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	535025	A. BUILDING _____ B. WING _____	07/15/2021

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F 000	INITIAL COMMENTS A recertification survey which included a COVID-19 focused infection control survey was conducted by Healthcare Licensing and Surveys from 7/12/21 to 7/15/21. The following common abbreviations are used throughout this document: BIMS- Brief interview for mental status CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set LPN- Licensed Practical Nurse RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		8/20/21

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

Electronically Signed | 08/06/2021

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, and resident interview the facility failed to ensure the meal service process was provided in a dignified and respectful manner during 1 of 2 meals observed (7/12/21 noon meal), affecting residents #1, #31, #45, #62 and #77. The findings were: Review of the facility meal times schedule showed room trays were served for the breakfast meal: 7:45 AM to 9 AM; lunch meal: 11:45 AM to 1 PM and dinner meal: 5:45 PM to 7 PM. Due to an outbreak of infectious disease in the facility, meals were being served in the residents' rooms. The following concerns were identified related to	F 550	Preparation or execution of this plan of correction does not constitute 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 the provisions of federal and state law require it. The plan of correction serves as the facility□s allegation of compliance. F 550 Resident rights Dignity	

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F 550	Continued From page 2 residents' feelings of dignity and respect: a. Observation on 7/12/21 at 12:27 PM showed staff passed trays to rooms 104, 107, 108, 109, and 110; however, residents #1, #31, #45, #62, and #77, who resided in the rooms with a roommate, did not receive a meal tray when their roommates did. Observation on 7/12/21 at 12:31 PM showed resident #77 verbalized s/he was upset his/her roommate had a tray and s/he did not. b. Observation on 7/12/21 at 12:51 PM showed residents #1, #31, #45, #62, and #77 received their meal trays 24 minutes after their roommates had been served. c. Interview with resident #1 on 7/13/21 at 12:01 PM revealed the meal service was frequently an issue and the dietary staff rarely served the posted or requested meals. Further interview revealed the resident disliked when his/her roommate received a meal and s/he did not. The resident revealed watching the staff pass trays to his/her roommate and not receiving one at the same time made the resident feel like staff did not care about him/her.	F 550	CORRECTIVE ACTION Education was provided to the Dietary staff regarding loading the meal tray on to the Cambro carts by room order so that residents with room trays can easily be served together and completed prior to 8/20/21 by the dietary manager/designee. Education was provided to the C.N.A.s regarding the new system of loading the Cambro Carts by room order and that they are to serve both roommates (if both are eating in the room together) at the same time prior to 8/20/21 by the SDC/designee. As of 8/20/21 resident #1, #31, #45, 62 and #77 both roommates are served at the same time, if eating in their rooms. Education was provided to the Dietary Staff and completed prior to 8/20/21 by the Dietary Manager regarding serving the meal that is posted or changing the meal posting so that it accurately reflects what is being served. IDENTIFICATION OF OTHERS All residents have the potential to be affected by this practice SYSTEMIC CHANGE Education was provided to the Dietary staff regarding loading the meal tray on to the Cambro carts by room order so that	

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F 550	Continued From page 3	F 550	residents with room trays can easily be served together and completed prior to 8/20/21 by the dietary manager/designee. The Dietary Manager/designee monitors the sequence of the loading of the Cambro Carts to ensure that they are loaded by room order so that the C.N.A. staff can easily serve roommates together. The Dietary Manager/designee monitors random meals 3 times per week and corrects any errors as they occur. This monitoring will continue for 3 months. Education was provided to the C.N.A.s regarding the new system of loading the Cambro Carts by room order and that they are to serve both roommates (if both are eating in the room together) at the same time and completed prior to 8/20/21 by the SDC/designee. The Nurse Management team monitors 3 random meals per week to ensure that the roommates are being served together when eating in their rooms. Any identified concerns are addressed at the time the error is identified. These observations will continue for 3 months. Education was provided to the Dietary Staff and completed prior to 8/20/21 by the Dietary Manager regarding serving the meal that is posted or changing the meal posting so that it accurately reflects what is being served. The Dietary Manager/designee monitors 5	

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F 550	Continued From page 4	F 550		

random meals per week to ensure that the meal posted, and preferences are correct when the meal is being plated. These observations will continue for 3 months.

MONITORING

The Dietary Manager reports any identified patterns or trends from the observations of the order that the Cambro Cart is loaded to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. These observations will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.

The DON reports any identified patterns or trends from the distribution of room trays to roommates to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. These observations will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.

