STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING _____ B. WING _____	C 02/08/2018

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 2/5/18 to 2/8/18. Also reviewed in the course of the survey were complaint intakes WY00002506, WY00002521, and WY00002554. The following common abbreviations are used throughout the document: CNA: Certified Nursing Assistant DON: Director of Nursing LPN: Licensed Practical Nurse OT: Occupational Therapist PT: Physical Therapist RN: Registered Nurse SBAR: Situation, Background, Assessment Recommendation Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 574 SS=E	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and	F 574		3/25/18

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

Electronically Signed | 03/02/2018

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 574	Continued From page 1 procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage;	F 574		

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F 574	Continued From page 2 (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedure, and resident and staff interview, the facility failed to ensure the grievance policy contained all required information. Further, the facility failed to ensure information about filing complaints with the State Survey Agency was accessible to all residents. The census was 80. The findings were: 1. Interview with 9 residents on 2/6/18 at 10 AM revealed none of them knew how to file a complaint with the State Survey Agency. Observation on 2/6/18 at 6:52 PM showed green concern forms were posted throughout the facility but did not contain information on how to contact entities other than the corporation that owned the facility. An 8.5 by 11 inch framed document located on the wall by the front reception desk did contain the required information but was posted 6 feet up from the floor and was inaccessible to some residents. Interview with the corporate nurse at that time confirmed the document was	F 574	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F-574 CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: A new poster was created and posted within view, in larger print, with the other postings located in the facility lobby.	

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F 574	Continued From page 3 posted in a location that was not accessible to all residents. 2. Review of the policy and procedure entitled "Truly Listening to Our Customers (TLC) Program", last revised May 2017, and the "Concerns and Issues" form provided in the admission packet showed the policy failed to contain all required information including the contact information of the grievance official or the contact information of independent entities with whom a grievance could also be filed. 3. Review of the policy and procedure entitled "Abuse and Neglect Prohibition", revised August 2017, showed "Prevention... 2. Upon admission, the facility will inform the resident that he or she may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, and misappropriation of resident property in the facility. The facility will provide appropriate contact information to do so." 4. Interview with the customer service director on 2/7/18 at 7:05 PM confirmed the policy provided to residents did not contain the required information. .	F 574	A Contact Agency Notification section was created and is now a part of the Facility Guide that is reviewed with each Resident/Resident Representative at the time of admission. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this alleged deficiency. In the next resident council meeting, an announcement will be made informing the residents of how to report concerns to the Wyoming Department of Health and the reporting information included in the resident council minutes. The Contact Agency Notification Form will be given/sent to current residents/resident representatives. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Customer Service and Assistant Administrator were educated on the requirements of F574, specifically postings and notification on March 1, 2018. The Customer Service Coordinator and/or designee will check the location and integrity of the posting on a monthly basis. An audit will be completed weekly to ensure that the correct Notification Form	

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F 574	Continued From page 4	F 574	was provided to Resident/Resident Representative at the time of admission. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: Results of reports and/or audits will be submitted to the QAPI committee monthly for 3 months or until substantial compliance is achieved for input and direction to ensure continued compliance.	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not	F 582		3/25/18

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F 582	Continued From page 5 covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of liability notices showed the facility failed to provide an advance beneficiary notice for 1 of 3 sample residents (#67) reviewed. The findings were: Review of a "SNF [skilled nursing facility] Beneficiary Protection Notification Review" form filled out by the facility showed resident # 67 had a Medicare Part A episode starting on 12/4/17.	F 582	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by	

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F 582	Continued From page 6 Further review showed the last covered day of Part A services was 1/28/18. The form showed the facility initiated the discharge from Part A services before benefits were exhausted because the resident "met highest level of function." Interview with the acting manager on 02/06/18 at 03:40 PM revealed she was unable to locate an advance beneficiary notice for the resident. She further verified the dates on the form were correct.	F 582	the provisions of federal and state law. F-582 CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #67 has not had another skilled stay since 1/28/18. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Consultant completed a 100% audit on 3/1/18 of all skilled stay residents since 2/8/18 to ensure that a SNF Beneficiary Protection Notice Review form was completed within required time frames. and that all notices were given appropriately and documented correctly. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: On 3/1/18 Social Services, MDS, Therapy, Customer Service and Business office Departments were educated to the requirements of Advanced Beneficiary Notifications of skilled stay residents. IDT team will review all skilled residents at morning standup to ensure that all notices are given timely.	

