STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535039	A. BUILDING _____ B. WING _____	C 08/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 8/5/19 through 8/8/19. Also reviewed in the course of the survey was complaint intake WY00002832. The following common abbreviations are used throughout this document. ADL: Activites of Daily Living BIMS: Brief Interview for Mental Status CMS: Centers for Medicare and Medicaid Services CNA: Certified Nursing Assistant DON: Director of Nursing ED: Executive Director LPN: Licensed Practical Nurse MDS: Minimum Data Set RAI: Resident Assessment Instrument RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at	F 565		9/20/19

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

Electronically Signed | 08/30/2019

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F 565	Continued From page 1 the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: . Based on resident and staff interview, review of resident council meeting minutes, review of the facility grievance log, and policy and procedure review, the facility failed to act upon group grievances for 2 of 3 months of meeting minutes reviewed (June 2019, July 2019). The findings were: 1. Group interview with 10 residents on 8/6/19 at 4:08 PM revealed 2 of the 10 residents knew how	F 565	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of	

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F 565	Continued From page 2 to file a grievance and the group felt the facility did not always follow up with them after they voiced concerns. The following concerns were identified: a. Review of the resident council meeting minutes for June 2019 showed there were concerns related to dining room servers not asking or listening to what residents would like for meals and CNAs were "snappy" and "bossy" to residents. Review of the resident council meeting minutes for June 2019 and July 2019 showed no evidence the concerns were acted on or a resolution was provided to the residents. b. Review of the resident council meeting minutes for July 2019 showed the resident council voiced concerns related to a confused resident going in and out of resident rooms. Further review showed no evidence the concerns were acted on or a resolution was provided to the residents. c. Review of the grievance log for June 2019 and July 2019 showed no evidence the concerns from resident council or a resolution related to the concerns were addressed. d. Interview with the recreational director on 8/8/19 at 8:24 AM revealed she did not file grievances for concerns brought up in resident council; however, a comment card should have been completed and passed on to the appropriate department head and the resolution should have been reported back to her. Further interview revealed the facility did not report the resolution of concerns to the resident council. e. Interview with the ED on 8/8/19 at 8:38 AM confirmed resident council concerns should be filed as grievances, and the concerns identified in the resident council meeting minutes had not been filed as grievances. f. Review of the policy titled "Grievance	F 565	correction constitutes the facility's allegation of compliance in accordance with the State Operations manual. 1. Concern and Comment card was completed and logged regarding grievances shared in resident council for June and July 2019. Follow up will be reported at next resident council meeting in September. 2. All residents in attendance at resident council are at risk of the facility failing to act upon noted grievances. 3. Activities Director will be educated as facilitator of resident council regarding the grievance procedure and the importance of reporting any concerns brought forth from resident council to the grievance officer. She will also be educated on the importance of following up with resident council in regards to the resolution. 4. The Executive Director will conduct monthly audits for 3 months of resident council minutes to ensure any concerns are reported and logged and resolutions are followed up with resident council the following month. 5. Results of these audits will be reviewed during the monthly Performance Improvement meetings for 3 months or until the committee is able to determine the process in place is effective. Performance Improvement meetings consist of at a minimum the Executive Director, Director of Nursing, the Medical Director and additional staff as needed. The Performance Improvement committee identifies issues with respect to	

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F 565	Continued From page 3 Procedures and Concern & Comment Program" dated 5/6/19 showed "...The Social Services staff and/or the Executive Director are responsible for the following:...Maintaining a record keeping system of all complaints reported via the Concern & Comment Program or any other means of reporting that includes 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) [sic], 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...Following up with the resident and family to communicate resolution or explanation and ensure that the issue was handled to the resident and family's satisfaction....All staff are responsible for the following:...Immediately communicating all grievances and concerns expressed by residents, families, and/or visitors to a licensed nurse or department manager..."	F 565	which quality assessment and assurance activities are necessary and develops and implements appropriate plans of action to correct identified quality deficiencies.	
F 567 SS=E	. Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a	F 567		9/20/19

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F 567	Continued From page 4 resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: . Based on resident and staff interview and policy and procedure review, the facility failed to ensure resident funds were available for 3 of 4 sample residents (#8, #18, #20) who maintained a	F 567	1. Residents including #8, #18 and #20 and resident council will be notified via facility letter to inform them of the procedure now in place to access personal funds after business hours. 2. All residents who have persona funds	

