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MISSION AT CASTLE ROCK REHABILITATION CENTER	1445 UINTA DRIVE GREEN RIVER, WY 82935

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 12/11/17 through 12/14/17. The following common abbreviations are used throughout this document: ADON- Assistant Director of Nursing BIMS- Brief Interview for Mental Status DON- Director of Nursing MDS- Minimum Data Set SSD- Social Services Director Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		1/8/18

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

Electronically Signed | 01/08/2018

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 578	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents' advance directive preferences were up to date for 2 of 15 sample residents (#13, #41). The findings were: 1. Review on 12/12/17 at 2:27 PM showed no information about code status for resident #41 in the facility emergency book (located at the nursing station). Review of the electronic medical record showed the resident was admitted on 12/31/14, and had a do not resuscitate (DNR) code status. Interview on 12/14/17 at 10:21 AM with the SSD confirmed there was no WyoPOLST (Wyoming Provider Orders for Life Sustaining Treatment) document in the facility emergency book. In addition, she stated the resident's son	F 578	F. Tag. 578 - Advanced Directives: Resident #13 and Resident #41 had Advanced Directives in their electronic medical record that did not match their POLST Form. Immediate corrective action: Verification of Advanced Directives for Resident #13 and Resident #41 with corrections as necessary. Audit POLST form and Advanced Directive in electronic medical record on all residents. How the facility will identify other residents having the potential to be affected: All residents have the potential to be affected	

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F 578	Continued From page 2 was going to come in and sign one as soon as he could. 2. Review of the medical record showed resident #13 had diagnoses that included stage 2 chronic kidney disease, type 2 diabetes mellitus, and chronic pain syndrome. Review of the record of admission, located in the electronic medical record and dated 12/28/16, showed the advance directive of the resident was to be resuscitated. Review of the facility emergency binder, located at the nursing station, showed resident #13 had a signed WyoPOLST form signed and dated on 12/30/16 by the resident and later signed by the physician indicating the wish to be DNR. Interview with the DON and SSD on 12/14/17 at 10:18 AM confirmed the resident had two different code statuses. Further they revealed the staff would follow the POLST form instructions. Additionally, they stated the facility was not completing consistent audits to ensure the code status in the EMR (electronic medical record) and emergency book matched and accurately reflected the resident's wishes.	F 578	Measures put in place or system changes to ensure correction in this area include: Resident POLST form and Advanced Directives will be reviewed quarterly and on all admissions/readmissions. Updates will be made as necessary by DON/Designee Social Services/Designee will provide a copy of newly signed POLST forms to the DON/Designee to be updated into electronic medical record. Who will monitor the new system: The DON/Designee How frequently will we monitor: Quarterly with MDS Assessment, and on Admission. How will we incorporate the new system into our Quality Assurance Performance Improvement system: Identified Trends will be reviewed monthly in QA until lesser frequency is deemed necessary by committee.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656		1/31/18

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F 656	Continued From page 3 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to develop and/or implement a comprehensive person-centered care plan for 2 of 15 sample residents (#5, #33) reviewed. The findings were: 1. Review of the medical record for resident #5	F 656	F. Tag. 656 □ Comprehensive Care Plan. Resident #33 did not have bathing preferences followed or care-planned. Resident #5 care-planned states that the Foley bag will be placed below the level of the bladder	