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F 582	Continued From page 7	F 582	MDS Coordinator/designee will audit weekly all skilled stay residents to ensure that all notices are documented and given appropriately. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: Results of audits will be submitted to the QAPI committee monthly for 3 months or until substantial compliance is achieved for input and direction to ensure continued compliance.	
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		3/25/18

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F 609	Continued From page 8 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility investigations, review of concern forms, review of disciplinary action records, medical record review, resident and staff interview, and policy and procedure review, the facility failed to report 11 incidents to the State Survey Agency that required such reporting. These incidents involved residents #9, #12, #28, #32, #37, #46, #65, #70, #81, and #231. The findings were: 1. Review of an investigation completed by the facility showed a resident to resident altercation involving resident #12 and #70 occurred on 11/19/17. The investigation showed resident #70 slapped resident #12 on the cheek. Review of the State Survey Agency incident reporting log showed no evidence the incident was reported. 2. Review of a concern form dated 9/2/17 showed resident #32 complained of neglect by a CNA. Review of the State Survey Agency incident reporting log showed no evidence the incident was reported. 3. Review of a concern form completed by a resident's family member and dated 9/4/17 showed an allegation resident #9 was verbally	F 609	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F-609 I. CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On February 8, 2018 the following residents concerns were reviewed and as indicated, residents were interviewed using QIS questions that directly related to previously identified areas of concern. The following were the findings of these reviews/interviews: 1-1: Resident #70 and Resident #12:	

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F 609	Continued From page 9 abused by a staff member. Review of the State Survey Agency incident reporting log showed no evidence the incident was reported. 4. Review of a concern form dated 12/11/17 showed an allegation resident #37 had been neglected by two aides which resulted in the resident not receiving incontinence care for over 8 hours. Review of the State Survey Agency incident reporting log showed no evidence the incident was reported. 5. Review of a concern form dated 12/15/17 showed resident #46 complained of being neglected and verbally abused by the "night shift." Review of the State Survey Agency incident reporting log showed no evidence the incident was reported. 6. Review of a concern form dated 12/20/17 showed an allegation resident #32 had been neglected. The resident was found "wearing only a soaked brief no linen on bed [and] laying on soaked chux [an incontinence product][and] when bed pulled away from wall - plugs partially out of wall [and] covered by soaked linen, blanket [and] chux-fire hazard! resident could not have put those items there." Review of the State Survey Agency incident reporting log showed no evidence the incident was reported. 7. Review of a concern form dated 1/16/18 showed an allegation resident #28 had been verbally abused by two aides. Review of the State Survey Agency incident reporting log showed no evidence the incident was reported. 8. Review of a nurse's note dated 11/5/17 showed resident #81 was involved in resident-to-resident	F 609	reported incident to Health Department 1-2: Resident #32 was interviewed; resolved. 1-3: Resident # 9 was interviewed; resolved. 1-4: Resident #37 was interviewed; resolved. 1-5: Resident #46 was interviewed; resolved. 1-6: Resident #32 was interviewed; resolved. 1-7: Resident #28 was interviewed; resolved. 1-8: Resident #81 no longer resides at the facility. 1-9: Resident #65 was interviewed; resolved. 1-10/11: Resident #231 no longer resides at the facility. II. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: On 2/08/2018 a 100% audit of SBAR notes was completed to identify any incidents that had not been reported to administration. All incidents had been appropriately reported to administration. III. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Beginning 02/08/2018 all staff education regarding reporting of all incidents to	