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F 567	Continued From page 5 personal funds account with the facility. The findings were: 1. Interview with resident #8 on 8/6/19 at 9:18 AM revealed residents were unable to get money from their personal funds accounts on the weekends when the business office was "closed" because "nobody is here on the weekends." 2. Interview with resident #18 on 8/6/19 at 2:28 PM revealed residents got money from the business office, but the business office did not work on the weekends. Further, it was revealed if residents needed money on the weekends they must plan ahead and get their money during business office hours. 3. Interview with resident #20 on 8/6/19 at 8:27 AM revealed the resident had a personal funds account at the facility and s/he was not able to get money on the weekends. 4. Interview with the business office manager on 8/8/19 at 8:59 AM revealed residents were not able to get money for the weekends unless it was requested during business office hours. 5. Review of the "LCCA Resident Trust Policy and Procedure" dated 3/10/16 showed "...4. Provide residents with access to his or her funds within a reasonable amount of time. a. Requests for $50.00 or less ($100.00 or less for medicare residents) should be honored within the same day. b. Requests for more than $50 ($100.00 or more for Medicare residents) should be honored within three (3) banking days...Facility Banking Hours...Some states require that residents have access to cash on a twenty-four (24) hours a day, seven (7) days a week basis. In these states, this	F 567	at the facility are at risk of being unable to access those funds after business hours including weekends. 3. A cash box will be placed at the Central Nurses Station so that those residents who have personal funds will be able to access those funds after business hours including weekends. 4. Business office staff, nursing staff and social services will be educated regarding the policy and procedure regarding residents accessing personal funds 24 hours a day 7 days a week. 5. This process will be reviewed during the monthly Performance Improvement meeting for 3 months or until the committee is bale to determine the process in place is effective.	

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F 567	Continued From page 6 requirement shall be met while maintaining all other procedures with regard to cash distribution and documentation. In addition, the business office shall verify on a daily basis that cash kept for after-hours access is properly secured and accounted for..."	F 567		
F 585 SS=D	. 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. §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	F 585		9/20/19

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F 585	Continued From page 7	F 585		

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 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,

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F 585	Continued From page 8 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 resident and staff interview, review of the facility grievance log, and policy review, the facility failed to implement the grievance process for 2 of 2 sample residents (#18, #115) with reported grievances. The following concerns were identified: 1. Interview with resident #115 on 8/6/19 at 10:49	F 585	1. A concern and comment card was filled out for resident #115 and #18 regarding missing items which was logged and resolution obtained with follow up with both residents. 2. All residents are at risk of the facility failing to implement the grievance process. 3. All staff will be educated on the grievance procedure for all	

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F 585	Continued From page 9 AM revealed the resident had lost 2 shirts and had not gotten them back. Further interview revealed the shirts had been lost for "about 3 weeks" and the resident had reported the missing items to laundry staff. Interview with laundry staff member #1 on 8/8/19 at 8:19 AM revealed the resident had reported the missing items and she did not complete a grievance form. 2. Interview with resident #18 on 8/6/19 at 2:29 PM revealed the resident was missing 2 watches and some slacks. Further interview revealed the resident had also been missing slippers. When s/he reported the missing items to a staff member, the slippers were replaced; however, the watches and slacks had not been found or replaced. 3. Group interview with 10 residents on 8/6/19 at 4:08 PM revealed 2 of the 10 residents knew how to file a grievance and the group felt the facility did not always follow up with them after voicing concerns. 4. Review of the grievance logs from January 2019 through July 2019 showed no evidence of a grievance related to missing items for resident #18 or resident #115. 5. Interview with the environmental services manager on 8/7/19 at 5:28 PM revealed environmental services staff let residents know they were looking for missing items; however, they did not file grievances on behalf of the residents. 6. Interview with the ED on 8/8/19 at 8:34 AM revealed she expected staff to look for missing items and fill out a grievance card if they were	F 585	concerns/grievances including missing items. 4. The Executive Director will conduct an audit monthly for 3 months of the grievance log to ensure the grievance process is implemented for any reported concerns including missing items. Monthly audits will also be conducted of the resident council meeting minutes to ensure any reported concerns are addressed according to grievance policy and procedures. 5. Results of these audits will be reviewed during the monthly Performance Improvement meetings for 3 months or until the committee is able to determine the process in place is effective.	

