STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535057	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN HEALTHCARE COMMUNITY	2009 LARAMIE STREET TORRINGTON, WY 82240

(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 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 2/25/19 through 2/28/19. Also reviewed in the course of the survey were complaint intakes WY00002560, WY00002750, and WY00002779. The following common abbreviations are used throughout this document. DON: Director of Nursing MDS: Minimum Data Set mg: Milligrams Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 623 SS=E	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.	F 623		4/10/19

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

Electronically Signed | 03/22/2019

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F 623	Continued From page 1 §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 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	F 623		

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F 623	Continued From page 2 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 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	F 623	1. Corrective action: Event occurred in	

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F 623	Continued From page 3 interview, the facility failed to ensure a transfer notice was issued for 7 of 7 sample residents (#1, #29, #32, #37, #78, #90, #93) with facility-initiated hospital transfers. The findings were: 1. Review of the medical record for resident #1 showed s/he was admitted to the hospital for an acute change of condition on 12/26/18 and was readmitted to the facility on 12/29/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 2. Review of the medical record for resident #29 showed s/he was admitted to the hospital for an acute change of condition on 11/20/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 3. Review of the medical record for resident #32 showed s/he was admitted to the hospital for an acute change of condition on 2/3/19 and readmitted to the facility on 2/4/19. In addition the resident was admitted to the hospital for an acute change of condition on 2/16/19 and was readmitted to the facility on 2/18/19. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative for either transfer. 4. Review of the medical record for resident #37 showed s/he was admitted to the hospital on 3/13/18 for an acute change of condition and readmitted to the facility on 3/15/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative.	F 623	the past for residents #1, #29, #32, #37, #78, #90, #93 and cannot be corrected. 2. Others Potentially Effected: All residents who are discharged/transferred are at risk for not receiving a written notice of transfer with facility-initiated hospital transfers to the resident or resident□s representative. 3. Systemic Changes: Notices of transfer were reviewed to determine the form contains required information. Licensed nurses will be educated by the Director of Nursing or designee on the requirement of written notice to all residents that transfer or discharge and the facility□s responsibility to ensure that the resident or resident□s representative receives notification. Unit Managers or designee will follow up with resident and/or resident representative to obtain signature if resident unable to sign during hospital transfer. 4. Monitoring: The Director of Nursing or designee will audit all residents discharged or transferred monthly for appropriate notification of transfer. These audits will continue monthly for six months. Results of the audits will be discussed by the Director of Nursing or designee at monthly QAPI Meeting to identify trends or additional education needs and will include discussion on the continuation or discontinuation of the audit based on findings.	

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F 623	Continued From page 4 5. Review of the medical record for resident #78 showed s/he was admitted to the hospital for an acute change of condition on 1/28/19 and was readmitted to the facility on 2/1/19. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 6. Review of the medical record for resident #90 showed s/he was admitted to the hospital for an acute change of condition on 12/10/18 and was readmitted to the facility on 12/18/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 7. Review of the medical record for resident #93 showed s/he was admitted to the hospital for an acute change of condition on 11/25/18 and was readmitted to the facility on 12/4/18. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. Interview on 2/27/19 at 4:16 PM with the DON revealed the facility did not issue written notices of transfer with all required information to the residents or the residents' representatives.	F 623		
F 625 SS=E	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	F 625		4/10/19

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F 625	Continued From page 5 specifies- (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 provide written information on the bed-hold policy for 7 of 7 sample residents (#1, #29, #32, #37, #78, #90, #93) reviewed for facility-initiated transfers. The findings were: 1. Review of the medical record for resident #1 showed s/he was admitted to the hospital for an acute change of condition on 12/26/18 and was readmitted to the facility on 12/29/18. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 2. Review of the medical record for resident #29	F 625	1. Corrective action: Event occurred in the past for residents #1, #29, #32, #37, #78, #90, #93 and cannot be corrected. 2. Others Potentially Effected: All residents who are discharged or transferred are at risk for not receiving written notice of the bed-hold policy. 3. Systemic Changes: Bed-hold Policy reviewed to determine the form contains required information. Licensed nurses will be educated by the Director of Nursing or designee on the requirement of providing written bed-hold notice for all residents that discharge or transfer, and the	

