STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING _____ B. WING _____	01/09/2020

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CASPER MOUNTAIN REHABILITATION AND CARE CENTER	4305 S POPLAR CASPER, WY 82601

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 1/6/20 to 1/9/20. Also reviewed in the course of the survey was complaint intake WY00003002. The following common abbreviations are used throughout this document: ARD- assessment reference date DON- Director of Nursing MAR- medication administration record MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 636 SS=E	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.	F 636	F 636 Correction Resident #133 had their MDS Admission Assessment completed on 01/14/2020 with an ARD of 12/19/19 was late per the RAI Guidelines. Resident #133's Care Plan was reviewed for accuracy. Resident #184 had their MDS Admission Assessment completed on 01/06/2020 with an ARD date of 12/26/19 was late per the RAI Guidelines. Resident #184's Care Plan was reviewed for accuracy. As stated in the 2567, Resident #82 had a significant change MDS assessment with a late completion date of 12/17/19, The Resident is due for a Quarterly Assessment on 02/18/2020. Identification Audit completed of Residents currently residing in the facility to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 2/19/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This plan of correction was accepted with Matthew Guerttman, NHA, on 2/20/2020 at 9:00 AM.
Jean Stinnett

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F 636	Continued From page 1 (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. (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.	F 636	ensure that there are no late annual assessments. This will be done by the MDS Coordinator. Residents who are being admitted to the facility are being reviewed during the AM morning meeting to ensure that their MDS's are being completed timely. Systemic The Director of Clinical Services will provide education to the IDT regarding MDS completion timeframes utilizing the RAI Manual. The MDS Coordinator will review MDS's due for the day morning business meeting Monday through Friday with the IDT. The MDS Coordinator will review her MDS scheduler on a weekly basis for 4 weeks, then every other week for 3 months with the NHA to validate timeliness of assessments. Director of Clinical Services will review the MDS Scheduler on a weekly basis for 4 weeks then every other week for 3 months and will communicate with the MDS Coordinator any concerns in regard to the timeliness of assessments. Monitoring	

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F 636	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure comprehensive MDS assessments were completed timely for 3 of 23 sample residents (#82, #133, #184). The findings were: 1. Review of the medical record showed resident #133 was admitted on 12/12/19. Review of the MDS assessment information in the electronic medical record showed an admission MDS assessment, with an ARD of 12/19/19, was still in progress and not completed. 2. Review of the medical record showed resident #184 was admitted on 12/12/19. Review of the MDS information on the electronic record showed the admission MDS with an ARD date of 12/26/19 was still in process and was overdue 3. Review of the medical record showed resident #82 had a significant change MDS assessment with an ARD of 11/18/19 and a due date of 12/2/19. Review of MDS section Z0500B in the electronic record showed a late completion date of 12/17/19. 4. During an interview on 1/8/20 at 2:52 PM the Director of Clinical Services (nurse consultant) confirmed the facility was behind on MDS assessments. She stated the MDS coordinators were both out in late November, and the facility was trying to catch up on the late assessments.	F 636	The facility will audit compliance through weekly reviews of validation reports for 4 weeks then every other week for 3 months then re-evaluate. MDS Coordinator will report results to the QAPI committee for tracking and trending. Date of Compliance 2/13/2020	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment	F 638	F 638 Correction Resident #5 had their MDS Quarterly Assessment with an ARD of 12/23/19	