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F 656	Continued From page 4 showed diagnoses included obstructive and reflux uropathy, use of an indwelling catheter, and stage 3 pressure ulcer on the right buttock. The following concerns were identified: a. Observation on 12/13/17 at 11:10 AM showed the resident sitting in the dining room waiting for lunch. Further, his/her catheter bag was secured on his/her wheelchair higher than the level of the bladder and had visible urine in the tubing draining back toward the bladder. b. Observation on 12/13/17 at 4:35 PM showed the resident in the dining room waiting for dinner. Further, his/her catheter drainage bag was secured on his/her wheelchair higher than the level of the bladder and had visible urine in tubing draining back toward the bladder. c. Review of the urinary catheter care plan, last revised 12/11/17, showed nursing interventions included "... Keep drainage bag of Foley below the level of bladder at all times... Check catheter tubing for proper drainage and position..." d. During an interview on 12/13/17 at 4:56 PM the ADON (who was also the infection control nurse) stated catheter bags should be kept below the level of the bladder. She stated the catheter bag should be placed on the crossbars underneath the wheelchair, unless this would cause the bag to drag on the floor. 2. Review of the 11/17/17 initial MDS assessment showed resident #33 had a BIMS score of 15/15 (indicating the resident was cognitively intact), and required extensive assistance for bathing. Review of the care plan (printed 12/13/17) showed "provide routine bathing per resident's preference." However, further review of the care plan showed the resident's preference for frequency of bathing was not addressed. During	F 656	Immediate corrective action: Resident #33 had a bath and hair washed on 12/13/17. Determine resident #33 preferences and update bath schedule and care-plan to reflect those preferences. Resident #5 catheter bag was placed below bladder level and care-plan updated to reflect appropriate position of catheter bag. How the facility will identify other residents having the potential to be affected: All residents have the potential to be affected Measures put in place or system correction in this area include: All resident care plans will be reviewed for development and review of interventions implemented and followed by the DON/Designee. Updates will be made as appropriate. Monthly Audits will be completed by DON/Designee on 4 random care-plans for development and review of interventions implemented and followed. Education provided to all staff by DON/Designee on care-plan development and implementation. Who will monitor the new system: DON/Designee How frequently will we monitor: Monthly How will we incorporate the new system into our QAPI system:	

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F 656	Continued From page 5 an interview on 12/12/17 at 9:17 AM the resident stated s/he received a bath every 4 days "which drives me crazy." The resident stated his/her hair was greasy and s/he preferred more frequent bathing. During an interview on 12/14/17 at 10:15 AM the DON and SSD confirmed the care plan did not address the resident's preference for frequency of bathing.	F 656	Identified Trends will be reviewed monthly in QA until lesser frequency is deemed necessary by committee.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		1/31/18

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F 657	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff and resident interview, the facility failed to ensure the care plan was developed by an interdisciplinary team which included the resident for 1 of 15 sample residents (#33). The findings were: During an interview on 12/12/17 at 9:26 AM resident #33 stated s/he had never been to a care planning meeting. Review of the 11/17/17 initial MDS assessment showed the resident had a BIMS score of 15/15, indicating the resident was cognitively intact. Review of "Medicare Meeting" notes provided by the facility as documentation of care planning meetings showed the notes were dated 11/6/17, 11/20/17, 11/27/17, 12/4/17, and 12/11/17. Further review of the notes showed the resident was not listed as an attendee. During interview on 12/14/17 at 10:15 AM the DON and SSD confirmed there was no evidence to show the resident was involved in the development of the care plan.	F 657	F.Tag 657 - Care Plan Meetings Immediate corrective action: Care Conference was held with resident #33 on 12/19/2017. How the facility will identify other residents having the potential to be affected: All residents have the potential to be affected. Measures put in place or system changes to ensure correction in this area include: All appropriate IDT members to be invited to attend comprehensives and quarterlies IDT meetings by Social Services Director/Designee. Audit to be conducted by DON/Designee of the last quarter of care conferences/IDT meetings; care conferences with all residents/family/representative will be conducted. Who will monitor the new system: DON/Designee How frequently will we monitor: Monthly audit by administrator/designee for verifying that ALL members of IDT are offered to attend to include resident. How will we incorporate the new system into our Quality Assurance Performance Improvement system: Identified Trends will be reviewed monthly in QA until lesser frequency is deemed necessary by committee.	