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F 625	Continued From page 6 showed s/he was admitted to the hospital for an acute change of condition on 11/20/18. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 3. Review of the medical record for resident #32 showed s/he was admitted to the hospital for an acute change of condition on 2/3/19 and readmitted to the facility on 2/4/19. In addition the resident was admitted to the hospital for an acute change of condition on 2/16/19 and was readmitted to the facility on 2/18/19. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative for either transfer. 4. Review of the medical record for resident #37 showed s/he was admitted to the hospital on 3/13/18 for an acute change of condition and readmitted to the facility on 3/15/18. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 5. Review of the medical record for resident #78 showed s/he was admitted to the hospital for an acute change of condition on 1/28/19 and was readmitted to the facility on 2/1/19. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 6. Review of the medical record for resident #90 showed s/he was admitted to the hospital for an acute change of condition on 12/10/18 and was readmitted to the facility on 12/18/18. Further review showed no evidence the facility issued a	F 625	facility□s responsibility to ensure provide to the resident or resident□s representative. 4. Monitoring: The Director of Nursing or designee will audit all residents transferred or discharged for appropriate written bed-hold notification. These audits will continue monthly for six months. Results of the audits will be discussed by the Director of Nursing or designee at monthly QAPI Meeting to identify trends or additional education needs and will include discussion on the continuation or discontinuation of the audit based on findings	

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F 625	Continued From page 7 written notice of the bed-hold policy to the resident or the resident's representative. 7. Review of the medical record for resident #93 showed s/he was admitted to the hospital for an acute change of condition on 11/25/18 and was readmitted to the facility on 12/4/18. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. Interview on 2/27/19 at 4:16 PM with the DON revealed the facility did not issue written notices of the bed-hold policy with all required information to the residents or the residents' representatives.	F 625		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph	F 645		4/10/19

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F 645	Continued From page 8	F 645		

(k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental

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F 645	Continued From page 9 disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a pre-admission screening and resident review (PASARR) Level II was completed for 1 of 3 sample residents (#36) reviewed for PASARR screening. The findings were: Review of the annual MDS assessment dated 9/19/18 showed resident #36 was admitted to the facility on 9/13/13 and was not currently considered by the state Level II PASARR process to have a serious mental illness and/or intellectual disability or related condition. Further review showed the resident had diagnoses which included schizophrenia and anxiety disorder. The following concerns were identified: a. Review of the face sheet showed the resident was admitted to the facility with diagnoses which included schizophrenia. b. Review of the PASARR Level I completed on admission showed the diagnosis of schizophrenia was not included and thus did not trigger for a PASARR Level II. c. Review of the PASARR Level I dated 1/12/17 showed the resident had diagnoses of unspecified schizophrenia and a single episode of major depression which triggered the PASARR Level II. A LT101 (functional assessment) request was completed at that time; however the medical record showed no evidence the PASARR Level II had been completed.	F 645	1. Corrective action: PASARR level II completed on resident #36. 2. Others Potentially Effected: All residents with a mental disorder and/or intellectual disability are at risk. All residents with a mental disorder and/or intellectual disability will be audited to ensure that PASARR Level II are completed. 3. Systemic Changes: Social Worker and licensed nurses will be educated by the Director of Nursing or designee on the requirement of PASARR Level II prior to admission for potential admits with a mental disorder and/or intellectual disability. Social Worker or designee will follow up with PASSAR to obtain level II for residents with a mental disorder and/or intellectual disability that is discovered after admission to the facility. 4. Monitoring: The Social Worker or designee will audit residents admitted to the facility monthly for appropriate PASARR completed based on diagnosis. These audits will continue monthly for six months. Results of the audits will be discussed by the Social Worker or designee at monthly QAPI Meeting to	

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F 645	Continued From page 10 Interview with the administrator on 2/28/19 at 11:15 AM verified the diagnosis of schizophrenia was present on admission and the medical record did not contain the completed PASARR Level II.	F 645	identify trends or additional education needs and will include discussion on the continuation or discontinuation of the audit based on findings	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		4/10/19

