STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A050	A. BUILDING _____ B. WING _____	03/30/2018

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STAR VALLEY CARE CENTER	110 HOSPITAL LANE AFTON, WY 83110

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 3/26/18 to 3/30/18. Also reviewed in the course of the survey were complaint intakes WY00002370 and WY00002536. The following common abbreviations are used throughout this document. ADON: Assistant Director of Nursing DON: Director of Nursing MDS: Minimum Data Set NHA: Nursing Home Administrator RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 585		5/11/18

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

Electronically Signed | 04/19/2018

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 585	Continued From page 1 §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as	F 585		

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F 585	Continued From page 2 necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedure, and staff interview, the facility failed to ensure the grievance policy contained all required	F 585	The facility will ensure that the residents have the right to voice grievances to the facility or other agency or entity that hears	

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F 585	Continued From page 3 information. The census was 16. The findings were: 1. Observation of the facility during the survey from 3/26/18 to 3/30/18 showed no evidence information about the facility's grievance policies and procedures was posted in any resident areas. 2. Review of the Policy and Procedure entitled "Patient Complaint Resolution," last revised 11/2016, did not address the process on how to file a grievance anonymously, did not contain contact information for the grievance official, and did not specify a reasonable expected time frame for completion of the grievance review. In addition, the policy did not include the right to obtain a written decision and did not specify all evidence pertaining to the grievance would be maintained for at least 3 years. 3. Interview with the social worker on 3/29/18 at 6:23 PM revealed the facility did not have a formal concern form, and any concerns or grievances were communicated verbally to administration. 4. Interview with the NHA on 3/30/18 at 8:11 AM revealed when residents were admitted to the facility they were given a brochure created by the Long-term Care Ombudsman Program in regard to Residents' Rights, and then a form was signed which acknowledged receipt. However, this brochure did not contain information on how to contact outside entities other than the Ombudsman. The NHA confirmed the policy did not contain the required information.	F 585	grievances without discrimination or reprisal and without fear of discrimination or reprisal. This will be accomplished by: 1) The grievance policy will be posted in the Activities Room, Commons Area and Dining Room. The grievance policy will be updated to address the process on how to file a grievance anonymously, include the contact information for the grievance official, and specify a reasonable expected timeframe for completion of the grievance review. It will also include the right to obtain a written decision and that the evidence pertaining to the grievance is maintained for 3 years. A formal concern form will be created for resident and public use. The Admission packet will be updated to include information on how to contact outside entities beyond the ombudsman. 2) All residents and/or responsible parties will be informed of the updates to the grievance policy as listed in #1. They will also be notified of the location of the grievance policy for their review if they wish. Future admissions into the facility will receive the updated admission packet upon arrival. 3) Education will be provided to all care center staff on the updated grievance policy and its locations. Education will also take place to all care center staff on the concern form and updates to the admission packet.	

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F 585	Continued From page 4	F 585	4) The DON or designee will perform audits weekly for 2 weeks, then monthly to ensure the updated grievance policy is located in the three specified locations mentioned in #1, new admissions have received the updated admission packet, and that the concern form is available for public use. Results of these findings will be reported on the monthly quality calendars and reviewed by the quality advisory committee monthly.	
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		5/11/18

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F 623	Continued From page 5 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with	F 623		

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F 623	Continued From page 6 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure a transfer notice was issued to 2 of 2 sample residents (#3, #15) with hospital transfers. The findings were: 1. Review of the medical record showed resident #3 was transferred to the hospital for an acute change of condition on 2/5/18 and readmitted to	F 623	The facility will ensure that all residents receive adequate and timely notification of transfer or discharge. This will be accomplished by: 1) Resident #3 and #15 have since returned to the Care Center. Written notice of transfer will be updated for future	

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F 623	Continued From page 7 the facility on 2/8/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. Interview with the MDS coordinator and the ADON on 3/29/18 at 12:10 PM revealed the facility did not issue a written notice of transfer for residents who were sent to the hospital. 2. Review of the medical record showed on 3/23/18 at 11:44 AM resident #15 was transferred to the hospital for a scheduled surgery. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. Interview on 3/29/18 at 2:54 PM with the administrator and the DON confirmed no transfer documentation was completed.	F 623	use for residents who transfer or discharge to another facility. 2) All future residents will receive the updated notice of transfer within the timeframe specified in 483.15(c)(4). 3) Education to be provided to the Interdisciplinary team and charge nurses on issuing a notice of transfer for all transfers and discharges. Education will include issuing the transfer notice within 24 hours if the resident is transferred emergently for their safety/health, and documentation of attempts to reach the responsible parties if unable to contact them at the time of transfer or discharge. 4) The DON or designee will perform audits weekly for 4 weeks, then monthly to ensure all residents that have transferred to another facility have received a notice of transfer within the timeframe specified in 483.15(c)(4). Results of these findings will be reported on the monthly quality calendars and reviewed by the quality advisory committee monthly.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F 625		5/11/18

