limb through. The top gap measure 4 inches by 6 inches and the bottom gap measured 4 inches by 4 inches.<br>c. Review of the resident's medical record showed no evidence that a safety assessment of the enabler was completed.<br><br>3. Review of the 1/3/17 quarterly MDS assessment showed resident #37 had diagnoses that included macular degeneration, osteoarthritis, fatigue, and hypertrophic pyloric stenosis. Further, the resident required one person physical assistance for bed mobility and transfers and was not coded as having physical restraints while in bed. The following concerns were identified:<br>a. Observation on 2/6/17 at 6:30 PM showed the resident had an enabler applied to one side of the bed with the other side of the bed placed against the wall.<br>b. Observation on 2/9/17 at 9:35 AM showed the enablers were designed to have 2 gaps between the bars which were large enough for the the resident to place a limb through. The gaps measured 4 inches by 4 inches and 4 inches by 6 inches.<br>c. Review of the resident's medical record showed no evidence that a safety assessment of the enabler was completed. | F 323 | members on the need for a completed Enabler / Transfer Bar / Pre-Restraint Assessment to assess the use, need and safety risks involved with the use of a device upon admission, quarterly, and as needed.<br>7. Director of Nursing or designee to complete audit of all the residents who currently utilizing an enabler / transfer bar and/or noodle to ensure all identified residents have a completed assessment stating the potential risks as a result to utilizing the device as well as have it on the care plan the use of this device and the safety risks.<br>8. Director of Nursing or designee will audit monthly the residents utilizing Enabler / Transfer Bar / Pre-Restraint device upon admission, quarterly, and with any significant change of condition via the RAI process. Care plans to be added accordingly to address the device being used, the need for the device and the potential risks of utilizing the device. | |

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| F 323 | Continued From page 9<br><br>4. Review of the 1/24/17 annual MDS assessment showed resident #34 had diagnoses that included left-side cerebrovascular accident (CVA), hemiplegia, cramps and spasms. The resident required extensive assistance for bed mobility and transfers and was not coded as having physical restraints while in bed. The following concerns were identified:<br>a. Observation on 2/6/17 at 6:25 PM showed the resident had an enabler applied to one side of the bed and the other side of the bed was placed against the wall.<br>b. Observation on 2/9/17 at 9:25 AM showed the enabler had 2 gaps between the bars which were large enough for the resident to place a limb through. The gaps measured 4 inches by 4 inches and 4 inches by 6 inches.<br>c. Review of the resident's medical record showed no evidence that a safety assessment of the enabler was completed.<br><br>5. Review of the 12/5/16 quarterly MDS assessment showed resident #41 had diagnoses that included non-Alzheimer's dementia and was severely cognitively impaired. The resident required the extensive assistance of 2 people for bed mobility and total assistance of 2 people for transfers. Further the resident was not coded as having physical restraints in bed. The following concerns were identified:<br>a. Observation on 2/8/16 at 2:10 PM showed the resident had a "noodle (a foam tube for positioning)" placed in his/her room. CNA #3 placed the "noodle" under the resident's fitted sheet. Interview with the CNA at that time revealed she was unsure if the resident could remove it and the facility used it to try and keep the resident in bed. | F 323 | 9. Director of Nursing or designee will bring the audit results to the QAPI monthly meeting for review and corrective actions taken where necessary until resolved | |

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| F 323 | Continued From page 10<br>b. Review of the resident's medical record showed no evidence a safety assessment of the device had been completed.<br>c. Review of the care plan last revised on 12/20/16 showed the device was to be used for "positioning and to define boundaries" however, safety concerns were not identified.<br><br>6. Interview with the DON on 2/9/17 at 9:45 AM revealed the facility had completed safety assessments for the devices. However, none had been completed prior to 2/9/17. Further, it was confirmed that enabler use could result in resident injury and the "noodle" restricted the resident's movement.<br><br>7. Review of the "Restraint Policy" last revised 11/2013 showed "...1. A physical restraint is a mechanical or physical device that is used to immobilize a client or extremity, restricts the freedom of movement or normal access to a person' [sic] body, and is not a usual part of treatment plans indicated by the person' [sic] condition or symptoms...10. Restraints shall only be used after a pre-restraining assessment is completed and the interdisciplinary team has tried other alternatives unsuccessfully. If any factors are identified as unfavorable the pre-restraining assessment tool, devise appropriate interventions and document accordingly in the progress note and on the care plan..." | F 323 | | |
| F 371 SS=E | 483.60(l)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>(l)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. | F 371 | Corrective action:<br>The undated and unlabeled sauces, meat and cheese in both walk-ins were removed and disposed of by Dietary Manager. | 2/10/17 ~~02/08/2017~~ |



Diane Palu-McArthur phone call, ok to Δ to 2/10/17

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| F 371 | Continued From page 11<br>(I) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>(I)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure outdated food items were not available for resident consumption in 2 of 3 food storage areas (walk-in cooler #1, walk-in cooler #2). The findings were:<br><br>1. Observation of walk-in cooler #2 on 2/6/17 at 6:30 PM showed sliced cheese dated 1/23/17, a bottle labeled "mayo" dated 1/24/17, ketchup dated 1/24, a squirt bottle with yellow substance that was not labeled or dated, and sliced meat dated 1/19/17. All of the items had been removed from the original packaging.<br><br>2. Observation of walk-in cooler #2 on 2/8/17 at 3:05 PM showed sliced cheese dated 1/23/17 and sliced meat that was unlabeled dated | F 371 | Identification of Others:<br>The Dietary Manager and reviewed by the Registered Dietitian conducted a check of the kitchen area and refrigerators for areas of noncompliance and corrective action was done immediately.<br><br>Systemic Changes:<br>A daily kitchen review checklist has been updated to include the checking for proper labeling/dating and for any out of date items. Dietary staff were educated on February 8th, 2017 on the process as well as the proper labeling and dating of product including discard dates and storage guidelines. | |