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F 756	Continued From page 11 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure the drug regimen was free of unnecessary medications for 3 of 6 residents (#39, #79, #83)reviewed. The findings were: 1. Review of the medical record showed resident #39 was prescribed lorazepam (used to treat anxiety) 0.5 mg in the evening. Review of the pharmacist's consultation report dated 1/30/19 showed a recommendation to consider a gradual dose reduction (GDR) of lorazepam to 0.25 mg every evening. The signed physician documentation showed, "GDR is not recommended for this patient." Further review of the document failed to show a rationale for keeping the medication at the higher dose. Interview on 2/27/19 at 5:06 PM with the DON confirmed the physician did not document a rationale. 2. Review of the medical record showed resident #79 was prescribed alprazolam (used to treat anxiety) 1 mg three times a day. Review of the pharmacist's consultation report dated 12/20/18 showed a recommendation for a GDR to alprazolam to 0.5 mg three times a day. Further review showed a checked box that indicated "I accept the recommendation above with the following modifications..." which showed	F 756	1. Corrective action: Residents #39, #79, #83 will have their physician contacted regarding the noted medications and the physician asked about the GDR for the medication. If the physician wishes to continue the medication, the physician will see the resident, document the diagnosis, provide rationale and a specified duration for the use of the medication. 2. Others Potentially Effected: All residents on psychotropic meds are at risk for not having appropriate GDRs for their medications with supported rationale from the physician. All residents on psychotropic medications will be audited to ensure that they have the appropriate GDR documented and rationale for use. 3. Systemic Changes: Licensed nurses will be educated by the Director of Nursing or designee on the requirement of having GDRs for residents on psychotropic medications and the facility□s responsibility to ensure the GDR is followed up on with the appropriate rationale. The nursing administration team will review pharmacy recommendations to ensure physicians give rationale for continued use of psychotropic if GDR not	

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F 756	Continued From page 12 no documentation of the modifications. Additional review showed "GDR is not recommended for this patient at this time," but failed to show a rationale for keeping the medication at the higher dose. Interview on 2/27/19 at 5 PM with the DON confirmed the physician did not document a rationale. 3. Review of the medical record showed resident #83 was prescribed escitalopram (used to treat depression) 20 mg once daily. Review of the pharmacist's consultation report dated 11/26/18 showed a recommendation for a GDR to escitalopram 10 mg once daily; the physician documented "to implement as planned", and signed on 11/26/18. Further review showed a nursing note that read "[physician name] contacted on 11/30/18 at 1530; at this time a dose reduction of Escitalopram is not beneficial for resident at this time." Additional review failed to show a rationale for keeping the medication at the higher dose. Interview on 2/27/19 at 5 PM with the DON confirmed the physician did not document a rationale. 4. Review of the Psychopharmacologic Medication Assessment and Review policy revised 11/17 showed, "...A Gradual Dose Reduction would not be warranted if the following has occurred and documented by the MD:...the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability...".	F 756	ordered. 4. Monitoring: The Director of Nursing or designee will audit all GDRs monthly to ensure that there is appropriate follow up and rationale if the medication is continued. These audits will continue monthly for six months. Results of the audits will be discussed by the Director of Nursing or designee at monthly QAPI Meeting to identify trends or additional education needs and will include discussion on the continuation or discontinuation of the audit based on findings.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		4/10/19

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§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 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

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F 758	Continued From page 14 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, staff interview, and review of policy and procedure, the facility failed to ensure PRN (as needed) orders for psychotropic drugs did not extend beyond 14 days for 1 of 6 sample residents (#27) reviewed for psychotropic medications. The findings were: Review of the current physician orders showed resident #27 was prescribed lorazepam (anti-anxiety) 0.25 mg by mouth every 6 hours as needed for anxiety and agitation on 1/8/19. Further review of the orders showed a stop date had not been included in the order, nor a rationale for extending the use beyond 14 days. Review of the January and February 2019 MAR (medication administration record) showed the resident received the medication 7 times in January and zero times in February. Interview on 2/27/19 at 4:19 PM with the DON confirmed the resident's PRN medication did not have a stop date and had not been addressed by the facility. Review of the policy titled "Psychopharmacologic Medication Assessment and Review", last revised November 2017, showed "4. a. PRN orders for psychotropic drugs are limited to 14 days, except if the attending clinician believes that it is appropriate for use extended beyond 14 days -	F 758	1. Corrective action: Resident #27 physician has been contacted regarding the PRN lorazepam. If the physician orders the continuation of the medication, a rationale and duration will be obtained from the physician. 2. Others Potentially Effected: All residents on PRN psychotropic medications are at risk for having medications beyond regulatory guidelines. All residents on PRN psychotropic medications will be audited to ensure that PRN medications are ordered for the appropriate duration or evaluation will take place by physician with rationale if continued. 3. Systemic Changes: Facility policy review and revised. Licensed nurses will be educated by the Director of Nursing or designee on the limit of 14 days for residents on PRN psychotropic medications, requirements to continue and the facility□s responsibility to ensure that residents are free from unnecessary medications. 4. Monitoring: The Director of Nursing or designee will audit residents on PRN	