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F 585	Continued From page 10 unable to locate the missing items. 7. Review of the policy titled "Grievance Procedures and Concern & Comment Program" dated 5/6/19 showed "...The Social Services staff and/or the Executive Director are responsible for the following:...Maintaining a record keeping system of all complaints reported via the Concern & Comment Program or any other means of reporting that includes 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) [sic], 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...Following up with the resident and family to communicate resolution or explanation and ensure that the issue was handled to the resident and family's satisfaction....All staff are responsible for the following:...Immediately communicating all grievances and concerns expressed by residents, families, and/or visitors to a licensed nurse or department manager..."	F 585		
F 606 SS=E	. Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect,	F 606		9/20/19

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F 606	Continued From page 11 exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: . Based on review of employee personnel files and staff interview, the facility failed to ensure the State nurse aide abuse registry was checked prior to resident contact for 3 of 5 sample CNAs (#2, #3, #4) reviewed. The findings were: 1. Review of the employee files for CNAs #2, #3, and #4 revealed that a search of the State nurse aide abuse registry was not documented and abuse/neglect findings were not available for CNA #2, hire date of 7/10/19; CNA #3, hire date of 6/20/19; and CNA #4 hire date of 3/7/19. 2. Interview with the human resource director on 8/7/19 at 9:11 AM revealed she was unaware of this requirement. 3. Interview with the ED on 8/7/19 at 9:32 AM	F 606	1. State Nurse Aide Abuse Registry was completed for C.N.A #2, #3, and #4. 2. All residents are at risk of the facility failing to complete the State Nurse Aide Abuse registry for newly hired C.N.A's. 3. A 100% audit of all C.N.A personnel files will be completed to ensure the abuse registry was completed per regulation and facility policy. 4. Payroll Clerk was educated regarding the importance of completing the State Nurse Aide Abuse Registry for all newly hired C.N.A's prior to any resident contact. Payroll clerk will conduct monthly audits for 3 months of all newly hired C.N.A's to ensure the State Nurse Aide Abuse Registry is completed prior to them having any resident contact. 5. Results of these audits will be reviewed during the monthly Performance	

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F 606	Continued From page 12 confirmed the State CNA abuse registry needed to be checked prior to the CNA having contact with residents.	F 606	Improvement meetings for 3 months or until the committee is able to determine the process in place is effective.	
F 609 SS=D	. Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		9/20/19

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F 609	Continued From page 13 This REQUIREMENT is not met as evidenced by: . Based on medical record review, State Survey Agency incident report database review, staff interview, and policy and procedure review, the facility failed to ensure allegations of abuse were reported to the State Survey Agency for 1 of 2 sample residents (#64) with allegations of abuse or neglect. The findings were: 1. Review of a "Plan of Care Note" dated 3/19/19 showed the former DON and social worker met with resident #64's representative to discuss "staff concerns regarding [the representative's] interaction with the Resident." Witnessed events included the resident being hit on the back of his/her head, forced to drink water to take medications and sticking a finger down the resident's throat to "push down" his/her medications. Further review showed the social worker had been in contact with APS (adult protective services) regarding these concerns as well as informing them of the date the resident was expected to be discharged. 2. Review of an 'Event Note" dated 3/21/19 showed the former DON and social worker had met with the resident's representative and discussed how the staff felt uncomfortable with verbal and physical aggression directed towards the resident. Further review showed the former DON spoke to the resident's representative "about the way that residents, staff members and patients must be treated and that forcing a finger down someones (sic) throat to take pills, smacking them on the face or on the back of the head, yelling, cussing, and shaking their	F 609	1. Resident #64 no longer resides at the facility. 2. All residents involved in allegations of abuse are at risk of the facility failing to report the incident to the State Survey Agency. 3. A 100% audit of the investigation log will be completed by the Executive Director to ensure investigations involving family or staff are reported as required by federal regulation. 4. Director of Nursing and Social services Director will be educated on reporting all allegations of abuse to the State Survey Agency according to federal regulation and facility policy. Director of Nursing and Social Services Director also educated on the use of reporting allegations via state web portal as well as the timeliness of making any reports. The Executive Director will conduct monthly audits for three months to ensure all allegations of abuse are investigated and reported to the State Survey Agency per federal regulation and facility policy. 5. Reports of these audits will be reviewed during the monthly Performance Improvement meetings for three months or until the committee is able to determine the process in place is effective.	

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F 609	Continued From page 14	F 609		

shoulders forcibly in order to take medication is unacceptable behavior." The resident's representative was informed that "certain behaviors necessitate reporting to outside agencies if the behavior and treatment in that manner did not cease." The resident's representative acknowledged that the facility would not allow the above behavior to continue.

3. Interview with the social worker on 8/8/19 at 8:39 AM revealed the resident had discharged on 3/29/19 and APS had been contacted on 3/28/19 related to a follow-up home visit. Further interview revealed she had spoken to the resident's representative about the inappropriate behavior, and educated staff to keep the resident in sight when the representative visited and to intervene if necessary.

