| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 535030 | A. BUILDING _____ B. WING _____ | 05/17/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| NEW HORIZONS CARE CENTER | 1111 LANE 12 LOVELL, WY 82431 |

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| F 000 | INITIAL COMMENTS<br><br>A recertification survey was conducted by Healthcare Licensing and Surveys from 5/14/18 to 5/17/18. Also reviewed in the course of the survey was complaint intake WY00002452.<br><br>The following common abbreviations are used throughout this document:<br><br>ADLs- Activities of Daily Living<br>CNA- Certified Nurse Aide<br>DON- Director of Nursing Services<br>MDS- Minimum Data Set<br>RN- Registered Nurse<br><br>Less commonly used abbreviations will be annotated in each deficiency. | F 000 | | |
| F 623 SS=E | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(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.<br>(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<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section. | F 623 | | 7/1/18 |

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

Electronically Signed | 06/06/2018

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 623 | Continued From page 1<br>§483.15(c)(4) Timing of the notice.<br>(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.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(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<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(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;<br>(v) The name, address (mailing and email) and | F 623 | | |

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| F 623 | Continued From page 2<br>telephone number of the Office of the State Long-Term Care Ombudsman;<br>(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 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<br>(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.<br><br>§483.15(c)(6) Changes to the notice.<br>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.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>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).<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff | F 623 | A.) The facility will ensure a written notice | |

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| F 623 | Continued From page 3<br>interview, the facility failed to provide a written transfer notice for 6 of 6 sample residents (#4, #9, #11, #13, #19, #62) reviewed for transfers. The findings were:<br><br>1. Review of the medical record showed resident #9 was transferred to the emergency room on 1/11/18 and 2/4/18. Further review of the medical record showed no evidence the resident or the resident's representative was provided with a written notice of transfer for either transfer.<br><br>2. Review of the medical record showed resident #19 was transferred to the emergency room on 2/1/18. Further review of the medical record showed no evidence the resident or the resident's representative was provided with a written notice of transfer.<br><br>3. Review of the medical record showed resident #4 was transferred to the hospital on 2/20/18 related to a change in condition. The records showed the resident returned to the facility on 2/23/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative.<br><br>4. Review of the medical record showed resident #62 was transferred to the hospital on 5/2/18 with a return date of 5/10/18, and on 3/29/18 with a return date of 4/9/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative for either transfer.<br><br>5. Review of the medical record showed resident #11 was transferred to the hospital for an acute change of condition on 1/31/18, 2/12/18, and again on 2/21/18. Further review showed no | F 623 | of transfer will be provided upon transfer of residents # 4, #9,#11,#19, and #62 and all other residents. To the resident being transferred or the residents representative.<br>B.) All staff will be educated on the importance of providing a written notice of transfer with all transfers.<br>C.) Quality monitoring on written notices of transfer will be done weekly by supervisors of all transfers using the quality improvement monitoring tool until substantial compliance has been met.<br>D.) Any staff not providing written notice will receive immediate in-service and corrective action will be taken.<br>E.) Results will be reported quarterly as part of the facility quality assurance program by a supervisor. | |

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| F 623 | Continued From page 4<br>evidence the facility issued a written notice of transfer to the resident or the resident's representative for any of the transfers.<br><br>6. Review of the medical record for resident #13 showed s/he transferred to the emergency room for an acute illness on 3/20/18 and returned to the facility on 3/23/18. Further review of the record showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative.<br><br>7. During an interview on 5/17/18 at 10:36 AM the DON stated the facility was unable to locate evidence of written transfer notices for the sample residents. She stated the facility did complete a transfer notice, but she thought they were shredded at the hospital. | F 623 | | |
| F 625 SS=E | Notice of Bed Hold Policy Before/Upon Trnsfr<br>CFR(s): 483.15(d)(1)(2)<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§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-<br>(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;<br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a | F 625 | | 7/1/18 |