The Dietary Manager monitors reports to identified patterns or trends related to observations of the correct meal and preferences being served and reports his findings to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee

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F 550	Continued From page 5	F 550	deems it prudent to continue	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (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	F 645		8/20/21

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F 645	Continued From page 6 paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental 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 Preadmission Screening and Resident Review (PASARR) assessments were completed in a timely manner for 2 of 2 sample residents (#11, #73) reviewed for PASARR assessment.	F 645	F 645 PASRR Screens CORRECTIVE ACTION The Level II for resident #73 was	

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F 645	Continued From page 7 1. Review of the 1/21/21 admission MDS assessment showed resident #73 was admitted to the facility on 1/14/21. Review of the medical record showed a PASARR Level I assessment was completed at that time, and a categorical 6 determination resulted, due to the resident being forecasted for a short term stay at the facility of, or less than, 120 days. Review of the Quarterly Discharge Planning Review dated 4/20/21 showed a change in the resident's discharge prognosis. His/her anticipated length of stay was documented as "Long Term", noting the resident "Expects to remain in this facility" and "Discharge determined to be not feasible." Review of the active census list of residents showed the resident resided at the facility as of 7/12/21. The following concerns were identified: a. Review of the medical record showed the facility had requested a PASARR Level II assessment on 7/7/21. b. Interview with social worker #1 on 7/15/21 at 9:02 AM revealed she was unsure of the circumstances surrounding the delay in completion of the PASARR Level II assessment because this resident was managed by a previous social worker prior to April 2021. She stated she took on the resident " ... about the middle of April, which was still in [the resident's] 120 window ..." c. Interview with social worker #1 on 7/15/21 at 9:19 AM revealed that a PASARR Level II assessment should have been completed at the time of the status change, noting the categorical 6 determination would no longer have been applicable. Further, she confirmed that submission of the PASARR Level II on 7/7/21 was late, and should have been submitted on 4/20/21.	F 645	completed on 7/9/21. A new level I was submitted for resident #11 on 8/3/21. A psycho-social evaluation was requested on 8/3/21 and the facility requested a Level II PASRR on 8/4/21 IDENTIFICATION OF OTHERS An audit was conducted by the social worker on 8/6/21of all Level I and Level II PASRR screens to ensure all Level II PASRRs were submitted withing the required time frame, and that all PASRRs have the correct diagnosis. Any identified concerns were addressed at the time of identification. SYSTEMIC CHANGE Information for the Level I PASRR Screen is entered into the electronic PASRR system by the admissions staff prior to admission and a determination is received and then it is submitted electronically. The social service team monitors for any changes in diagnosis or medication and update the Level I as needed, and they follow up on any additional PASRR Level II requirements if needed based on the determination from the PASRR Level I within the required time frame. The social worker tracks the dates of the determination for prompt submission of the Level II if needed. Education was provided to the Admissions staff and Social Service staff regarding submission and necessary updating of	

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F 645	Continued From page 8 2. Review of the admission MDS assessment dated 4/14/21 showed resident #11 admitted to the facility on 4/9/21 and had diagnoses which included post-traumatic stress disorder (PTSD) and expected to remain in the facility with no active discharge planning. Review of the activities care plan initiated on 4/14/21 showed the resident was a long term care resident. The following concerns were identified: a. Review of a PASARR level I completed on 4/9/21 showed no psychiatric diagnoses were indicated. Further review showed no additional information was required as there was no evidence of mental illness or mental retardation. b. Review of the resident's diagnosis list showed the resident received diagnoses of unspecified PTSD and acute PTSD on 4/11/21. c. Review of a PASARR level I completed on 6/1/21 showed the resident had both PTSD diagnoses indicated; however, the resident received a categorical 6 determination which indicated the resident was approved for convalescent care not to exceed 120 days and a PASARR II would be required on the 121st day of stay at the facility. d. Interview with the social services director on 7/14/21 at 9:12 AM revealed a PASARR level I should have been completed at the time the PTSD diagnoses were received.	F 645	PASRRs by Social Service Consultant prior to 8/20/21. MONITORING The social worker verifies accurate submission of each PASRR Level I Screen, monitors the need for a new submission of an updated Level I and monitors the timely submission of the required Level II□s. The Level I and Level II submissions are tracked, and any identified patterns or trends are reported to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	
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	F 656		8/20/21

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F 656	Continued From page 9 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (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 observation, medical record review, and staff interview the facility failed to ensure the comprehensive care plan addressed all required	F 656	F 656 Corrective Action	