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F 638	Continued From page 3 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 and staff interview, the facility failed to ensure quarterly MDS assessments were completed no less frequently than quarterly for 1 of 18 sample residents (#5) with quarterly MDS assessments. The findings were: 1. Review of the MDS assessment information in the electronic medical record showed resident #5 had a quarterly MDS assessment completed with an ARD of 9/23/19. Further review showed the subsequent quarterly MDS assessment, with an ARD of 12/23/19, was still in progress and not completed. 2. During an interview on 1/8/20 at 2:52 PM the Director of Clinical Services (nurse consultant) confirmed the facility was behind on MDS assessments. She stated the MDS coordinators were both out in late November, and the facility was trying to catch up on the late assessments.	F 638	completed on 01/20/20, which was late per the RAI Guidelines. Identification Audit completed of Residents currently residing in the facility to ensure that there are no late quarterly assessments. This will be done by the MDS Coordinator. Systemic The Director of Clinical Services will provide education to the IDT regarding MDS completion timeframes utilizing the RAI Manual. The MDS Coordinator will review MDS's due for the day morning business meeting Monday through Friday with the IDT. The MDS Coordinator will review her MDS scheduler on a weekly basis for 4 weeks, then every other week for 3 months with the NHA to validate timeliness of assessments. Director of Clinical Services will review the MDS Scheduler on a weekly basis for 4 weeks then every other week for 3 months and will communicate with the MDS Coordinator any concerns in regard to the timeliness of assessments. Monitoring The facility will audit compliance through weekly reviews of validation	
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	F 645		

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F 645	Continued From page 4 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 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,	F 645	reports for 4 weeks then every other week for 3 months then re-evaluate. MDS Coordinator will report results to the QAPI committee for tracking and trending. Date of Compliance 2/13/2020 F 645 Correction The PASRR Levell II for resident #82 was completed on 12/16/2019. The PASRR Level II Determination Report has been obtained. The recommendations from the PASRR Level II have been implemented and care planned for resident #82 Identification All potential new admissions, and all residents with primary Major Mental Illnesses and /or primary Intellectual Disabilities could potentially be affected by this alleged deficient practice. An audit will be completed for all current residents in order to ensure that all of the required PASRR documentation is in place and is accurate. Systemic Prior to admission, all potential admissions will have a PASRR Level I completed, and, if necessary, the PASRR Level II will also be completed prior to admission. After admission, if the	

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F 645	Continued From page 5 (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 (PASRR) was completed timely for 1 of 2 sample residents (#82) reviewed for PASRR screening. The findings were: 1. Medical record review showed resident #82 admitted to the facility on 3/28/19, with a plan to remain at the facility following a failed discharge to the community. The resident had a psychiatric diagnosis of Bipolar Disorder, indicating the need for completion of a PASRR Level II prior to admission. a. Review of the PASRR Level I showed it was not completed until 7/2/19 and a PASRR Level II was not completed until 12/16/19. b. Interview with the Social Services Director (SSD) on 1/8/20 at 3:10 PM revealed the resident	F 645	resident is admitted under a time-limited/categorical approval, Social Services will ensure that a current LT101 is in place, and that the resident is referred for a PASRR Level II prior to the 90th day after admission. An education was performed with Social services regarding the above procedure. Monitoring Social Services will review the PASRR process, and any identified issues/concerns, with the QAPI Committee monthly for three months. Date of Alleged Compliance 2/18/2020	

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F 645	Continued From page 6 had previously discharged from the facility following successful completion of therapy goals and returned to the facility about 1-2 months later. He confirmed the resident had a completed PASRR Level I on his/her prior stay at the facility, but one would still be required on the second admission on 3/28/19. The SSD shared concerns the facility has had difficulties with timely PASRR completion in the past. c. Interview with the facility's social work consultant on 1/9/20 at 10:15 AM revealed the facility was required to complete a PASRR Level 1 prior to admission. She also confirmed that the PASRR forms for resident #82 were not completed within the required time frames.	F 645		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on medical record review, resident and staff interview and facility documentation, the facility failed to ensure staff provided needed services for 2 of 2 sample residents (#3, #71) who were unable to carry out daily living activities of personal hygiene. The findings were: 1. Review of the annual MDS assessment dated 9/20/19 showed resident #3 had diagnoses which included obstructive uropathy, diabetes mellitus, deforming dorsopathies lumbar spine, macular degeneration, and morbid obesity. Further review showed the resident was dependent on staff for bathing. The following concerns were identified:	F 677	F 677 Correction Resident #3 has been interviewed to determine bathing preferences and is receiving showers per wishes. The care plan has been reviewed to reflect preferences.	