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| F 625 | Continued From page 5<br>resident to return; and<br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to provide written information on the bed-hold policy for 6 of 6 sample residents (#4, #9, #11, #13, #19, #62) reviewed for transfers. The findings were:<br><br>1. Review of the medical record showed resident #9 was transferred to the emergency room on 1/11/18 and 2/4/18. Further review of the medical record showed no evidence the resident or the resident's representative was notified of the bed-hold policy in writing.<br><br>2. Review of the medical record showed resident #19 was transferred to the emergency room on 2/1/18. Further review of the medical record showed no evidence the resident or the resident's representative was notified of the bed-hold policy in writing.<br><br>3. Review of the medical record showed resident #4 was transferred to the hospital on 2/20/18 related to a change in condition. The records showed the resident returned to the facility on 2/23/18. Further review showed no evidence the facility issued a written notice of the bed-hold | F 625 | A.) The facility will ensure a written notice of the bed hold policy is issued to the resident or resident's representative upon transfer for residents #4, #9, #11, #13, #19 and #62 and all other residents.<br>B.) All staff will be educated on the importance of issuing a bed hold policy to the resident or residents representative upon transfer for all residents.<br>C.) Quality monitoring of bed hold notices will be done weekly by supervisors on all transfers using the quality improvement monitoring tool until substantial compliance has been met.<br>D.) Any staff not issuing a bed hold policy upon transfer will receive immediate in-service and corrective action will be taken.<br>E.) Results will be reported quarterly as part of the facility quality assurance program by supervisors. | |

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| F 625 | Continued From page 6<br>policy to the resident or the resident's representative.<br><br>4. Review of the medical record showed resident #62 was transferred to the hospital on 5/2/18 with a return date of 5/10/18, and on 3/29/18 with a return date of 4/9/18. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative.<br><br>5. Review of the medical record showed resident #11 was transferred to the hospital for an acute change of condition on 1/31/18, 2/12/18, and again on 2/21/18. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative.<br><br>6. Review of the medical record for resident #13 showed s/he transferred to the emergency room for an acute illness on 3/20/18 and returned to the facility on 3/23/18. Further review of the record showed no evidence the facility issued a written notice of the bed hold policy to the resident or the resident's representative.<br><br>7. During an interview on 5/17/18 at 10:36 AM the DON stated the facility was unable to locate evidence that the residents or their representatives received the bed-hold policy. She stated the facility did provide a copy of the bed-hold policy, but she thought they were shredded at the hospital. | F 625 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments. | F 641 | | 6/21/18 |

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| F 641 | Continued From page 7<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview the facility failed to ensure MDS assessments were accurately completed for 1 of 18 sample residents (#11) reviewed. The findings were:<br><br>Review of the 2/18/18 quarterly MDS assessment for resident #11 showed the resident was coded as having received tracheostomy care while a resident. Review of the medical record showed no evidence the resident had a tracheostomy. Interview with the MDS coordinator on 5/17/18 at 8:03 AM verified the coding of the tracheostomy was an error. | F 641 | The facility will ensure that each resident receives an accurate assessment reflective of the residents status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident status, needs, strengths, and areas of decline.<br>A.) The facility will complete an accurate quarterly MDS assessment of 2/18/18 for resident #11 and all other residents.<br>B.) All of the MDS team will be educated on the importance of correct documentation of the residents medical, functional and psychosocial problems using the appropriate resident assessment instrument (RAI).<br>C.) Monitoring of compliance will be done by weekly random review/audit of 2 MDS assessments from that week's schedule by the MDS coordinator using the quality improvement tool assessing for accuracy of data to reflect the current status of the resident.<br>D.) Any MDS team member not accurately completing the resident assessment instrument will receive immediate in-service and corrective action will be taken.<br>E.) Results will be reported quarterly as part of the facility quality assurance program. | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1) | F 656 | | 7/1/18 |

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| F 656 | Continued From page 8<br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(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<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the | F 656 | | |