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F 609	Continued From page 10 altercation which involved "taking [his/her] walker and purposely running into other residents." An intervention of a one-to-one staff member was in place at the time. Review of the State Survey Agency incident reporting log showed no evidence the incident was reported. 9. Interview with resident #65 on 2/5/18 at 2:43 PM revealed s/he had money stolen by an employee. Interview with the assistant administrator on 2/7/18 at 11:27 AM revealed the resident gave a resident assistant (RA) $20 to go buy a coffee. The RA failed to get the coffee or return the money. An investigation was done and documented on a "Disciplinary Action Record" form. The incident occurred on 10/29/17 and the RA was terminated on 11/2/17. Review of the State Survey Agency incident reporting log showed no evidence the incident was reported. Interview with the acting manager on 2/7/18 11:52 AM revealed the incident was not reported because the money was "given" and not "stolen." 10. Review of an SBAR dated 8/10/17 showed resident #231 was approached by another resident who was "inappropriately trying to touch [him/her]..." Resident #231 hit the other resident, and then was hit by that resident. The residents were separated and no injuries were noted. Interview on 02/08/18 at 12:15 PM with the acting manager revealed she did not think this was a reportable incident, and it was just documented as a resident behavior. 11. Review of an SBAR dated 10/17/17 showed resident #231 "got into a verbal altercation with another resident that has dementia. Verbal aggression turned into physical aggression before staff could intervene. Resident states the two	F 609	administration. On 3/1/18 Nurse Consultant educated Leadership Team to the requirements of F609 specifically, state reporting obligations. If the complaint/concern identifies alleged abuse/neglect, exploitation, mistreatment, injuries of unknown origin, or misappropriation of resident's property in accordance with the state law, a thorough investigation will be completed and documented accordingly and reported to State Survey Agency. In morning stand up meeting all SBAR notes and complaint/concerns will be reviewed for any unreported incidents or potentially reportable incidents. IV. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: Results of audits will be submitted to the QAPI committee monthly for 3 months or until substantial compliance is achieved for their input and direction to ensure continued compliance.	

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F 609	Continued From page 11 were yelling in the tv room then [the other resident] hit [resident #231] in the mouth and [the other resident] threw [his/her] blood on [resident #231]..." Interview on 02/08/18 at 10:26 AM with the acting manager revealed staff intervened at the time of the incident; however, this incident was not reported to the administration. She added the facility was currently conducting an investigation, including interviews, and there would be further education and disciplinary action. Additionally, the facility was going to review 100% of SBARs to make sure there were no other incidents the administration did not know about. 12. Interview with the acting manager on 2/8/18 at 12:18 PM confirmed these allegations of abuse, neglect, or misappropriation of resident property had not been reported. 13. Review of the "Abuse and Neglect Prohibition" policy, last revised August 2017, showed "...1. STATE REPORTING OBLIGATIONS: The facility will report all allegations and substantiated occurrences of abuse, neglect, exploitation, mistreatment including injuries of unknown origin, and misappropriation of property to the administrator, State Survey Agency..."	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		3/25/18

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(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 610	Continued From page 12 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 concern forms, medical record review, staff and resident interview, and policy and procedure review, the facility failed to ensure a thorough investigation of allegations of neglect, and physical and verbal abuse were completed for 6 random incidents identified. These incidents involved residents (#9, #28, #32, #37, and #231). The findings were: 1. Interview with resident #28 on 2/6/18 at 8:42 AM revealed staff treated him/her well most of the time. The resident then mentioned a certain CNA who "doesn't like me." The resident stated the CNA yelled at his/her roommate and sat on the bed playing on the phone when the resident was on the toilet. The resident further stated the CNA swore when providing cares saying such things as to sit on the "damn toilet." The resident identified this CNA as CNA #3. The following concerns were identified: a. According to the original schedule provided on 2/5/18, CNA #3 was scheduled to work on the	F 610	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F-610 CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On February 8, 2018 the following residents concerns were reviewed and as indicated, residents were interviewed using QIS questions that directly related to	