4. Interview with RN #1 and RN #2 on 8/8/19 at 10:53 AM revealed staff were vigilant in keeping the resident in sight whenever the resident's representative was in the facility. They stated the former DON and social worker had spoken to the resident's representative and informed the representative law enforcement would be called if the physical abuse of the resident did not stop.

5. Review of the State Survey Agency incident report database showed no evidence this allegation was reported to the agency.

6. Interview with the ED on 8/8/19 at 10:58 AM confirmed the allegation of visitor to resident abuse had not been reported.

7. Review of the "Reporting Alleged Abuse" policy last revised 2/7/17 showed "...12. Federal requirements mandate that facilities must ensure

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F 609	Continued From page 15 all allegations of abuse, neglect, exploitation, or mistreatment are reported immediately to their state survey agency." In addition "Facilities must satisfy the federal requirement to report the results of an investigation within 5 working days from the date of the incident (or knowledge of the incident)."	F 609		
F 636 SS=D	. Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status.	F 636		9/20/19

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F 636	Continued From page 16 (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: . Based on medical record review, staff interview, and review of the CMS RAI version 3.0 manual, the facility failed to complete a comprehensive	F 636	1. The Annual MDS assessment for resident #3 was scheduled, completed and transmitted on 8/7/19. The Admission MDS assessment for resident #114 was scheduled, completed and transmitted on	

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F 636	Continued From page 17 assessment within 14 days after admission or not less than every 12 months for 2 of 5 sample residents (#3, #114) reviewed for timeliness of comprehensive assessments. The findings were: 1. Review of the MDS assessment history for resident #3 showed an admission assessment was completed on 6/29/18, with subsequent quarterly assessments on 9/28/18, 12/27/18, and 3/29/19. There was no evidence an annual, significant change, or discharge assessment had been completed since 3/29/19. 2. Review of the medical record showed resident #114 had a discharge return not anticipated assessment completed on 6/2/19. The resident was re-admitted to the facility on 7/18/19. Review of the MDS assessment history showed no evidence an admission MDS assessment was in process or had been completed since the resident's re-admission. 3. Interview with the MDS coordinator on 8/7/19 at 4:21 PM revealed the assessments were not completed timely. Further interview confirmed resident #3 and resident #114 did not have assessments scheduled at that time. 4. Review of the "CMS RAI version 3.0 manual, October 2018," showed "...The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if:...this is the resident's first time in this facility, OR the resident has been admitted to this facility and was discharged return not anticipated, OR the resident has been admitted to this facility and was	F 636	8/20/19. 2.All residents requiring a comprehensive assessment are at risk of facility failing to complete an assessment within 14 days after admission or not less than every 12 months. 3.A 100% audit of the last 90 days was completed by the MDS Coordinator and Corporate Clinical Reimbursement Specialist to ensure comprehensive assessments have been scheduled or completed per federal regulation and facility policy and RAI manual. 4. The MDS Coordinator will be re-educated regarding the RAI process for completing comprehensive assessments. MDS Coordinator will utilize the tools available in Point Click Care to ensure all assessments are being scheduled and completed timely and appropriately according to the RAI manual. MDS and CRS will complete a weekly audit for 4 weeks and monthly thereafter for 3 months to ensure comprehensive assessments are scheduled and completed timely and appropriately according to the RAI manual. 5. Results of these audits will be reviewed during the monthly Performance Improvement meetings for 3 months or until the committee is able to determine the process in place is effective.	

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F 636	Continued From page 18 discharged return anticipated and did not return within 30 days of discharge...The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless a SCSA [significant change in status assessment] or a SCPA [significant correction to prior comprehensive assessment] has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments' ARDs and completion dates..." .	F 636		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: . Based on medical record review, staff interview, and review of the CMS RAI version 3.0 manual, the facility failed to complete a quarterly MDS assessment once every 3 months for 1 of 5 sample residents (#2) reviewed for timeliness of MDS assessments. The findings were: 1. Review of the MDS history for resident #2 showed a quarterly MDS assessment was completed on 9/26/18, an annual MDS	F 638	1. Quarterly MDS assessment for resident #2 was completed and transmitted on 8/8/19. 2. All residents requiring a quarterly assessment are at risk of the facility failing to complete an assessment at least every 92 days following the previous OBRA assessment of any type. 3. A 100% audit of the last 90 days was completed by the MDS Coordinator and Corporate Clinical Reimbursement Specialist to ensure quarterly	9/20/19