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F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interviews, the facility failed to ensure assistance with bathing was provided to maintain personal hygiene for 1 of 4 sample residents (#33) reviewed for activities of daily living (ADL) status. The findings were: Review of the 11/17/17 initial MDS assessment showed resident #33 had a BIMS score of 15/15 (indicating the resident was cognitively intact) and required extensive assistance for bathing. The following concerns were identified: a. Review of the care plan (printed 12/13/17) showed "provide routine bathing per resident's preference." However, further review of the care plan showed the resident's preference for frequency of bathing was not addressed. b. During an interview on 12/12/17 at 9:17 AM the resident stated s/he received a bath every 4 days "which drives me crazy." The resident stated his/her hair was greasy and s/he preferred more frequent bathing. Review of the ADL documentation for November 2017 confirmed the resident regularly went 4 or more days between baths. c. Observation on 12/12/17 at 9:28 AM showed the resident's hair was visibly greasy and the resident asked staff to put baby powder into his/her hair to help with the grease. d. On 12/13/17 at 10:22 AM the resident's hair was visibly greasy.	F 677	F. Tag. 677 - Care-plan Preferences. Resident #33 did not have bathing preferences followed or care-planned. Immediate corrective action: Determine resident #33 preferences to bath 3 times per week on December 14, 2017. Update bath schedule and care-plan to reflect those preferences on December 14, 2017. How the facility will identify other residents having the potential to be affected: All residents have the potential to be affected Measures put in place or system correction in this area include: A bathing preference UDA to be created and completed with each resident and on new admission, by DON/Designee to determine preferences. Care-plan will be updated with preferences. 4 random Care-plans per month will be reviewed by DON/Designee for bathing preference accuracy and completion. CNA's will be educated on bathing preferences by DON/Designee	1/31/18

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F 677	Continued From page 8 e. During an interview on 12/14/17 at 10:15 AM the DON and SSD confirmed the care plan did not address the resident's preference for frequency of bathing.	F 677	Who will monitor the new system: DON/Designee How frequently will we monitor: Weekly How will we incorporate the new system into our QAPI system: Identified Trends will be reviewed monthly in QA until lesser frequency is deemed necessary by committee.	
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(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. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by:	F 700		1/31/18

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F 700	Continued From page 9 Based on observation, medical record review, policy and procedure review, and staff interview, the facility failed to ensure a safety assessment was completed prior to use of bed rails for 5 of 5 sample residents (#5, #13, #41, #49, #51) with bed rails. The findings were: 1. Observation on 12/12/17 at 9:21 AM revealed one metal side rail on each side of the head of the bed for resident #5. The following concerns were identified: a. Observation on 12/12/17 at 9:21 AM showed the bed was in a low position and a fall mat was present on the floor. Review of the medical record showed the resident was at risk for falls and had 2 falls since 9/1/17. The first fall occurred on 10/4/17 and another on 11/15/17, due to the resident reaching for things on the floor and self-transferring. b. Review of the care plan, dated 12/13/17, showed no evidence the use of side rails had been addressed. c. Review of active physician orders showed no evidence an order was obtained for use of the side rails. d. Review of the medical record showed no evidence of a consent for the use of a side rail. Further, there was no evidence a safety assessment was completed by the facility to determine entrapment risk. 2. Observation on 12/12/17 at 9:50 AM revealed one metal side rail on the left side of the bed for resident #13. The following concerns were identified: a. Review of the care plan, printed 12/13/17, showed the resident was at risk for falls. The care plan failed to address the use of the side rail. b. Review of active physician orders showed	F 700	F.Tag 700 Risk Assessment not complete on resident #5, #13, #41, #49, and #51 with side-rails. Immediate corrective action: Risk Assessment completed on all residents, to include #5, #13, #41, #49, and #51 and care-plan updated as necessary. How the facility will identify other residents having the potential to be affected: All residents using side-rails have the potential to be affected. Measures put in place or system changes to ensure correction in this area include: Education to all staff on Bed Safety and Side Rail Policy All residents being reviewed for bed rails will have a risk assessment completed by DON/Designee prior to determining bed rail safety and placement. Administrator/Designee will complete a bed safety assessment monthly. Who will monitor the new system: The DON/Designee How frequently will we monitor: Monthly How will we incorporate the new system into our QAPI system: Identified Trends will be reviewed monthly in QA until lesser frequency is deemed necessary by committee.	