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F 610	Continued From page 13 resident's hallway (200) Wednesday 2/7/18. b. Review of a concern form dated 1/16/18 showed an allegation that resident #28 had been verbally abused by CNA #3 and CNA #4. The allegation stated the two aides "get mouthy with [him/her]." The follow-up action taken was "[Resident] has voiced concerns about people of color who care for [him/her] in the past. These two aides did not have issues with any other resident. They have been asked to go in two's (sic) into [the resident's] room." c. A follow-up note dated 2/6/18 (21 days after the initial date of the concern) showed CNA #3 had been moved to a different hall and CNA #4 had not been back. Staff were educated to enter the room in pairs. There was no evidence a thorough investigation had been completed. 2. Review of an SBAR dated 10/17/17 showed resident #231 "got into a verbal altercation with another resident that has dementia. Verbal aggression turned into physical aggression before staff could intervene. Resident states the two were yelling in the tv room then [the other resident] hit [resident #231] in the mouth and [the other resident] threw [his/her] blood on [resident #231]..." Interview on 2/8/18 at 10:26 AM with the acting manager revealed staff intervened at the time of the incident; however, this incident was not reported to the administration. She added the facility was currently conducting an investigation, including interviews, and there would be further education and disciplinary action. Additionally, the facility was going to review 100% of SBARs to make sure there were no other incidents the administration did not know about. 3. Review of a concern form completed by OT #1 and PT #1, dated 12/11/17 showed an allegation	F 610	previously identified areas of concern. The following were the findings of these reviews/interviews: 1-1: Resident #28 was interviewed. The available information, interviews, corrective action information has been compiled into an investigation packet/report and a summary of investigation findings completed. 1-2/5: Resident #231 no longer resides at the facility. The available information, interviews, corrective action information has been compiled into an investigation packet/report and a summary of investigation findings completed. 1-3: Resident #37 was interviewed. The available information, interviews, corrective action information has been compiled into an investigation packet/report and a summary of investigation findings completed. 1-4: Resident #32 was interviewed. The available information, interviews, corrective action information has been compiled into an investigation packet/report and a summary of investigation findings completed. 1-6: Resident #9 no longer resides at the facility. The available information, interviews, corrective action information has been compiled into an investigation packet/report and a summary of investigation findings completed.	

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F 610	Continued From page 14 that resident #37 had been neglected by aides on the night shift. The concern form showed "During therapy session with [resident] at 10 AM it was noticed upon entering [his/her] room that there was a strong urine odor and [his/her] clothing, bedding, and pillows were completely soaked with urine, both dried and fresh. The resident stated s/he had last been cared for on the evening shift the day before. Follow-up action showed education was provided to the staff and to the resident, however there was no evidence a thorough investigation was completed. 4. Review of a concern form completed by RN #1, dated 12/20/17, showed an allegation resident #32 had been neglected. The resident was found by the RN "wearing only a soaked brief no linen on bed [and] laying on soaked chux [incontinence product] [and] when bed pulled away from wall - plugs partially out of wall [and] covered by soaked linen, blanket [and] chux-fire hazard! resident could not have put those items there." Follow-up action revealed education was provided to the staff, however there was no evidence a thorough investigation was completed. 5. Review of an SBAR dated 8/10/17 showed resident #231 was approached by another resident who was "inappropriately trying to touch [him/her]..." Resident #231 hit the other resident, and then was hit by that resident. The residents were separated and no injuries were noted. Interview on 2/8/18 at 12:15 PM with the acting manager revealed she did not think this was a reportable incident, and it was just documented as a resident behavior. 6. Review of a concern form completed by a family member of resident #9, dated 9/4/17	F 610	HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: On 2/08/2018 a 100% audit of SBAR notes was completed to identify any incidents that had not been reported to administration. All incidents had been appropriately reported to administration. The complaint concerns were reviewed for the previous 30 days to identify any concerns that required further investigation. During this review, it was identified there were 3 instances of missing items that had been replaced/scheduled to be replaced but not reported. These complaints were reported on 3/2/18. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Education was completed on 3/1/18 with Leadership team by Consultant regarding the requirements of F610 specifically related to completion of investigation documentation. The complaint/concern form was updated to include the follow up and resolution of the complaint as acceptable to the complaintant, with signature and date of resolution. If the complaint/concern identifies alleged abuse/neglect, exploitation, mistreatment, injuries of unknown origin, or misappropriation of	