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F 625	Continued From page 8 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure a notice of the bed-hold policy was issued to 2 of 2 sample residents (#3, #15) who transferred to the hospital. The findings were: 1. Review of the medical record showed resident #3 was transferred to the hospital on 2/5/18 and returned to the facility on 2/8/18. Further review showed a written notice of the bed-hold policy was issued, however it was not signed by the resident or the resident's representative until 2/8/18 (72 hours after transfer). 2. Review of the medical record showed resident #15 was transferred to the hospital on 3/23/18 for a scheduled surgery. Further review showed a	F 625	The facility will ensure that all residents are issued adequate notice of the bed hold policy who are transferred for hospitalization or therapeutic leave. This will be accomplished by: 1) Resident #3 and #15 have since returned to the care center. The current bed hold notice will be reviewed and/or updated as necessary. 2) All future residents who are transferred out of the facility for hospitalization or therapeutic leave will have a bed hold notice issued to them before, or within 24 hours of the transfer.	

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F 625	Continued From page 9 written notice of the bed-hold was issued, however it was not signed by the resident or the resident's representative until 3/29/18 (6 days after the transfer). 3. Interview with the social worker and the facility's secretary on 3/29/18 at 12:15 PM revealed the facility did issue a written notice of the bed-hold policy when residents were transferred to the hospital. However, they did not always provide the notice before, or within 24 hours, of the transfer.	F 625	3) Education will be provided to the Social Worker, Office Manager and Charge Nurses on giving the resident or responsible party the bed hold notice prior to, or within 24 hours of transfer. 4) The DON or designee will perform audits weekly for 4 weeks, then monthly to ensure all residents are issued the notice of bed hold within 24 hours of transfer. Results of these findings will be reported on the monthly quality calendars and reviewed by the quality advisory committee monthly.	
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 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).	F 656		5/11/18

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F 656	Continued From page 10 (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 medical record review, and staff interview, the facility failed to ensure care plans were developed to meet individual care needs in 1 of 16 sample residents (#3). The findings were: Review of the 1/4/18 significant change MDS assessment showed resident #3 was admitted to the facility on 9/6/17. Further review showed the resident took an anticoagulant on 7 days of the 7-day look-back period. Review of the March 2018 MAR (medication administration record) showed the resident was prescribed apixaban (an anticoagulant) 2.5 mg twice daily for atrial fibrillation. Interview with the NHA on 3/29/18 at 3:11 PM verified the resident had taken the medication since admission. Review of the care plan, created 2/26/18, showed no evidence a plan	F 656	The facility will ensure that all residents have a comprehensive person-centered care plan developed and implemented. This will be accomplished by: 1) Resident #3's care plan has been developed related to the use of an anticoagulant. 2) All other residents' care plans have been checked to ensure they have been developed related to use of anticoagulants, if applicable. 3) Education to be given to the interdisciplinary team on ensuring all residents have complete, comprehensive	

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F 656	Continued From page 11 of care had been developed related to the use of an anticoagulant. Interview with the MDS coordinator on 3/29/18 at 3:11 PM confirmed the care plan had not been fully developed.	F 656	care plans based on their personal needs, including the use of anticoagulants if applicable. 4) The DON or designee will complete audits on 4 residents weekly for 4 weeks, then monthly, alternating residents to ensure everyone has been reviewed. These audits will be to check that the resident has a complete, comprehensive care plan based on their personal needs, including use of anticoagulants if applicable. Results of these findings will be reported on the monthly quality calendars and reviewed by the quality advisory committee monthly.	
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	F 657		5/11/18