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F 638	Continued From page 19 assessment on 12/25/18, and a quarterly assessment on 3/27/19. There was a quarterly MDS assessment in progress with a date of 7/17/19; however, it was not complete. 2. Interview with the MDS coordinator on 8/7/19 at 4:21 PM revealed the assessment was in progress; however, it had not been completed timely. 3. Review of the "CMS RAI version 3.0 manual, October 2018," showed "...The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type..."	F 638	assessments have been scheduled and/or completed per federal regulation, facility policy and RAI manual. 4. The MDS Coordinator will be re-educated regarding the RAI process for completing quarterly assessments. MDS Coordinator will utilize the tools available in Point Click Care to ensure all assessments are being scheduled and completed timely and appropriately according to the RAI manual. MDS Coordinator and CRS will complete a weekly audit for 4 weeks and monthly thereafter for 3 months of the assessment schedule to ensure quarterly assessments are scheduled and completed timely and appropriately according to the RAI manual. 5. Results of these audits will be reviewed during the monthly Performance Improvement meetings for 3 months or until the committee is able to determine the process in place is effective.	
F 641 SS=D	. Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: .	F 641	1. Annual MDS assessment for resident #26 dated 5/7/19 section K0300 was	9/20/19

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F 641	Continued From page 20 Based on medical record review and staff interview, the facility failed to ensure MDS assessment information was an accurate reflection of resident status for 1 of 16 sample residents (#26). The findings were: 1. Review of the quarterly MDS assessment dated 6/19/19 showed resident #26 with a documented weight of 105 pounds and coded as having weight loss. The following concerns were identified: a. Review of the medical record showed the resident weighed 103.4 pounds on 3/13/19, 104.8 pounds on 5/2/19, and 104.4 pounds on 6/1/19. b. Interview with the dietitian on 8/7/19 at 4:23 PM revealed she looked at the resident's chart for weights and would communicate any concerns to everyone on the administrative team. It was acknowledged there was not a system in place to advise the MDS coordinator of a change of condition or any change in the MDS coding. c. Interview with the MDS coordinator on 8/7/19 at 4:26 PM revealed she coded the resident care areas of the MDS and that other departments such as physical therapy and dietary filled in the sections relevant to their knowledge of the residents. Dietary filled in the K section of the MDS. The MDS coordinator confirmed the assessment was not coded accurately.	F 641	modified to show that there was no weight loss as previously indicated. 2. All residents are at risk of the facility failing to ensure MDS assessment information is an accurate reflection of resident status. 3. A 100% audit of completed comprehensive assessments in the last 30 days will be conducted by the MDS Coordinator to ensure section K is coded accurately to reflect any changes in status. 4. IDT will be re-educated on the RAI process and the importance of ensuring all assessments are coded accurately. A weekly audit of comprehensive assessments will be conducted by the MDS Coordinator for 4 weeks then monthly thereafter for 3 months of the completed MDS assessments to ensure section K is completed accurately per federal regulation and facility policy. 5. Results of these audits will be reviewed during the monthly Performance Improvement meetings for three months or until the committee is able to determine the process in place is effective.	
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	F 645		9/20/19

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F 645	Continued From page 21 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 (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	F 645		

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F 645	Continued From page 22 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 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 performed for 1 of 5 sample residents (#114) with a qualifying diagnosis. The findings were: 1. Review of the care plan for resident #114, last revised on 8/5/19, showed the resident had diagnoses which included cerebral amyloid angiopathy, anxiety disorder, and other specified	F 645	1. PASARR level 1 was resubmitted with the diagnosis not originally included on the initial PASARR which are anxiety disorder and other depressive disorder. Upon resubmission of the PASARR the codes for anxiety and depressive disorder did not trigger a level 2 for resident #114 2. All residents with a psychiatric diagnosis are at risk for the facility failing to ensure a PASARR level 2 is completed according to federal regulation. 3. a 100% audit of all new admissions in the last 30 days will be conducted by the	

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F 645	Continued From page 23 depressive disorder. The following concerns were identified: a. Review of the PASARR level I completed on 7/18/19 showed the diagnosis listed was cerebral amyloid angiopathy. Further review showed the resident was marked no for all questions related to mental illness screening and mental retardation screening and did not trigger for a PASARR level II based on the listed diagnosis. b. Interview with the admissions director on 8/7/19 at 5:35 PM revealed "the hospital" completed the PASARR and she was aware the resident had triggering diagnoses which were not included on the PASARR. Further interview revealed she informed the hospital of the diagnoses; however, a new PASARR level I was not completed and a PASARR level II had not been requested. .	F 645	Admissions Director to ensure the PASARR was completed accurately and appropriately reflects any psychiatric diagnosis. 4. Admissions Director will be educated on the importance of completing the PASARR accurately and is appropriately reflects any psychiatric diagnosis. The PASARR will be completed prior to admission by the facility Admission Director to ensure it is completed accurately and if appropriate reflects any psychiatric diagnosis which would trigger a level 2 PASARR. A monthly audit for 3 months of new admissions will be conducted by the Admissions Director to ensure all new admissions have an accurately completed PASARR and reflects any psychiatric diagnosis. 5. Results of these audits will be reviewed during the monthly Performance Improvement meetings for 3 months or until the committee is able to determine the process in place is effective.	
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 -	F 656		9/20/19