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F 610	Continued From page 15 showed an allegation the resident was told by staff member #1 "[the resident] would not get another appt. [appointment] of any kind if it was up to her." The concern form showed staff member #1 was educated and apologized to the resident, however there was no evidence a thorough investigation was completed. 7. Interview with the administrator and assistant administrator on 2/8/18 at 2:04 PM revealed the concern forms were reviewed within 24 hours and assigned to the appropriate department manager. Progress notes were to be reviewed by the DON or her designee on a daily basis. Their goal was to have the concern resolved within 72 hours and the person who filed the concern contacted with the resolution. The administrator stated the follow-up to the concerns was not documented as well as it could be. 8. Interview with the acting manager on 2/8/18 at 12:18 PM revealed incidents were not treated as allegations unless the criteria of "fear, injury, or intent" were met. 9. Review of the "Abuse and Neglect Prohibition" policy, last revised August 2017, showed "...Protection 1. The facility will protect residents from harm during the investigation...Investigation 1. The facility will timely conduct an investigation of any alleged abuse/neglect, exploitation, mistreatment, injuries of unknown origin, or misappropriation of resident property in accordance with state law. 2. Any employee alleged to be involved in an instance(s) of abuse and/or neglect will be interviewed and suspended immediately, and will not be permitted to return to work unless and until such allegations of abuse/neglect are unsubstantiated."	F 610	resident's property in accordance with the state law, a thorough investigation will be completed and documented accordingly. All complaint/concern forms will be reviewed in morning stand up and the IDT will provide input and direction. All incidents of alleged abuse/neglect, exploitation, mistreatment, injuries of unknown origin, or misappropriation or resident's property in accordance with the state law, will also be reviewed with temporary management staff/ corporate staff. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: Results of audits will be submitted to the QAPI committee monthly for 3 months or until substantial compliance is achieved for their input and direction to ensure continued compliance.	

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F 610	Continued From page 16	F 610		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences.	F 660		3/25/18

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F 660	Continued From page 17 (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's	F 660		

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F 660	Continued From page 18 discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview and resident interview, the facility failed to ensure a discharge plan was developed for 2 of 5 sample residents (#28, #73) who desired to discharge to the community. The findings were: 1. Interview with resident #28 on 2/5/18 at 2:15 PM revealed s/he would like to be discharged to an apartment. The resident stated s/he had been working with an outside agency and at one point "had everything set up." The resident was unhappy because s/he was not meeting therapy goals, making discharge not possible at that time. The resident wanted to continue to work toward discharge. The following concerns were identified: a. Review of the resident care plan showed no mention of attempts or desire to discharge to community. b. Interview on 2/7/18 at 2:54 PM with the social service director and social services assistant #1 confirmed the resident desired to leave the facility and had worked toward goals with therapy in the past. The two staff members were aware of the involvement with the outside service for housing placement, however, were unsure if this placement would be a possibility. The director verified a discharge plan related to the discharge potential and goals was not developed. 2. Interview on 2/5/18 at 3:16 PM revealed resident #73 was hoping to move out in April or May. The resident stated the discharge depended on "lots of things" and s/he "really wants to get home." Review of the 9/7/17 social service note	F 660	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F-660 CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: A discharge planning meeting will be held on 3/2/18 with Resident #28. A detailed discharge care plan will be developed at this time. A discharge planning meeting will be held on 3/2/18 with Resident #73. A detailed discharge care plan will be developed at this time. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: 100% of the residents/resident representatives were asked the following question: Do your goals for care include	