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F 657	Continued From page 12 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. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the comprehensive care plan was revised as needed to reflect the resident's current needs for 1 of 15 sample residents (#14). The findings were: Observation on 3/27/18 at 12:04 PM showed resident #14 was seated in the dining room and had 2 glasses with thickened liquids in front of him/her. Review of a 3/6/18 SLP (Speech Language Pathologist) evaluation showed recommendations which included nectar thick liquids, sitting upright at a 90 degree angle, "liquids from a straw", and "small bites and sips." Review of the care plan, created 2/26/18, showed the resident was at risk for dehydration with interventions which included "offer variety of beverages", "needs consistent encouragement to promote adequate PO/Fluids [fluids by mouth]" and to "encourage fluids with meals, meds, and activities." Interview with the dietitian on 3/29/18 at 3:41 PM revealed he had implemented the changes the SLP had made and had educated the dietary staff. Further, he was responsible for updating the comprehensive care plan and he verified he had not revised the care plan to include the SLP recommendations.	F 657	The facility will provide a comprehensive care plan that is revised as needed to reflect the residents' current needs. This will be accomplished by: 1) Resident #14's care plan has been updated to reflect thickened liquids, sitting upright at a 90 degree angle, liquids from a straw and small bites and sips. 2) All other residents have been reviewed by the Dietician to ensure that recommendations and alterations have been included into the care plan, as necessary. 3) Education will be provided to the Interdisciplinary team on ensuring that specific interventions related to the care and treatment of residents are added into the care plan. Education will also include the need to review and revise the care plans as needed to reflect the resident's current needs. 4) The DON or designee will perform audits weekly for 4 weeks, then monthly on 4 residents, alternating to ensure all residents have been reviewed. These	

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F 657	Continued From page 13	F 657	audits will be to check and make sure that the care plan has been reviewed and revised as necessary to reflect the resident's current needs. Results of these findings will be reported on the monthly quality calendars and reviewed by the quality advisory committee monthly.	
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, family and staff interview, the facility failed to ensure residents who required assistance to carry out activities of daily living received the necessary services to maintain grooming in 1 of 15 sample residents (#12). The findings were: 1. Review of the 12/15/17 quarterly MDS assessment showed resident #12 was severely cognitively impaired, required the extensive assistance of 1 person for hygiene, and had diagnoses which included Alzheimer's disease. Review of the care plan, created 2/26/18, showed "ADL impairment...personal hygiene: extensive with 1 person assist" The following concerns were identified: a. Observation on 3/26/18 at 6:52 PM and again on 3/28/18 at 12:15 PM showed the resident had multiple whiskers on his/her chin and neck; which varied in length from 0.5 inch to 1.5 inches; and were white and black in color. b. Interview with family members visiting from	F 677	The facility will ensure residents who require assistance to carry out activities of daily living receive the necessary services to maintain grooming. This will be accomplished by: 1)Resident #12 has had the identified hairs on his/her chin and neck removed. 2) All other residents have been assessed to ensure that necessary services have been provided to maintain grooming. 3) Education to be provided to Charge Nurses and CNA staff on checking all female residents at each bathing opportunity. Clippers are available in each shower room to remove facial hair from female residents. Education also provided on assisting residents as needed with providing necessary services to maintain grooming, as needed.	5/11/18

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F 677	Continued From page 14 out of town on 3/27/18 at 11:13 AM revealed they thought the whiskers were worse on this visit than they had been in the past. c. Interview with the NHA and DON on 3/28/18 at 4:42 PM revealed the usual procedure was for CNAs to communicate with the nurse about the need for facial hair removal and then clippers were used to remove the hair. At that time they were not aware of the whiskers on the resident's chin and neck.	F 677	4) The DON or designee will perform audits three times per week for 2 weeks, then weekly for 4 weeks, then monthly on ensuring that necessary services have been provided to maintain grooming for all residents. Results of these findings will be reported on the monthly quality calendars and reviewed by the quality advisory committee monthly.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interview, and policy and procedure review, the facility failed to ensure neurological assessments were completed as necessary for 1 of 2 sample residents (#1) who experienced falls. The findings were: Interview with resident #1 on 3/28/18 at 9:41 AM revealed s/he had fallen in October 2017, and the fall resulted in black eyes and a broken nose. Review of a nurse's note dated 10/22/17 revealed the resident had attempted to get up without assistance. The fall resulted in a small open laceration on the back of his/her head. The	F 684	The facility will ensure neurological assessments are completed as necessary. This will be accomplished by: 1) Resident #1 has been assessed by the physician since the fall, and is stable at this time. 2) All other residents who have had a recent fall have been reviewed to ensure they have been assessed appropriately. 3) Education to Charge Nurses on ensuring that neurological checks are	5/11/18

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F 684	Continued From page 15 resident was sent to the emergency department and was later released. Review of the fall event report dated 10/22/17 showed vital signs were taken at the time of the fall, but there was no evidence neurological checks had been performed. During an interview with the DON on 3/29/18 at 10:49 AM she was unable to locate documentation that neurological checks were done at the time of the fall or for the 72 hours following the fall. Review of the policy entitled "Fall Protocol", last revised 1/2018, showed "Fall Assessment and Documentation...If the resident experienced a head trauma, vital signs and neurological checks should be done: every 15 minutes x 2; then, every 30 minutes x 2; then every 60 minutes x 2; then every shift x 3 days...The charge nurse should assess the resident and provide narrative documentation in the resident's medical record progress notes every shift for 3 days post fall. The narrative documentation could include vital signs, neurological check..."	F 684	performed for 72 hours as outlined in the policy for anyone that has experienced a witnessed fall with injury to the head, or unwitnessed fall with suspicion of head injury. 4) The DON or designee will perform audits 3 times per week for 2 weeks, then weekly for 4 weeks, then monthly on ensuring that neurological checks are performed for 72 hours as outlined in the policy for anyone that has experienced a witnessed fall with injury to the head, or unwitnessed fall with suspicion of head injury. Results of these findings will be reported on the monthly quality calendars and reviewed by the quality advisory committee monthly.	
F 812 SS=F	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.	F 812		5/11/18