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F 656	Continued From page 10 services for 1 of 25 sample residents (#79). The findings were: Review of the 6/23/21 admission MDS assessment showed resident #79 was admitted to the facility on 6/17/21 with diagnoses which included end stage renal disease. The review showed the resident had a BIMS (brief interview for mental status) score of 6 (severely impaired). Observation on 7/12/21 at 11:30 AM showed the resident returned to the facility from the local dialysis center. The observation showed the resident had a left arm A-V (arterial venous) fistula utilized for dialysis treatments. The following concerns were identified: a. Observation on 7/12/21 at 11:30 AM showed no signage in the resident's room to alert staff not to complete labwork blood draws or blood pressure readings on the resident's left arm. b. Review of the 6/17/21 admission physician orders showed the resident required dialysis 3 times a week. The orders included "Auscultate and Palpate AV Shunt [fistula], check for bruit and thrill [twice] in 8 hours post-return from dialysis..." Review of the care plan showed the facility failed to address the resident's need for dialysis treatment, which would include not drawing blood for labwork, and not taking blood pressure readings, on the resident's left arm. c. Interview with the MDS coordinator on 7/14/21 at 10:15 AM confirmed her expectation would be to include the resident's requirement for hemodialysis 3 times a week, and the corresponding risk factors to include risks concerning the resident's left A-V fistula on the care plan.	F 656	A care plan for dialysis was developed for resident #79 on 7/14/21 by the RCMD. Identification of Others The MDS Coordinator completed an audit of all current residents who receive dialysis to ensure current care plans are in place for each resident on 7/15/21. All other residents who receive dialysis has a current care plan in place. Systemic Change In-service education was provided to the MDS Coordinators, prior to 8/20/21by the DON/designee regarding the need to ensure accurate and timely care plans are in place for all residents who receive dialysis. The MDS Coordinators audits 2 residents per week to ensure accurate care planning is completed for all residents who receive dialysis. The MDS Coordinators review the medical record for new admissions to determine if a dialysis care plan is needed and implement as appropriate. Monitoring The MDS Coordinators review these audits monthly and report any patterns or concerns to the Quality Assessment Performance Improvement committee monthly for their review and resolution. These audits will continue as planned	

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F 656	Continued From page 11	F 656	above unless the Quality Assessment Performance Improvement Committee deems it prudent to continue.	
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 observation, medical record review, resident and staff interview, and policy and procedure review, the facility failed to ensure interventions were followed to prevent pressure ulcer development for 1 of 4 sample residents (#57) reviewed for pressure ulcers. The findings were: 1. Review of the quarterly MDS assessment dated 6/2/21 showed resident #57 had diagnoses which included diabetes mellitus, Parkinson's disease, bipolar disease, anoxic brain damage, and muscle weakness and a brief interview for mental status (BIMS) score of 14 out 15 which indicated the resident was cognitively intact. Further review showed the resident was at risk for pressure ulcer development, required extensive physical assistance of 2 or more people for transfers, and required extensive physical assistance of 1 person for bed mobility and personal hygiene. Review of the "...at risk for skin	F 684	F684 Quality of Care CORRECTIVE ACTION Resident #57 interventions are being followed to continue to prevent her from development of pressure ulcers by ensuring that she is frequently being repositioned. IDENTIFICATION OF OTHERS Residents currently residing in the facility who are identified as dependent on staff for positioning, transfers, mobility, and personal hygiene, who are at risk for pressure ulcers are at potential risk. Their care plans have been reviewed by Interdisciplinary Team (IDT) to ensure	8/20/21

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POLARIS REHABILITATION AND CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