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F 660	Continued From page 19 showed the resident had completed an application for an apartment. Review of the 1/11/18 social service note showed the resident was making positive progress with therapy and was working toward discharge to the community. The following concerns were identified: a. Review of the care plan showed a discharge plan of care was initiated on 8/1/17 and last updated on 10/17/17. The plan identified a target date of 1/26/18 however, there were no updates to reflect status after this target date. b. Interview with the social service director on 2/7/18 at 2:10 PM revealed he was aware the resident wished to go back to the community. The director verified the discharge plan could be better developed, with more specific goals, and time frames to determine progress.	F 660	discharge to the community? If yes, care plans will be updated to reflect goals. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: The MDS Coordinator, Customer Service Representative, Director of Therapy, Admissions Coordinator, and Social Services Department were in-serviced by Consultant on 3/1/18 on the requirements of F660 specifically the requirement of the responsibility to develop a discharge plan. Discharge plans will be reviewed upon admission, at least quaterly and/or with any other scheduled assessment. The care plan will be updated to reflect resident goals. A weekly audit of discharge goals for those individuals with a scheduled assessment will be completed by the MDS coordinator or designee. The Social Services Department will be responsible to update care plans based upon these resident goals and submit these care plans to the MDS Coordinator for review weekly. The IDT will review each of these plans for accuracy during daily Care Management Meetings. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: Results of audits will be submitted to the	

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F 660	Continued From page 20	F 660	QAPI committee monthly for 3 months or until substantial compliance is achieved for their input and direction to ensure continued compliance.	
F 677 SS=E	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, staff and resident interview, review of bathing documentation, and medical record review, the facility failed to ensure 3 of 10 sample residents (#46, #70, #231) who were dependent on staff for activities of daily living (ADLs) were provided the required assistance. The findings were: 1. Review of the 1/17/18 quarterly minimum data set (MDS) assessment showed resident #46 was cognitively intact with a brief interview for mental status (BIMS) score of 15/15. Further, the resident required the extensive physical assistance of two or more persons with bathing. The following concerns were identified. a. Interview on 2/5/18 at 1:08 PM with the resident revealed s/he was not getting baths like s/he wanted. The resident stated it was because the facility didn't have any hot water in the shower. Observation at that time showed the resident's hair appeared greasy. Observation on 2/6/18 at 10:51 AM showed the resident's hair continued to appear greasy. b. Observation on 2/6/18 at 9:50 AM of the 400 shower room showed a note on the door	F 677	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F-677 CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #46 had a bath on 02/23/2018 and again on 2/28/2018. Additionally the shower room on Hall 4 was reopened on 02/28/2018 after mechanical/plumbing repairs were completed. Resident #70 had a bath on 02/28/2018.	3/25/18

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F 677	Continued From page 21 indicating the shower had been out of order since 1/25/18. Interview at that time with CNA #6 revealed the water temperature in the 400 hall shower room would be hot one second then turn cold the next, so the shower was put out of order. The facility was only providing showers in the 600 hall shower room. c. Review of ADL bathing documentation for December 2017, January 2018, and February 2018 showed there were periods the resident went without a shower. In December the resident had a documented shower on 12/4. The next documented shower occurred on 12/11 (7 days). The resident had a documented shower on 12/18, with the next documented shower on 12/28 (10 days). In January the resident had a documented shower on 1/4. The next documented shower occurred on 1/11 (7 days). Further, the resident had a documented shower on 1/29, with the next documented shower on 2/6 (8 days). Review of the bath schedule showed the resident was to have a shower/bath on Monday, Wednesday, and Friday. 2. Observation on 2/5/18 at 4:20 PM showed resident #70 wore a hat, and the hair underneath appeared greasy. Review of the 1/17/18 ADL care plan showed the resident had a self-care performance deficit related to dementia and activity intolerance. Further, the resident required extensive assistance by 1 staff member with showering. The following concerns were identified: a. Review of the ADL bathing documentation for December 2017, January 2018, and February 2018 showed there were periods the resident went without a shower. In December the resident had one documented shower on 12/13. In January the resident had documented showers	F 677	Resident #231 was the review of a closed record and the resident no longer resides at the facility. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: 100% audit of all residents bathing activity since 02/23/2018 was completed. The identified concern is that the documentation of resident choice is not currently available in the electronic charting system. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: Resident choice interviews were completed prior to the initiation of the Weekly Bath Schedule and new admissions will be interviewed at the initial plan of care review to ensure choice is honored. As a matter of systemic change, documentation of resident choice/refusal of care will be recorded on the Weekly Bath Schedule sheet included in the RCS daily task assignment sheets. The electronic medical record does not currently allow documentation of resident choice/refusal. Nurse Manager will be responsible for reviewing this documentation weekly and IDT will address concerns during weekly High Risk Meeting.	