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| F 371 | Continued From page 12<br>1/19/17.<br><br>3. Observation of walk-in cooler #1 on 2/8/16 at 3:15 PM showed five 2-ounce containers labeled "honey mustard" were not dated and had been removed from the original container.<br><br>4. Interview with the dietary manager on 2/8/17 at 3:10 PM revealed all items in the walk-in coolers should be labeled and discarded after 5 days.<br><br>5. 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 | Monitoring:<br>The dietary cook will monitor the food borne illness checklist that includes the daily monitoring and proper label, dating and storing of products, including the checking of the refrigerators for undated, or past dated products. The Dietary manager or designee will do a kitchen inspection weekly for one month, then twice per month until resolved. The Dietary Manager will conduct a report to be given at the QAPI meeting for review and corrective actions taken where necessary until resolved. | |
| F 496 SS=B | 483.35(d)(4)-(6) NURSE AIDE REGISTRY VERIFICATION, RETRAINING<br><br>d)(4) Registry verification<br><br>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless-<br><br>(i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or<br><br>(ii)The individual can prove that he or she has recently successfully completed a training and | F 496 | Plan of Correction for Verification of Nursing Licenses Prior to Patient Contact<br>The facility will ensure that employees meet competency evaluation requirements. This will be accomplished by:<br>• Upon receipt of employment application for any licensed patient care positions: | 03/23/2017 |

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| F 496 | Continued From page 13<br>competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.<br><br>(d)(5) Multi-State registry verification<br>Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.<br><br>(d)(6) Required retraining<br>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.<br>This REQUIREMENT is not met as evidenced by:<br>Based on employee record review and staff interview, the facility failed to ensure employees met competency evaluation requirements for 2 of 2 employees (CNA #1, CNA #2) working at the facility. The findings were:<br><br>1. Review of the employee file for CNA #1 on 2/9/17 at 9 AM showed the CNA was hired on 11/15/16. Further review showed the CNA certification was not verified until 12/7/16 and the CNA abuse registry was not verified until 12/16/16.<br><br>2. Review of the employee file for CNA #2 on | F 496 | ○ Human Resources Assistant will print applicable license from the Board of Nursing. The license will be scanned along with the employment application being submitted for consideration.<br>○ At this time, in addition, if the applicant is a C.N.A. the Abuse Registry will be checked, printed, and scanned with the employment application being submitted for consideration.<br><br>• A further step, as a failsafe, on orientation day, the Human Resources Assistant will provide the new employee files to the Director of Human Resources to verify the pertinent items have been completed, i.e. license copy printed, Abuse Registry, OIG, SAM, etc. prior to the new employee being allowed to leave Human Resources for their Department. This was completed March 3, 2017. | |

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| F 496 | Continued From page 14<br>2/9/17 at 9 AM showed the CNA was hired on 11/1/16. Further review showed the CNA certification was not verified until 12/7/16 and the CNA abuse registry was not verified until 12/7/16. The information to place the CNA on the registry was sent in to the State survey agency on 12/7/16 since the CNA had recently received her certification on 10/20/16.<br><br>3. Interview with the human resources coordinator on 2/9/17 at 9:12 AM revealed the facility usually checked licensure and the abuse registry before staff were hired; however, she did not have evidence the verification was done prior to employment or resident contact. | F 496 | • Director of Human Resources will educate all Human Resources Department staff and all nursing administration staff on March 23, 2017, on the requirements above involving verifications prior to patient contact,<br>• Director of Human Resources will monitor all employee files to ensure compliance and report to PI committee monthly. | |
| F 499 SS=B | 483.70(f)(1)(2) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS<br><br>(f) Staff qualifications.<br><br>(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.<br><br>(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.<br>This REQUIREMENT is not met as evidenced by:<br>Based on employee record review and staff interview, the facility failed to ensure staff were licensed for 1 of 1 employees (LPN #1) in accordance with State law. The findings were:<br><br>Review of the employee file for LPN #1 on 2/9/17 at 9:10 AM revealed the LPN was hired on 10/11/16. Further review showed the LPN's | F 499 | Plan of Correction for Verification of Nursing Licenses Prior to Patient Contact<br>The facility will ensure that employees meet competency evaluation | 03/23/2017 |

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| F 499 | Continued From page 15<br>license was verified on 12/8/16. Interview with the human resource coordinator on 2/9/17 at 9:12 AM revealed the facility usually checked licensure before staff were hired; however, she did not have evidence the verification was done prior to employment or resident contact. | F 499 | requirements. This will be accomplished by:<br>• Upon receipt of employment application for any licensed patient care positions:<br>o Human Resources Assistant will print applicable license from the Board of Nursing. The license will be scanned along with the employment application being submitted for consideration.<br>o At this time, in addition, if the applicant is a C.N.A. the Abuse Registry will be checked, printed, and scanned with the employment application being submitted for consideration.<br>• A further step, as a failsafe, on orientation day, the Human Resources Assistant will provide the new employee files to the Director of Human Resources to verify the pertinent items have been completed, i.e. license copy printed, Abuse Registry, OIG, SAM, etc. prior to the new employee being allowed to leave Human Resources for their Department. This was completed March 3, 2017.<br>• Director of Human Resources will educate all Human Resources Department staff and all nursing administration staff on March 23, 2017, on the requirements above involving verifications prior to patient contact.<br>• Director of Human Resources will monitor all employee files to ensure compliance and report to PI committee monthly. | |