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F 684	Continued From page 12 impairments..." care plan last revised on 3/5/21 showed interventions which included to assist the resident to reposition and turn at frequent intervals to provide pressure relief. The following concerns were identified: a. Observation on 7/14/21 from 8:54 AM to 12:29 PM in the resident's room showed s/he was sitting in his/her wheelchair with his/her legs slightly elevated on the foot pedals. The resident requested to go to the lobby at 12:29 PM and CNA #3 emptied the resident's catheter drainage bag and assisted the resident to the lobby. The resident did not receive physical assistance and staff did not offer to assist the resident to lie down, reposition, or off-load during the observation. b. Observation on 7/14/21 from 1:16 PM to 4:43 PM showed the resident was sitting in his/her wheelchair with his/her legs slightly elevated on the foot pedals. The resident did not receive physical assistance and staff did not offer to assist the resident to lie down, reposition, or off-load during the observation. Continued observation showed the resident was assisted to the dining room for the evening meal at 4:43 PM. Interview with the resident at that time revealed s/he had been sitting in her wheelchair since 5 AM and his/her "bottom" was sore from sitting. c. Observation on 7/14/21 at 4:52 PM showed CNA #4, CNA #5, and the DON assisted the resident to his/her room, applied a full body mechanical lift sling, and assisted the resident to lie down. The resident reported s/he was in the middle of a bowel movement and the staff left the room to allow privacy. Observation at 5:10 PM showed CNA #4, CNA #5, and the DON returned to the room. The CNAs assisted the resident to roll toward the wall and provided incontinence care. After care was provided, the DON assessed	F 684	interventions are in place regarding frequent positioning needs and that staff are aware of these that they are being addressed. SYSTEMIC CHANGE All facility nursing staff have been educated on importance of providing frequent repositioning and/or offloading for dependent residents when up out of bed or as needed while in bed. If resident chooses to decline offers to lay down or bathroom checks, position changes still need to be completed to allow pressure relief for those who are unable to self-move. Residents who can self-off load require reminders to do so, as well. This education was provided by the Staff Development Coordinator/designee prior to 8/20/21. Facility nurses are completing weekly skin checks to identify residents with new skin issues. Residents are reviewed on admission, re-admission and with change of condition as needed to identify any needed changes in their plan of care by the IDT. These changes are communicated to the appropriate nursing staff through the use of the care plan and point of care. MONITORING Nurse Managers are completing random observation of dependent residents to observe for position changing, they will choose 5 dependent residents the first 2	

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F 684	Continued From page 13 the resident's buttocks which were red and blanchable with no open areas noted. At that time, the resident requested to remain in bed for dinner. d. Interview with the DON on 7/14/21 at 4:50 PM revealed her expectation was for staff to reposition residents "every couple of hours." e. Interview with CNA #5 on 7/14/21 at 5:23 PM revealed the CNA was assigned to care for the resident and she had not repositioned the resident since she began her shift at 2 PM. Further interview revealed the CNA did not normally work the evening shift. f. Interview with CNA #6 on 7/14/21 at 5:27 PM revealed she was assigned to care for the resident on the day shift and she had provided care when she first arrived at the facility, at 6 AM, following the resident having a bowel movement which required incontinence care to be performed. Further interview revealed the CNA did not provide any other care to the resident during the day shift; however, the other CNA on the day shift emptied the resident's catheter drainage bag and checked to see if the resident was "dirty." g. Interview with the administrator on 7/14/21 at 5:30 PM revealed the resident usually notified staff when s/he wanted to lie down and the resident was resistant to laying down at times. h. Interview with the director of clinical operations on 7/14/21 at 5:52 PM confirmed staff should offer to reposition or offload residents, even when the resident does not want to reposition. 2. Review of the policy titled "Prevention of Pressure Injuries" last revised April 2020 showed "...Mobility/Repositioning 1. Reposition all residents with or at risk of pressure injuries on an	F 684	months to monitor, then 3 residents x 1 month. DON/designee will present the issues identified from the random observations to the QAPI committee for purpose of process improvement x3 month to ensure compliance is maintained.	

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F 684	Continued From page 14 individualized schedule, as determined by the interdisciplinary care team. 2. Choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines. 3. Teach residents who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Remind and encourage residents to change positions..."	F 684		
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 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 medical record review and staff interview, the facility failed to ensure a nutritional assessment was completed when a significant	F 692	F692 Nutrition	8/20/21

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F 692	Continued From page 15 weight loss was identified for 1 of 8 sample residents (#84). The findings were: Review of the 6/21/21 significant change MDS assessment showed resident #84 had diagnoses that included Alzheimer's dementia. The resident required supervision with oversight, encouragement or cueing for eating, and was marked as having a non-prescribed weight loss of 5% in 30 days, or 10% in 6 months. The MDS assessment showed the resident's weight was 98 pounds. Observation on 7/13/21 at 11:32 AM showed the resident ate his/her meals in the assisted dining room and received adequate supervision. The following concerns were identified: a. Review of the medical record failed to show the registered dietitian (RD) had assessed the resident related to the significant weight loss in June 2021. The RD assessment available in the record was from admission dated 10/13/20. b. Review of the 2/21/21 care plan showed the resident was at potential nutritional risk related to dementia, low body mass index (BMI) and having a modified diet texture. The goal was updated on 7/13/21 to maintain a weight of 95 pounds or more with no significant weight loss. Interventions were included and revised on 7/13/21. c. Interview with the RD on 7/13/21 at 3:08 PM confirmed she was working on catching up with assessments and notes. She stated she no longer completed the nutritional section (K) of the MDS assessment and there was not a formal process to let her know if a resident triggered for a significant weight loss. She verified there was not an assessment or a note completed at the time the weight loss was identified during the 6/21/21 MDS assessment.	F 692	CORRECTIVE ACTION A Nutrition Data Collection was completed by RD for resident #84 on 7/23/21. IDENTIFICATION OF OTHERS: An audit to identify all current residents with weight loss was completed by the Registered Dietician on 7/14/21. For any residents identified as having weight loss for whom no assessment was completed a Nutrition Data Collection was completed. SYSTEMIC CHANGE Education was provided to the Registered Dietician by prior to 8/20/21 regarding the requirements of timely assessments by the DON/designee. RD will do Section K for all MDSs, therefore identifying any residents with a Significant Change. A Nutrition Data Collection assessment will be completed for all residents who have a Significant Change MDS. This will be recorded on the RDs Significant Change Spread Sheet. MONITORING The Registered Dietician monitors any identified patterns or trends related to assessments and reports to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. This tracking will continue for	