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F 677	Continued From page 7 a. Review of the care plan dated 10/29/19 showed the resident required extensive to total assistance by 1-2 staff with showering 1-2 times a week, and preferred to have his/her showers before breakfast. b. Review of the bathing/shower documentation in the care record showed between the dates of 12/6/19 at 9:59 PM and 1/9/20 at 4:14 AM the resident received showers only 2 times, specifically 12/11/19 at 1:59 PM and 12/18/19 at 1:59 PM. 2. Review of the annual MDS assessment dated 11/08/19 showed resident #71 had diagnoses which included muscle wasting and atrophy, dorsalgia, spondylosis lumbar spine and sacrococcygeal disorders. Further review showed the resident required supervision and oversight for toileting and bathing. The following concerns were identified: a. Interview with resident #71 on 1/7/20 at 1:36 PM revealed "I haven't had a shower in seven days". b. Review of the care plan dated 12/16/19 showed the resident required supervisory to limited assist of 1 staff for bathing and the resident preferred to have a shower 3 times a week. c. Review of the bathing/shower documentation in the care record showed the resident received a shower on 12/27/19 at 1:59 PM, and did not receive another shower until 1/8/20 at 1:47 AM. 3. Interview on 1/8/20 at 10:53 AM with CNA #1 revealed "We have just changed to having the floor aides do their own baths. There is not a really good way to make sure they all get done."	F 677	Resident #71 has been interviewed to determine bathing preferences and is receiving showers per wishes. The care plan has been reviewed to reflect preferences. Identification Resident currently residing in the facility are at potential risk of this finding. Residents currently residing in the facility were reviewed for their preferences prior to survey entering the building, they are being offered showers on days chosen by them and their care plans have been reviewed. Systemic On or before Feb 3rd, the C.N.A.'s have been educated and designated to focus on completion of scheduled showers by the DON/designee. The education included the Shower schedule based off resident preferences, which is clearly organized. If a Resident refuses a scheduled shower, the nurse will be notified. If the resident refuses for the nurse, a shower will be offered the next day, if still refusing a bed bath will be offered. If the resident continues to refuse the nurse will be notified.	

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F 677	Continued From page 8 4. Interview on 1/9/20 at 9:06 AM with the Director of Clinical Services (nurse consultant) and the DON revealed it was recognized the bath plan and documentation needed work. They stated it was possible residents had gone many days without a shower. They further stated the care plan for bathing should be followed.	F 677	The Unit Managers will complete daily shower audits Monday through Friday monthly x3, then weekly x3 months. New admissions will be reviewed for bathing preferences and added to the shower schedule by the Unit Manager. Care plans will be updated at that time	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and family interviews, and review of bowel movement (BM) records, the facility failed to provide care for constipation for 1 of 2 sample residents (#5) reviewed for constipation. The findings were: 1. During an interview on 1/7/20 at 10:01 AM a family member stated resident #5 had issues with constipation. Review of a 12/2/19 nursing note showed the resident was receiving more PRN (as needed) morphine, so nursing staff requested an order for a stool softener. Review of physician orders showed on 12/4/19 the physician ordered Miralax powder 17 grams in the morning and SennaCon 2 tablets at bedtime. Review of the 12/16/19 bowel and bladder evaluation showed the resident had symptoms of constipation and	F 684	New nursing staff will be educated on this process during the orientation process by the Unit Managers/designee upon hire. Monitoring Unit Managers will trend compliance/refusal of showers through their monitoring audits and review it at the monthly QAPI meeting with the committee to ensure that compliance is sustained. Date of Compliance 2/13/2020 F684 Quality of Care Correction Resident #5 has not shown any signs/symptoms of constipation. The care	