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F 700	Continued From page 10	F 700		

no evidence an order was obtained for use of the side rails.

c. Review of the medical record showed no evidence of a consent for the use of the side rail. Further, there was no evidence a safety assessment was completed by the facility to determine entrapment risk.

d. During interview with the clinical resource nurse on 12/13/17 at 9:52 AM she stated the facility did not use restraints or side rails. Further, she revealed side rail safety assessments were not completed.

e. Observation of resident #13's bed on 12/13/17 at 2:52 PM showed the side rail had been removed from the bed.

3. Observations on 12/12/17 at 10:50 AM and 12/13/17 at 11:31 AM revealed one metal side rail in place on the left side of the bed for resident #49. The following concerns were identified:

a. Review of the medical record showed no physician's orders or consents related to the side rail. The care plan (dated 12/13/17) did not address the side rail. Furthermore, there lacked evidence the facility had completed a safety assessment for the side rail to determine the risk for entrapment.

b. On 12/13/17 at 2:24 PM the DON stated the facility had not completed a safety assessment for the side rail for this resident, or any other resident in the facility who used side rails. She stated the facility was "working on that now."

c. Observation on 12/13/17 at 2:52 PM revealed the side rail had been removed. Interview with the DON on 12/13/17 at 3:08 PM revealed the side rail was removed. She stated an assessment was done and found it was not needed. Review of the assessment completed by

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F 700	Continued From page 11 the facility on 12/13/17 showed the resident had two risks related to side rail use: bedrail could cause loss of function and balance, and bedrail could cause negative psychosocial outcome. The assessment showed side rails were not needed at this time. 4. Observation on 12/12/17 at 10:22 AM showed resident #51 was in bed, the bed was low to ground, and a large fall mat was on floor by the bed. The half side rail was up on the outside of the head of the bed. A gap of 4 inches was noted between the mattress and the side rail. Review of the care plan, last reviewed on 12/12/17, showed the resident was a high risk for falls related to activity intolerance, balance, weakness, difficulty walking, Parkinson's disease and confusion. It showed that s/he needed extensive assistance with activities of daily living. The following concerns were identified: a. Review of the medical record showed no risk assessment related to the side rail. b. Review of active physician orders showed no order for the use of side rails. c. Measurement taken on 12/13/17 at 11:41 AM of the side rail revealed it was 25 inches high,15 inches wide and 4 inches from the mattress to the side rail. There was also a 4 inch gap between 1 set of rails and a 5 inch gap between another set of rails. d. Interview on 12/14/17 at 9:41 AM with the clinical resource nurse revealed, "We just did a risk assessment on [him/her]." 5. Observation on 12/13/17 at 11:27 AM of resident #41's bed side rails showed two metal bed rails on each side of the bed measured 3 feet vertical by 18 inches horizontal with 3 openings measuring 8 inches wide, and 2 openings	F 700		

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	535033	A. BUILDING _____ B. WING _____	12/14/2017

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F 700	Continued From page 12 measuring 4 inches wide. Review of resident's care plan last reviewed 12/12/17 included the resident needed limited to extensive assistance with dressing related to effects of CVA, difficulty walking, and muscle spasms. The following concerns were identified: a. Medical record review showed no risk assessment related to the side rails. b. Review of active physician orders showed no order for the use for side rails. c. Interview on 12/13/17 at 11:32 AM with the maintenance supervisor revealed he was told he had to remove the rails. d. Observation on 12/14/17 at 10:03 AM of a new, smaller side rail attached to the inside of the resident's bed frame showed it measured 4.5 inches from the inside of the rails to the mattress. 6. Review of the policy and procedure titled "Bed Safety," revised/reviewed 10/2017, showed: "... 5. If side rails are used, there shall be an interdisciplinary assessment of the resident, consultation with the Attending Physician, and input from the resident and/or legal representative... 8. Side rails may be used if assessment and consultation with the Attending Physician has determined that they are needed to help manage a medical symptom or condition, ... and no other reasonable alternatives can be identified... 10. When using side rails for any reason, the staff shall take measures to reduce related risks..." 7. Review of the policy and procedure titled "Bed Entrapment Hazard Assessment," reviewed/revised 10/2017, showed: "Procedure: 1. Every patient bed will be assessed on a monthly basis,and more frequently as required,to ensure compliance. Assessment findings are to	F 700		