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F 812	Continued From page 16 (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 review of the food code requirements the facility failed to ensure safe food handling practices in 1 of 2 food storage areas (dining room) and failed to ensure food was prepared under sanitary conditions in 1 of 1 kitchens. The findings were: 1. Observation on 3/27/18 at 11:59 AM showed 6 cartons of 4 fluid ounce Mighty Shakes in the freezer in the dining room. The Mighty Shakes had a use by date of 2/8/18. Interview with RN #1 at that time confirmed the shakes were available for resident use. Interview with the dietitian on 3/27/18 at 12:23 PM confirmed the Mighty Shakes were expired and should be discarded. He stated they did not have any residents at that time who were using the Mighty Shakes. 2. Observation on 3/28/18 at 11:48 AM showed the vent plate on the ice machine in the main kitchen was covered with dust. Sitting directly below the filter was a cart with clean water pitchers (face down) and the lids (face up). Interview with the dietary supervisor on 3/29/18 at 4:08 PM confirmed the vents needed to be cleaned and it was the responsibility of the kitchen staff to do so. 3. Observation on 3/28/18 at 10:50 AM showed 8 cutting boards of various sizes and colors were visibly scored, which created a surface that could	F 812	The facility will ensure food is prepared under sanitary conditions. This will be accomplished by: 1) All Mighty Shakes in the freezer have been checked for expiration and removed as necessary. The vent plate on the ice machine in the main kitchen has been cleaned. The water pitchers and lids below the vent have been washed. The lids have been stored face down. All cutting boards have been replaced to ensure the surface can be effectively cleaned. 2) All foods and fluids with expiration dates have been checked, and anything out of date has been discarded. All vent plates in the kitchen area have been checked and cleaned as necessary. All other storage containers and utensils have been evaluated by the kitchen staff for safe storage. All surface areas where food is prepared have been checked, and replaced or resurfaced as necessary to ensure the area is cleanable. 3) Education provided to dietary staff on checking for expiration of all foods and	

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F 812	Continued From page 17 not be effectively cleaned. Interview with the dietary supervisor on 3/29/18 at 4:08 PM confirmed the cutting boards were in poor condition and needed to be replaced. According to Food Code 2013, U.S. Public Health Service 4-501.12 "Surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and SANITIZED or discarded if they are not capable of being resurfaced."	F 812	fluids weekly. Education provided to the dietary staff on checking and/or cleaning all ice machine air vents weekly. Education provided to dietary staff on ensuring the surfaces of food preparation are cleanable, and how to properly notify the appropriate entities if corrective action is required. 4) A log form will be created to ensure that all foods and fluids are checked weekly for expiration, the ice machine air vents are checked weekly, and food preparation surfaces are checked monthly. The Dietary Supervisor or designee will perform audits weekly x4 weeks, then monthly on ensuring that these log forms have been completed. Results of these findings will be reported on the monthly quality calendars and reviewed by the quality advisory committee monthly.	
F 813 SS=D	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on staff interview the facility failed to ensure a policy regarding the use and storage of foods brought to residents by family or visitors had been developed. The findings were: Interview with the dietitian on 3/28/18 at 12:15 PM confirmed the facility did not have a policy	F 813	The facility will ensure that it has a policy regarding the use and storage of foods brought to residents by family and other visitors to ensure safe and sanity storage, handling and consumption. This will be accomplished by:	5/11/18

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F 813	Continued From page 18 concerning the use and storage of food brought in by visitors.	F 813	1) The facility currently has a policy on safe handling of food brought from outside the care center, originated on 3/9/17. This policy will be reviewed and revised as necessary. 2) This policy will be posted on the facility intranet site, so that all staff at the care center can review. 3) Education provided to charge nurses and CNA staff on the contents of the policy. 4) The DON or designee will perform audits weekly for four weeks, then monthly to ensure that the "Safe Handling of Food Brought From Outside The Care Center" policy is being followed at the care center. Results of these findings will be reported on the monthly quality calendars and reviewed by the quality advisory committee monthly.	