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F 758	Continued From page 15 rationale must be documented and indicate the duration for the PRN use after the physician does an on site or "hands on" assessment of the resident."	F 758	psychotropic medications monthly for appropriate duration and rationale for continued use. These audits will continue monthly for six months. Results of the audits will be discussed by the Director of Nursing or designee at monthly QAPI Meeting to identify trends or additional education needs and will include discussion on the continuation or discontinuation of the audit based on findings.	
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of	F 801		4/14/19

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F 801	Continued From page 16	F 801		

supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and

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F 801	Continued From page 17 (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the enrollment letter, the facility failed to ensure the dietary manager met the required qualifications. The facility census was 94. The findings were: Interview with the dietary manager on 2/27/19 at 3:30 PM revealed she was enrolled in the "Nutrition & Foodservice Professionals Training Course" through the University of North Dakota with an expected completion date of 9/18/19. Review of the enrollment letter showed the dietary manager enrolled in the course on 9/18/18.	F 801	1. Corrective action: We have employed two Dietary Managers (Co-Directors of Food and Nutrition Services)and our most recent Dietary Manager will pursue her FMP credentials through the National Restaurant Association Solutions. Our Dietary Manager will be permitted to sit for the exam within two weeks. In the interim, we will employ an Interim Dietician, Certified Food Service Manager and/or Certified Dietary Manager for two to four weeks or at which time our Dietary Manager receives her FMP credentials. 2. Others Potentially Effected: All residents have the potential to be affected. 3. Systemic Changes: The Dietary Manager will complete the proctored exam for her FMP credentials. 4. Monitoring: The Administrator will monitor the progress of the Dietary Manger to complete the proctored test by 5/14/2019. The progress and Completion of the program will be reported at the QAPI Meeting to determine any further follow up action if needed.	

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F 812	Continued From page 18	F 812		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of manufacturer's instructions, and review of sanitizer log sheets, the facility failed to ensure the sanitizer concentration of the water in the 3-compartment sink met the required concentration in 1 of 1 kitchen. The census was 94. The findings were: Review of the sanitizer log for January 2019 showed 32 of the 75 times the water was checked in the sink the sanitizer concentration was below 200 ppm (parts per million). Review of the February 2019 sanitizer log showed 15 of the 42 times the water was checked in the sink the sanitizer concentration was below 200 ppm.	F 812	1. Corrective action: Dietary Manager notified Ecolab to fix sanitizer equipment. 2. Others Potentially Effected: All residents have the potential to be affected. 3. Systemic Changes: Dietary Staff who wash dishes will be educated by the Dietary Manager on manufacturer recommendation, sanitizer log sheets and corrective actions to be taken if sanitizer concentration levels not met. 4. Monitoring: The Dietary Manager or	4/10/19

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F 812	Continued From page 19 Review of the manufacturer's instructions showed the recommended sanitizer strength was between 200 and 400 ppm and corrective action must be taken if the sanitizer concentration requirement was not met. Interview with the dietary manager on 2/28/19 at 9:58 AM revealed it was her expectation for staff to check the sanitizer concentration three times a day; each time the 3-compartment sink was refilled. She stated when the concentration requirement was not met it meant the machine was not dispensing the sanitizing solution correctly. In addition, she was unaware of the problem and needed to contact the company responsible for its maintenance.	F 812	designee will audit the sanitizer log sheets weekly for appropriate levels or corrective action as needed. These audits will continue weekly for three months, then monthly for three months. Results of the audits will be discussed by the Dietary Manager or designee at monthly QAPI Meeting to identify trends or additional education needs and will include discussion on the continuation or discontinuation of the audit based on findings	