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F 656	Continued From page 24 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: . Based on medical record review and staff interview, the facility failed to implement the comprehensive person-centered care plan for 1 of 21 sample residents (#5). The findings were: Review of the quarterly MDS assessment dated	F 656	1. Do not weigh and unavoidable weight loss was added to resident #5 care plan. 2. All residents who have an order for do not weigh or unavoidable weight loss are at risk for the facility failing to implement a person centered care plan. 3. A 100% audit will be completed by the Registered Dietician of all residents with	

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F 656	Continued From page 25 4/5/19 showed resident #5 had severe cognitive impairment and diagnoses which included seizure disorder, dementia, unspecified disorder of the brain, and a history of TIA (transient ischemic attack) and cerebral infarction. Further review showed the resident required extensive to total assistance for all ADLs. The following concerns were identified: a. Review of the nutrition care plan initiated 6/4/19 showed the resident was a "do not weight (sic) to support comfort and quality. [S/he] has been declining to be weighed and causes increased anxiety and discomfort lately." b. Review of the most current physician orders showed an order for "Do not weigh" and "Unavoidable weight loss" dated 5/21/19. c. Review of the "Weights and Vitals Summary" showed the resident was weighed on 7/4/19, 7/25/19, and 8/1/19. d. Interview with the dietitian on 8/7/19 at 9:10 AM revealed she created a weekly list for the CNAs of residents she needed a weight on. In addition, she stated she had failed to add DNW (do not weigh) next to the resident's name to alert the CNAs not to weigh the resident.	F 656	an order of do not weigh or unavoidable weight loss to ensure a comprehensive care plan was developed. 4. MDS Coordinator and Registered Dietician will be educated regarding the importance of developing and implementing a person centered care plan for each resident. The Registered Dietician will conduct weekly audits for 4 weeks then monthly thereafter for 3 months to ensure any resident that has a do not weigh order also has a care plan in place and is communicated on the weight list and Kardex to alert the C.N.A's. 5. Results of these audits will be reviewed during the monthly Performance Improvement meetings for 3 months or until the committee is able to determine the process in place is effective.	
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	F 657		9/20/19

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F 657	Continued From page 26 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: . Based on observation, medical record review, and staff interview, the facility failed to revise the comprehensive person-centered care plan for 2 of 21 sample residents (#5, #27). The findings were: 1. Review of the quarterly MDS assessment dated 4/5/19 showed resident #5 had severe cognitive impairment and diagnoses which included seizure disorder, dementia, unspecified disorder of the brain, and a history of TIA (transient ischemic attack) and cerebral infarction. Further review showed the resident required extensive to total assistance for all ADLs	F 657	1. Care plan for resident #5 was updated to include the wound on the resident's buttocks. Care plan for resident #27 was updated to include additional nutritional interventions as well as the use of the pommel cushion and/or instruction for use. 2. All residents are at risk of the facility failing to revise the comprehensive person centered care plan. 3. A 100% audit will be conducted by the Director of Nursing of all residents in the last 30 days to ensure current interventions are reflected in the care plan. 4. IDT was educated on the importance of	

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F 657	Continued From page 27 and was at risk for developing pressure ulcers. The following concerns were identified: a. Review of a nurse's progress note dated 7/29/19 showed a small wound on the resident's right buttock was identified with a plan to monitor and reposition the resident every 2 hours. b. Review of nurses' progress notes from 7/30/19 through 8/7/19 showed the wound was cleaned and dressed daily. c. Review of the wound care plan last revised 7/30/19 showed no evidence the wound to the resident's buttocks was addressed. d. Interview with the regional director of clinical services on 8/7/19 at 4:12 PM revealed the care plan should have been revised to include the wound to the resident's buttocks. 2. Review of the quarterly MDS assessment dated 5/22/19 showed resident #27 had diagnoses which included depression, osteoporosis, history of falling, and abnormal posture. The resident required extensive assistance for bed mobility, transfers, dressing, toilet use and personal hygiene and supervision with set-up help for eating. Further review showed the resident had 2 or more falls with no injury since the prior assessment, no or unknown weight loss in the last 6 months, and no use of restraint devices. Review of the resident's weight history showed a 5/8/19 weight of 150 pounds and a 8/1/19 weight of 126 pounds; a 16% loss. The following concerns were identified: a. Review of a "Nutrition/Dietary Note" dated 7/4/19 and timed 11:23 AM showed "...Resident's weight continues to trend down. Dietitian had discussed this with [him/her], however [s/he] was not concerned. At this time [s/he] had agreed to try 2 cal. [His/Her] 2cal intake is very hit and miss. [His/Her] current PO intake is sporadic at this	F 657	revising the comprehensive resident care plan to reflect the most current interventions in place for each area of concern. The Director of Nursing will conduct a weekly audit for 4 weeks then monthly thereafter for 3 months of scheduled care plans to ensure revisions are made on the comprehensive care plan to reflect the most current intervention implemented. 5. Results of these audits will be reviewed during the monthly Performance Improvement meetings for 3 months or until the committee is able to determine the process in place is effective.	