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F 677	Continued From page 22 on 1/4 and 1/25 with one refusal documented on 1/11. Between 1/25 and 2/7 (13 days) the resident had no documented showers. Review of the bath schedule showed that the resident was to receive a shower/bath on Thursday. 3. Review of the 9/29/17 quarterly MDS assessment showed resident #231 had diagnoses that included hemiplegia and seizure disorder. Further review showed the resident required extensive assistance of two staff members for showering. Review of the care plan showed the resident required extensive assistance of 1 staff to shower 2 times per week and as needed. The following concerns were noted: a. Review of October 2017 shower documentation showed the resident received a shower on 10/1, and did not receive another shower until 10/13 (12 days). Further review showed the resident was assisted with showering on 10/17, with the next documented shower was on 10/27 (10 days). b. Review of November 2017 shower documentation showed the resident received showers on 11/2 and 11/7. There was no documentation of the resident receiving another shower prior to discharge on 11/17 (10 days). 4. Interview with the DON and the corporate nurse on 02/08/18 at 02:15 PM revealed there was a lack of adequate documentation at times, and they were unable to explain the holes in the shower documentation.	F 677	Education of the new system for documenting bathing was completed by the Consultant with the nurse management team on 03/01/2018. Additional training for front line nursing staff will be completed via all staff meetings and huddles. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: Results of audits will be submitted to the QAPI committee monthly for 3 months or until substantial compliance is achieved for input and direction to ensure continued compliance.	
F 758	Free from Unnec Psychotropic Meds/PRN Use	F 758		3/25/18

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	535024	A. BUILDING _____ B. WING _____	C 02/08/2018

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F 758 SS=D	Continued From page 23 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758		

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F 758	Continued From page 24 appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure resident medication regimens were free from unnecessary psychotropic medications for 1 of 5 sample residents (#63) reviewed for unnecessary medications. The findings were: Review of the 1/14/18 admission MDS assessment showed resident #63 had diagnoses that included Alzheimer's disease and dementia. Further review showed the resident had physical and verbal behaviors which interfered with cares and put others at risk for injury. Review of physician orders showed the resident had an order for quetiapine (antipsychotic) 25 mg two times a day "for psych." The following concerns were noted: a. Review of the medication administration record for January 2018 and February 2018 showed the resident was administered quetiapine as ordered. Further review showed the resident on occasion refused or spit out the medications. b. Review of the medical record showed no evidence the facility was monitoring for behaviors or other indications for the use of an antipsychotic. c. Review of a "Behavioral Health Committee	F 758	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F-758 CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #63 passed away on 03/07/2018. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: 100% audit of the Behavioral Health	