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F 700	Continued From page 13	F 700		

be documented using the Bed Entrapment Hazard Report. This assessment will ensure all beds are free from potential entrapment hazards which include the following: ...b. If side rails are in use; 1) Gaps may exist within the rail its self which can present a risk of head entrapment. Assess any open space within the rail,between the perimeters of the rail,to ensure measurements are less than 4% [sic] inches. 2) A potential gap may exist under the rail,between the rail and the mattress. Such gaps may allow for head entrapment. Measure the area between the rail and the mattress which exists under the rail between the rail supports. Measurements are to be less than 4% [sic] inches. 3) A potential gap may exist between the inside surface of the rail and the mattress. Such gaps can present a risk of head entrapment. Measure the space between the inside surface of the bed rail and the mattress. Measurements are to be less than 4% [sic] inches. 4) A potential gap may exist under the rail at the ends of the rail which pose a risk of neck entrapment. Measure the space between the mattress and the lowermost portion of the ends of the rail. Measurements are to be less than 2 3/8 inches. 5) A potential gap may exist between split bed rails. When partial length head and split rails are used on the same side of the bed (as with many electric beds which have (4) split/1/2 rails),the space between the rails may present a risk of either neck or chest entrapment. (No dimensional recommendations provided by the FDA. Each resident to be individually assessed.) 6) A potential gap may exist between the end of the rail and the side edge of the head or foot board. This gap may present the risk of resident entrapment. (No dimensional recommendations provided by the FDA. Each resident to be

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F 700	Continued From page 14 individually assessed.)..."	F 700		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure food was stored according to food service safety standards in 1 of 1 food storage areas (kitchen refrigerator). The findings were: 1. Observation on 12/11/17 at 3:21 PM of the refrigerator revealed the following concerns: a. Two opened containers of an unknown substance without open dates on them. b. One container of natural fruit laxative dated 12/6/17.	F 812	F.Tag 812 - Expired Food, Undated Food Immediate corrective action: Outdated/Expired food found by surveyor was immediately disposed of by Cook on duty. An audit completed on 12/13/17 for expired or outdated food. Any food that was outdated or expired was disposed of. How the facility will identify other residents having the potential to be affected: All residents have the potential to be affected.	1/31/18

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F 812	Continued From page 15 2. Interview on 12/11/17 at 03:23 PM with the dietary manager revealed the facility process was to throw items out after 3 days from the written date. She stated the unknown substances must have been employee food, and she would throw them away. 3. Review of the policy titled "Food Provided by Resident Representative," not dated, showed: ..."6. Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the name and date. All foods not in the original containers with a displayed expiration date, will be destroyed after 72 hours..."	F 812	Measures put in place or system changes to ensure correction in this area include: The Administrator/Designee has educated all employees on the specific requirement related to food storage. Food Storage audit will be completed twice weekly by Administrator/Designee Who will monitor the new system: Administrator/Designee How frequently will we monitor: Every two weeks How will we incorporate the new system into our Quality Assurance Performance Improvement system: Identified Trends will be reviewed monthly in QA until lesser frequency is deemed necessary by committee.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		1/31/18