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F 684	Continued From page 9 received laxatives and/or stool softeners. The following concerns were identified: a. Review of the BM record showed no documented bowel movements on 12/5/19 through 12/10/19 (6 days). Review of nursing notes and the MAR showed no interventions, other than the routine medications, to address the constipation during that timeframe. b. Review of the physician's orders showed no PRN orders for constipation, and there lacked evidence the physician was notified of the resident's lack of BMs during that timeframe. c. During an interview on 1/9/20 at 8:49 AM the DON stated the facility did not have a bowel management protocol and confirmed the resident did not have PRN orders for constipation. She further stated there was no evidence the resident had a BM from December 5th through the 10th and no evidence the physician was contacted. d. Review of the current care plan showed constipation was not addressed. On 1/9/20 at 10:12 AM the DON confirmed constipation was not addressed in the care plan.	F 684	plan has been reviewed by the IDT and updated. Identification Residents currently residing in the facility on have been reviewed to ensure that they are having BM's routinely or have interventions initiated to avoid constipation. Their care plans are updated as needed. Systemic The nursing staff have been educated by the DON/designee to notify the Physician when a Resident has had no BM for 3 days, the nonpharmacological methods have not been successful, and no prn orders are in place.	
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.	F 756	DON/designee is completing a daily audit to ensure residents are having routine BM's. Care plans are being reviewed and updated as needed. New admissions are being reviewed by the IDT for risk of constipation, care plans are being implemented with interventions as needed. On or before 02/03/2020 newly hired nurses are being educated to the above	

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F 756	Continued From page 10 (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. §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, pharmacy report review, and staff interview, the facility failed to ensure a monthly medication regimen review was conducted as required for 5 of 5 sample residents (#6, #30, #43, #44, #64) reviewed for this area. The findings were: 1. Review of the medical record showed resident #6 was admitted to the facility on 12/28/15. Review of the record failed to show evidence of a pharmacy review of the medication regimen. Review of the October, November and December	F 756	procedure by the Unit Managers upon hire. Monitoring DON/designee will identify issues through their monitoring audits and review it at the monthly QAPI meeting with the committee to ensure that compliance is sustained. Date of Compliance 2/18/2020 F 756 Correction Resident #6 has had a Pharmacist review completed for the month of January and will have one done monthly as long as they remain in the facility. Resident #44 has had a Pharmacist review completed for the month of January and will have one done monthly as long as they remain in the facility. Resident #64 has had a Pharmacist review completed for the month of January and will have one done	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 756	Continued From page 11 2019 consulting pharmacy reports failed to show a review had been done for this resident. 2. Review of the medical record showed resident #30 was admitted to the facility on 8/27/14. Review of the record failed to show evidence of a pharmacy review of the medication regimen. Review of the October, November and December 2019 consulting pharmacy reports showed a review was done in December 2019, but not the other months. 3. Review of the medical record showed resident #43 was admitted to the facility on 12/4/18. Review of the record failed to show evidence of a pharmacy review of the medication regimen. Review of the October, November and December 2019 consulting pharmacy reports showed a review was done in November 2019 but not the other months. 4. Review of the medical record showed resident #44 was admitted to the facility on 7/2/18. Review of the record failed to show evidence of a pharmacy review of the medication regimen. Review of the October, November and December 2019 consulting pharmacy reports failed to show a review had been done for this resident. 5. Review of the medical record showed resident #64 was admitted to the facility on 9/6/19. Review of the record failed to show evidence of a pharmacy review of the medication regimen. Review of the October, November and December 2019 consulting pharmacy reports failed to show a review had been done for this resident. 6. Interview with the Director of Clinical Services (nurse consultant) on 1/9/19 at 11 AM revealed	F 756	monthly as long as they remains in the facility. Resident #30 has had a Pharmacist review completed for the month of January and will have one done monthly as long as they remain in the facility. Resident #43 has had a Pharmacist review completed for the month of January and will have one done monthly as long as they remains in the facility. Identification Residents currently residing in the facility have been reviewed for the month of January for possible Pharmacological recommendations by the Consultant Pharmacist. Systemic Director of Clinical Services discussed the requirements of the regulation with the consultant Pharmacist on 01/27/2020 via telephone conversation with the NHA present. The NHA followed the conversation on 01/28/2020 by emailing a copy of Ftag regulation 756 to the Pharmacist for her to review for complete understanding. DON will review monthly Pharmacy report to ensure that all residents have been reviewed. If any Residents had	