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F 758	Continued From page 25 & Provider Assessment" form, not dated, showed the committee recommended discontinuing the resident's quetiapine due to the resident spitting out medications and "it is unknown as to what behaviors are supposed to be being controlled with current medication regimen..." d. Interview with the DON on 02/08/18 at 11:57 AM revealed the behavioral health committee met and made the recommendation to discontinue the quetiapine on 1/17/18. She stated the recommendation was sent to the physician and the facility was still waiting for the physician's response. .	F 758	Committee recommendations were reviewed for PCP requests related to missing diagnosis or lack of current target behaviors, additional follow up requests were sent to the PCP for timely follow up. 100% audit of residents on psychotropic medications was completed to ensure that target behaviors were identified for use and included in the plan of care MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN: On 02/28/2018 a letter was created and sent to all providers, educating them on the requirements of long term care regulation(s) and the requirement for them to participate in the coordination of care in a timely manner. During quarterly care conference meetings, the IDT will identify individuals requiring psychotropic medications and will ensure that diagnosis and target behaviors are included in the review. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: Results of audits will be submitted to the QAPI committee monthly for 3 months or until substantial compliance is achieved for input and direction to ensure continued compliance.	

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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: §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:	F 880		3/25/18

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F 880	Continued From page 27 (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 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 and staff interview the facility failed to ensure effective infection control practices were followed during 2 random observations. The findings were: 1. Observation on 2/5/18 at 1:20 PM showed resident #67 was in bed and his/her catheter bag was lying flat on the floor. Observation on 2/6/18 at 10:38 AM showed the catheter bag was hanging upright from the bed frame; however the bag was hanging low enought to sit directly on the	F 880	Disclaimer Clause Preparation and/or execution of this plan of correction does not constitute the provider□s admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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F 880	Continued From page 28 floor. Observation on 2/7/18 at 5:43 PM showed the catheter bag had greater than 2000 ml of urine in it and although the bag was hanging upright from the bed frame, the bag was draped over the base of the over-bed table and was sitting directly on the floor. 2. Observation on 2/5/18 at 5:38 PM in the assisted dining area showed CNA #5 assisting two residents, one was a female and the other a male. The male resident was using a spoon to serve himself some yogurt, while the CNA had turned toward the female to assist her with a spoonful of food. The CNA turned back to the male and picked up the same spoon he had used and gave him a spoonful of food. The CNA continued to assist both residents with their food, using the same hand, without performing hand hygiene. Continued observation showed the CNA reached over and touched the male resident's back, then got up and turned the female resident's wheelchair away from the table and wiped her face. At 5:54 PM the CNA walked around the table and touched two other residents at the table. She then helped a different male resident with his food and touched a female's back, at which point she performed hand hygiene. 3. Interview on 2/8/18 at 8:48 AM with the infection control preventionist revealed it was her expectation catheter bags not sit directly on the floor, and CNAs use hand sanitizer between residents when assisting more than one resident with dining unless one hand was dedicated to each resident.	F 880	F-880 CORRECTIVE ACTION FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #67 had catheter bag emptied and hung appropriately on bed frame ensuring it was not touching the floor. No other residents were identified during survey as being affected by the improper hand hygiene identified in the 2567. HOW THE FACILITY IDENTIFIED OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: A 100% audit of all residents with catheters were reviewed by Nurse Consultant on 2/8/18 to ensure that all catheter bags were not exceeding 2000 ml and that the bags were hanging upright and not touching the floor. There were no concerns identified. All residents have the potential to be affected by the alleged deficient practice of handwashing. Personal sanitzers were provided to all CNA□s on 2/8/18 and education provided to proper hand hygiene during meal services. MEASURES OR SYSTEMIC CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WILL NOT OCCUR AGAIN:	

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F 880	Continued From page 29	F 880	Beginning on 2/8/18 in-service education sessions were conducted and proper infection control practices related to catheter care and proper hand hygiene during meal times was reviewed by Infection Control Preventionist. Infection Control Preventionist/designee will audit weekly all residents with catheters to ensure that bags are not exceeding 2000 mls and that bags are appropriately hung and not touching the floor. Infection Control Preventionist/designee will monitor 2 meals weekly to ensure that proper handwashing procedures are followed during meal times. HOW THE FACILITY PLANS TO MONITOR PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED: Results of audits will be submitted to the QAPI committee monthly for 3 months or until substantial compliance is achieved for their input and direction to ensure continued compliance.	