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F 657	Continued From page 28	F 657		

time as well. Due to the holiday will discuss with family next week. Will discuss with resident as well."

b. Review of a "Nutrition/Dietary Note" dated 8/1/19 and timed 2:22 PM showed "...Weight loss is well documented. PO intake is currently 25-100%, and very sporadic. No supplements as resident refuses them. Weight had trended up last week, however has trended back down by about 2# [pounds]. Family does bring some snacks like 'watchmacallit' bars. [S/he] does go to all meals and likes coffee. Will continue to monitor..."

c. Review of the nutrition care plan showed "Resident is at risk for unstable weight (loss/gain)..." and interventions included encourage walking to meals with CNA help, monitor oral intake, provide snacks if intake was less than 50 percent at meal time, referral to therapy if needed, 2 cal 60 ml twice per day between meals, and weigh per facility protocol.

d. Interview with the dietitian on 8/7/19 at 4:39 PM revealed the resident's weight started to decline "2 or 3 months ago" and the facility attempted using the supplement "2 Cal" to prevent further weight loss; however, the resident refused the supplement. The dietitian revealed the resident would sleep during meals and staff were expected to attempt to wake him/her to eat and also provide verbal and physical assistance if the resident needed them. Further interview revealed the facility should attempt health shakes and fortified foods, should offer alternative meals and snacks, and should place all of these interventions on the care plan.

e. Observation on 8/5/19 at 5:32 PM showed the resident was sitting in his/her wheelchair and a pommel cushion was in place. Further observation showed the resident had bruising to

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F 657	Continued From page 29 his/her right upper face and eye. f. Interview with the occupational therapist on 8/7/19 at 4:01 PM revealed she had completed an evaluation that day due to "suspicion there would be questions." Further interview revealed the pommel cushion was placed in May 2019 to prevent the resident from sliding out of the wheelchair when s/he fell asleep; however, the resident was able to independently reposition in the chair and was able to stand-up out of the chair with the same assistance as was previously required. g. Review of the care plan showed no evidence the pommel cushion or instructions for use was included. h. Interview with the regional clinical services director on 8/7/19 at 4:10 PM revealed the pommel cushion should have been included on the care plan.	F 657		
F 692 SS=D	. Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident	F 692		9/20/19

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F 692	Continued From page 30 preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: . Based on observation, staff interview, and medical record review, the facility failed to ensure interventions to prevent weight loss were implemented for 1 of 21 sample residents (#114). The following concerns were identified: 1. Review of the medical record showed resident #114 had a discharge return not anticipated assessment completed on 6/2/19. The resident was re-admitted to the facility on 7/18/19. Review of the MDS assessment history showed no evidence an admission MDS assessment was in process or had been completed since the resident's re-admission. Review of the physician order dated 7/26/19 and timed 7 AM showed "Pt [patient] to have divided plate at all meals..." The following concerns were identified: a. Observation of dining on 8/5/19 at 5:02 PM showed the resident was served his/her meal and a divided plate was not used. b. Observation of dining on 8/7/19 at 12:06 PM showed a staff member assisted the resident to eat his/her meal. Further observation showed the staff member cut the resident's food and the resident attempted to eat independently. A divided plate was not used. c. Review of the weight history showed the	F 692	1. Resident #114 was placed at the assisted dining table prior to the end of survey. Since then the family and physician placed resident on comfort care and signed orders for unavoidable weight loss and do not weigh. 2. All residents with nutritional interventions in place are at risk of the facility failing to ensure interventions to prevent weight loss are implemented. 3. A 100% audit of those residents receiving assisted devices will be conducted by the Dietary Manager to ensure those interventions to prevent weight loss are in place. 4. Dietary and nursing staff will be educated on the importance of implementing any intervention in place to prevent weight loss in accordance with federal regulations and facility policy. The Dietary Manager will conduct a weekly audit for 4 weeks then monthly thereafter for 3 months of those residents requiring interventions of assistive devices to assist in preventing weight loss to ensure they are in place. 5. Results of these audits will be reviewed during the monthly Performance Improvement meetings for 3 months or	