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F 880	Continued From page 16 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 17 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure proper standards of practice for catheter care were followed for 1 of 3 sample residents (#5) with catheters. The findings were: 1. Review of the medical record for resident #5 showed diagnoses which included obstructive and reflux uropathy, use of an indwelling catheter, and stage 3 pressure ulcer on the right buttock. The following concerns were identified: a. Observation on 12/13/17 at 11:10 AM showed the resident was sitting in the dining room waiting for lunch. His/her catheter bag was secured on the wheelchair higher than the level of the bladder and had visible urine in the tubing draining back toward the bladder. b. Observation on 12/13/17 at 4:35 PM showed the resident was in the dining room waiting for dinner. His/her catheter drainage bag was secured on the wheelchair higher than the level of the bladder and had visible urine in tubing draining back toward the bladder. c. Review of the urinary catheter care plan, last revised 12/11/17, showed nursing interventions included "... Keep drainage bag of	F 880	F.Tag 880 - Resident #5 Foley catheter was hung above bladder Immediate corrective action: Catheter for resident #5 was placed below bladder level and care-plan updated to reflect appropriate position of catheter bag How the facility will identify other residents having the potential to be affected: All residents that have a catheter have the ability to be affected Measures put in place or system changes to ensure correction in this area include: All residents with catheters were audited for appropriate placement, below the level of the bladder. The DON /Designee has educated all employees on the placement of Foley catheter bag. Weekly Random Audits will be completed on residents with catheters, to monitor placement of catheter bag. Who will monitor the new system:	

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F 880	Continued From page 18 Foley below the level of bladder at all times... Check catheter tubing for proper drainage and position..." d. During an interview on 12/13/17 at 4:56 PM the ADON (who was also the infection control nurse) stated catheter bags should be kept below the level of the bladder. She stated the catheter bag should be placed on the crossbars underneath the wheelchair, unless this would cause the bag to drag on the floor.	F 880	DON/Designee How frequently will we monitor: Weekly How will we incorporate the new system into our QAPI system: Identified Trends will be reviewed monthly in QA until lesser frequency is deemed necessary by committee.	
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, review of facility bed entrapment hazard reports, and staff interview, the facility failed to ensure regular inspections of bed rails for 5 of 5 sample residents (#5, #13, #41, #49, #51) with bed rails. The findings were: 1. The following observations were made related to side rails: a. Observations on 12/12/17 at 10:50 am and 12/13/17 at 11:31 AM revealed one metal side rail in place on the left side of the bed for resident #49. b. Observation on 12/12/17 at 9:21 AM revealed one metal side rail on each side of the	F 909	F.Tag 909 - Bedrails exceeding gap sizes/monthly inspection Immediate corrective action: The Maintenance Director completed an audit on all resident beds to include residents #5, #13, #41, #49,#51. Corrections made as necessary. How the facility will identify other residents having the potential to be affected: All residents have the potential to be affected. Measures put in place or system changes to ensure correction in this area include: The Administrator has educated the	1/31/18

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F 909	Continued From page 19 head of the bed for resident #5. c. Observation on 12/12/17 at 9:50 AM revealed one metal side rail on the left side of the bed for resident #13. d. Observation on 12/13/17 at 11:41 AM showed a side rail on the bed for resident #51. e. Observation on 12/13/17 at 11:27 AM of resident #41's bed showed two metal bed rails on each side of the bed. 2. Interview with the maintenance supervisor on 12/14/17 at 8:41 AM revealed he had not previously been completing bed safety inspections or entrapment hazard reports prior to 12/13/17. 3. Review of the "Bed Entrapment Hazard Reports" showed 12/13/17 was the first documented date of bed inspections completed by the maintenance director. 4. Review of the policy and procedure titled " Bed Safety," revised/reviewed 10/2017, showed: "... 2. ... a. Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks;..." 5. Review of the policy and procedure titled "Bed Entrapment Hazard Assessment," reviewed/revised 10/2017, showed: "All patient beds will be assessed by the community Administrator or his/her designee to ensure all beds are in compliance with FDA guidelines, are free from potential entrapment hazards and are in good repair... 1. Every patient bed will be assessed on a monthly basis, and more frequently as required, to ensure compliance. Assessment findings are to be documented using	F 909	Maintenance Director on the need for monthly maintenance checks for bed safety to include bed rails. The Maintenance Director/Designee will audit all residents for bed and rail safety monthly, on admission and readmission and corrections will be made as necessary. Who will monitor the new system: The Administrator/Designee How frequently will we monitor: Monthly and on admission/readmission How will we incorporate the new system into QAPI system: Identified Trends will be reviewed monthly in QA until lesser frequency is deemed necessary by committee.	

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F 909	Continued From page 20 the Bed Entrapment Hazard Report..."	F 909		