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F 756	Continued From page 12 the pharmacy consultant was emailing the information, and any additional information available for these residents would be provided.	F 756	been missed the Pharmacist will be notified to complete the review within the required time frame. DON will ensure that follow up of recommendations is completed timely. DON is notifying the Pharmacist when the New Admissions are entering the facility so that they may be completed within the required time frame. DON will ensure that follow up of recommendations is completed timely. Director of Clinical Services will review monthly Pharmacy reports during monthly visits with DON to make sure that all residents are being reviewed and follow up is complete. Monitor DON will trend any issues identified through this process of the Pharmacy reports and follow up and report on this to the QAPI Committee monthly x3, to ensure that substantial compliance is being maintained. Date of Compliance 2/13/2020	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of food temperature logs, and staff interview, the facility failed to ensure food preparation areas were clean for 1 of 1 food preparation areas, and failed to ensure food temperatures were taken prior to service. The census was 82. The findings were: 1. Observation on 1/8/20 at 11:56 AM showed the food for the noon meal was ready to be served on the steam cart. At that time dietary aide #1 dished up 2 meals to go to the secure unit. Review of the	F 812	F 812 Correction On or before 1/28/2020 an education of dietary staff was completed on the completion of temperature logs prior to service including pureed foods	

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F 812	Continued From page 13 temperature logs showed there were no temperatures recorded for the meal, and interview with cook #1 at that time revealed she had not written them down. The following concerns were identified with the food temperature system: a. Review of the temperature logs for that week (1/5/20 to 1/8/20) showed temperatures were not always taken. There were no temperatures available for foods served at breakfast or lunch on 1/6/20, and temperatures for food items at breakfast on 1/8/20 were lacking. b. The logs used were production sheets and there was an area to record temperatures. However, there was no area to record the temperature of pureed foods and these were not recorded for any meal from 1/5/20 to 1/8/20. In addition, alternatives to the main meal food items that included hamburgers and hotdogs on 1/8/20 were not listed and did not have a temperature recorded. c. Interview with the dietary manager on 1/8/20 at 11:59 AM revealed the expectation was to record the temperatures of foods prior to service. He verified the production sheets did not include temperatures for pureed foods and the alternative items. 2. Observation on 1/8/20 at 11:45 AM showed the ceiling tiles and vents above the food service line had a build up of dark colored grease and dust. In addition, the hood vents above the grill and range were heavily soiled with grease build up. Interview with the dietary manager on 1/8/20 at 12:28 PM revealed the ceiling vents and tiles had been cleaned approximately 4 month prior and the hood vents approximately 2 months prior.	F 812	On or before 1/28/2020, ceiling tiles were replaced in the kitchen and vents cleaned. Identification of others An audit of temperature logs revealed similar findings to those noted. Systemic Changes The Dining Services Manager or designee will develop a production log that includes tools for documenting temperature of pureed foods. The Dining services Manager or designee will review temperature logs weekly to ensure completion. The Dining Services Manager or designee will develop a cleaning schedule to include ceiling tiles and vents. Weekly checks will be completed to ensure continued compliance. Monitoring The facility will Audit compliance through weekly review of temperature logs and cleaning schedule for 4 weeks and then every month for 3 months. Dining Services manager will report results to the QAPI committee for tracking and trending. Date of Compliance 2/13/2020	

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