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F 692	Continued From page 31 resident weighed 192.4 pounds on 7/18/19 and 181.4 pounds on 8/6/19; a loss of 11 pounds (5.72%). d. Interview with the occupational therapist on 8/7/19 at 3:55 PM revealed the resident should have received a divided plate for all meals due to the resident's vision deficit. The resident used the divided plate to prevent food from falling when s/he attempted to scoop the food forward. Further interview revealed the occupational therapist recommended the resident be placed in assisted dining to allow more cues and assistance due to fatigue.	F 692	until the committee is able to determine the process in place is effective.	
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	F 812		9/20/19

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F 812	Continued From page 32 standards for food service safety. This REQUIREMENT is not met as evidenced by: . Based observation, staff interview, review of food temperature logs, review of manufacturer's product description, and review of the U.S. Public Health Service Food Code, the facility failed to ensure food temperatures were taken prior to service in 1 of 2 food service areas (main kitchen). In addition the facility failed to ensure proper dating of health shakes in 1 of 2 food storage areas (Saddle Ridge dining room). The census was 67. The findings were: Related to food temperatures: 1. Observation on 8/7/19 at 11:28 AM showed dietary aide #1 prepared mechanically-altered food which included meatballs with marinara sauce, cooked carrots, and instant mashed potatoes for residents that required a mechanically-altered diet. The dietary aide failed to take the temperature of these foods upon placing them on the steam table prior to service. Interview with the dietary aide at that time confirmed he had not taken the temperature of the mechanically-altered food because "the temperature usually stayed the same after it had been altered." 2. Review of the food temperature logs showed 4 of 111 meals reviewed from 7/1/19 through 8/6/19 did not have the temperature of the food logged. 3. Interview with the certified dietary manager (CDM) on 8/7/19 at 11:45 AM revealed she reviewed the logs and knew which staff members did not record the temperatures, but did not	F 812	1. No negative outcomes were noted from staff failing to temp the mechanically altered food prior to meal service. Health shakes that were not dated were immediately discarded from all food storage areas. 2. All resident are at risk of the facility failing to ensure food temperatures were taken prior to meal service as well as failing to ensure the health shakes were dated properly. 3. Dietary staff will be educated regarding the importance of taking the temperature of all food prior to meal service as well as dating refrigerated foods in accordance with federal regulation and facility policy. 4. The Dietary manager will conduct a weekly audit for 4 weeks then monthly thereafter for 3 months of the temperature logs to ensure all food are temped and recorded appropriately. Dietary manager will also conduct a weekly audit for 4 weeks and monthly for 3 months thereafter of all refrigerated health shakes to ensure they are dated accurately and in accordance with the product instruction, federal regulation and facility policy. 5. Results of these audits will be reviewed during the monthly Performance Improvement meetings for 3 months or until the committee is able to determine the process in place is effective.	

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F 812	Continued From page 33	F 812		

document what she had done to correct the error.

4. Interview with the dietitian on 8/7/19 at 5:08 PM revealed she was aware of the incomplete log sheets and felt more education was needed.

Related to the dating of food products:
1. Observation on 8/5/19 at 2:58 PM showed 6 health shakes were located in the Saddle Ridge dining room refrigerator. The thawed health shakes were not labeled with an open date or an expiration date.

2. Interview with LPN #1 and the DON on 8/5/19 at 3:39 PM confirmed the health shakes were not dated, and they were unable to state what the expiration date was.

3. Interview with the DON on 8/5/19 at 4 PM revealed dietary should have put a sticker with the expiration date on the health shakes when they were removed from the freezer. The DON discarded the health shakes at that time.

4. Review of the health shake product description showed the supplement was to be stored frozen, thawed under refrigeration, and could be refrigerated up to 14 days once thawed.

5. Interview with the CDM on 8/7/19 at 3:15 PM revealed it was her expectation the temperature of the food be taken and recorded when the food was placed on the steam table. In addition, the health shakes were to be labeled with the expiration date after being removed from the freezer.

6. According to Food Code 2017, U.S. Public Health Service: 3-501.16 "(A) Except during

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F 812	Continued From page 34 preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5ºC (41ºF) or less.	F 812		