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| F 656 | Continued From page 9<br>requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, and staff interview, the facility failed to develop a comprehensive care plan for 1 of 18 sample residents (#32). The findings were:<br><br>1. Review of the 3/13/18 admission MDS assessment revealed resident #32 wandered 4-6 days during the observation period. Observation on 5/15/18 at 10:16 AM revealed the resident was wandering in the hallway and into other residents' rooms. However, review of the care plan (initiated 3/20/18) provided by the facility showed wandering was not addressed. During an interview on 5/16/18 at 5:24 PM the unit manager stated the resident did wander and confirmed the care plan did not address wandering. She stated the care plan was current. | F 656 | The facility will develop a comprehensive person centered care plan for each resident consistent with resident's rights that includes measurable objectives and time frames to meet the resident's medical, nursing, mental and psychosocial needs as identified in the comprehensive assessment.<br>A.) The facility will develop a comprehensive care plan for resident #32 and all other residents.<br>B.) All nursing staff and MDS team will be educated on the importance of updating care plans appropriately with new information to keep the plan current.<br>C.) Monitoring of compliance will be done by weekly random review of the 2 care plans affected by a change on orders for that week by the MDS coordinator using the quality improvement tool assess for accuracy of current individualized goals, approaches and interventions for those residents.<br>D.) Any staff member not completing and updating the care plans will receive immediate in-service and corrective action will be taken.<br>E.) Results will be reported quarterly as part of the facility quality assurance program. | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services | F 755 | | 7/1/18 |

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| F 755 | Continued From page 10<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to ensure medications were not expired in 1 of 2 medication storage rooms (the first floor medication room). The findings were:<br><br>1. Observation of the refrigerated medications in the first floor medication storage room revealed | F 755 | A.) The expired insulin syringe and expired Ativan vials have been removed from the first floor medication storage room.<br>B.) The facility will ensure there are no expired medications in the medication storage areas. | |

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| F 755 | Continued From page 11<br>the following expired medications:<br>a. Apidra Solostar insulin glulisine (rDNA) origin injection pre-filled syringes with an expiration date of "2/18."<br>b. Ativan 2 mg/ml vials located in the emergency lock box in the refrigerator with an expiration date of "2/23/18."<br><br>2. Interview with RN #1 on 5/17/18 at 9:34 AM confirmed the medications in the refrigerator were for resident use and were past their expiration date. | F 755 | C.) All nurses will be educated on the importance of removing expired mediations from the medication storage areas upon expiration.<br>D.) Quarterly monitoring of expiration dates will be done by weekly random checking of 2 medication storage areas by supervisors using the quality improvement monitoring tool until substantial compliance has been met.<br>E.) Any nurses working with expired medications present will receive immediate in-service and corrective action will be taken.<br>F.) Results will be reported quarterly as part of the facility quality assurance program by supervisors. | |
| F 803 SS=E | Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)<br><br>§483.60(c) Menus and nutritional adequacy. Menus must-<br><br>§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;<br><br>§483.60(c)(2) Be prepared in advance;<br><br>§483.60(c)(3) Be followed;<br><br>§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;<br><br>§483.60(c)(5) Be updated periodically; | F 803 | | 7/1/18 |

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|---|---|---|---|
| | 535030 | A. BUILDING _____ B. WING _____ | 05/17/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| NEW HORIZONS CARE CENTER | 1111 LANE 12 LOVELL, WY 82431 |

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| F 803 | Continued From page 12<br><br>§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and<br><br>§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, menu review, and staff interview, the facility failed to ensure the menu was developed to include portion sizes and ensure nutritional adequacy. In addition, the menu was not followed during 1 of 1 meal service observation. The census was 70. The findings were:<br><br>1. Review of the menu from 5/15/18 to 5/17/18 showed there were no portion sizes included. Observation on 5/16/18 at 4:50 PM of the evening meal preparation showed cook #1 used various scoops to measure out the food provided for resident meals. Interview with the cook at that time revealed there were no serving sizes in writing, she just always used certain scoops. She used a #12 scoop (about 1/3 cup) for the pureed main dish and a #16 scoop (about 1/4 cup) for the pureed vegetable. Five residents had orders for a pureed diet. The cook stated the lasagna for the regular and mechanical soft textured meals was 1/12 of the lasagna (about 1/2 cup). She determined this amount based on the serving size information from the lasagna packaging. The regular and mechanical textured meals received 1/2 cup of the vegetable. The following concerns were identified:<br>a. Interview with the certified dietary manager (CDM) on 5/17/18 at 10 AM revealed a standard | F 803 | A.) All menus have been developed to include standard portion sizes to ensure nutritional adequacy.<br>B.) All dietary staff will be educated on the importance of using portion sizes for resident meals.<br>C.) Quality monitoring of portion sizes on tray line will be done by random monitoring of 2 resident meal trays by the dietary manager per week using the quality improvement monitoring tool until substantial compliance has been met.<br>D.) Any staff not using potion sizes will receive immediate in-service and corrective action will be taken.<br>E.) Results will be reported quarterly as part of the facility quality assurance program by the dietary manager.<br><br>A.) The facility will ensure menus are followed for resident #7 and all other residents.<br>B.) All dietary staff will be educated on the importance of following menus.<br>C.) Quality monitoring of trays for correct menus will be done by weekly random monitoring of two trays by the dietary manager using the quality improvement | |

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| F 803 | Continued From page 13<br>portion size for the menu items was not used. The CDM stated each cook may use different portion sizes, and the portions served to those with pureed meals on 5/16/18 may have been too small.<br>b. Interview with the registered dietitian on 5/17/18 at 10:30 AM verified the menu was in need of development and defined portion sizes were needed to ensure consistency and nutritional adequacy.<br><br>2. Observation on 5/16/18 at 4:50 PM showed cook #1 was preparing resident meals. The diet card for resident #7 showed s/he was to receive a mechanical soft diet. Review of the menu slip showed the resident had selected the alternate meal. Review of the menu showed the mechanical diet alternate meal was "canned fruit and cottage cheese plate." The following concerns were identified:<br>a. Observation showed the meal prepared for the resident was not canned fruit. The fruit plate had fresh fruit including un-cut red grapes.<br>b. Interview with cook #1 on 5/16/18 at 5:15 PM revealed she had not prepared the canned fruit for the mechanical textured option. She revealed the grapes would be removed for those who ordered this option with mechanical texture orders. She was unsure how many were ordered.<br>c. Observation on 5/16/18 at 5:21 PM showed resident #7 was finished eating and had been served the fruit plate with the grapes. Interview with RN #1 who was in the area passing medication revealed the resident had not had any difficulties with eating the meal.<br>d. Interview with the CDM on 5/17/18 at 10 AM confirmed the menu should have been followed. | F 803 | monitoring tool until substantial compliance has been met.<br>D.) Any staff not following menus will receive immediate in-service and corrective action will be taken.<br>E. ) Results will be reported quarterly as part of the facility quality assurance program by the dietary manager. | |

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| F 812 | Continued From page 14 | F 812 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure equipment/supplies in 1 of 2 kitchens (main kitchen) were maintained in a clean and sanitary condition. The findings were:<br><br>1. Observation on 5/14/18 at 4:58 PM showed the vents in the exhaust hood over the range and ovens were in need of cleaning. The vents had a build-up of grease and dust present. The condition of the vents remained un-cleaned when observed on 5/16/18 at 4:10 PM.<br><br>2. Observation of food equipment on 5/16/18 at 4:10 PM showed 6 plastic measuring cups in a clean storage area. These 6 cups were in poor | F 812 | A.) The facility will ensure the kitchen areas is kept clean and sanitary in accordance with standards established in the current edition of FDA food code.<br>B.) Vents in the exhaust hood over range and ovens have been cleaned and placed on a cleaning schedule to be done twice a month.<br>C.) Plastic measuring cups have been replaced<br>D.) Monitoring of compliance will be done by weekly rounds to ensure kitchen and equipment are sanitary and maintained using the quality improvement rounding tool until substantial compliance has been | 7/1/18 |

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| F 812 | Continued From page 15<br>condition with cracks and fissures permeating the plastic not allowing for effective sanitation.<br><br>3. Interview with the certified dietary manager on 5/17/18 at 10:04 AM confirmed the plastic cups needed to be replaced. She further stated the cleaning schedule needed to be "re-vamped" to ensure the vents were being cleaned more often.<br><br>4. According to Food Code 2017, U.S. Public Health Service 4-101.11: "Materials that are used in the construction of UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT may not allow the migration of deleterious substances or impart colors, odors, or tastes to FOOD and under normal use conditions shall be ...(E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition."<br><br>5. According to Food code 2013, Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." | F 812 | met by the dietary manager.<br>E.) Equipment in poor condition will be replaced.<br>F.) Results will be reported quarterly as part of the facility quality assurance program by the dietary manager. | |