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F 692	Continued From page 16	F 692	3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, policy an procedure review, and staff interview, the facility failed to maintain a medication error rate less than 5%. Two errors occurred during 30 opportunities which resulted in an error rate of 6.67% (which affected resident #25). The findings were: 1. Review of the active physician orders on 7/13/21 showed resident #25 had an order to receive lisinopril 2.5 mg by mouth daily for hypertension and Flonase 1 ml in both nostrils daily for seasonal allergies. Further review showed no evidence of parameters to hold medications. The following concerns were identified: a. Observation on 7/13/21 at 9:35 AM showed LPN #1 prepared medications for the resident. The LPN indicated the resident was to receive lisinopril and Flonase; however, the medications were not available in the medication cart. The LPN entered the resident's room, provided the medications that were prepared, and obtained the resident's blood pressure. The blood pressure was 128/66 at that time.	F 759	F 759 Free of Medication Error Rts 5 Prcnt or more CORRECTIVE ACTION Resident #25 is currently receiving his medication per his Physician order. IDENTIFICATION OF OTHERS Residents who currently reside at the facility receiving medication from LPN #1 have the potential to be affected by this deficient practice. SYSTEMIC CHANGE LPN #1 has been educated to the facility policy of Administering Medications, and specifically when questioning whether to hold a medication due to what she deems as an adverse vital sign and the process to follow.	8/20/21

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F 759	Continued From page 17 b. Interview with LPN #1 on 7/13/21 at 9:45 AM revealed she could pull the lisinopril from the emergency stock; however, she was not going to administer the medication to the resident due to the resident's history of the blood pressure "dropping significantly" with the medication. Further interview revealed she had to "order" the Flonase because there was none available. c. Interview with LPN #1 on 7/13/21 at 10:43 AM confirmed the order for lisinopril did not include parameters to hold the medication. d. Review of the medication administration record for July 2021 showed on 7/13/21 at 8 AM the Flonase was indicated to have been administered and the lisinopril was marked as "8" which indicated "other/see progress notes." Review of a progress note dated 7/13/21 and timed 9:44 AM showed only "Lisinopril Tablet 2.5 MG Give 1 tablet by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) BP 128/66." Review of a progress note dated 7/13/21 and timed 9:47 AM showed only "Flonase Allergy Relief Suspension 50 MCG/ACT 1 ml in both nostrils one time a day for seasonal allergies." Further review showed no other progress notes on 7/13/21 and nothing to indicate the medication was held or the physician was notified. e. Interview with the resident's physician on 7/14/21 at 11:32 AM revealed the physician would not expect nurses to hold the blood pressure medication unless the systolic blood pressure (the first number) was less than 100. Further interview confirmed a blood pressure of 128/66 would not be low enough for the nurse to hold the medication. f. Interview with the staff development coordinator (SDC) on 7/15/21 at 11:08 AM revealed if a resident was out of a prescription	F 759	LPN #1 was also educated on checking stock medications and the Stat Safe for medications that are not readily available in the med cart. The process of notifying the Physician of any held medications due to awaiting their arrival from the pharmacy or for any other reason that the nurse may feel the need to hold a medication and making sure that the nurse documents all actions that she has taken was educated to her. This education was provided by the DON/designee prior to 8/20/21. Facility Nurses have been educated on the above processes as well by the DON/designee on 8/20/21. All nurses new to the facility will be reviewed to ensure that they have had a medication pass evaluation completed during orientation by the Staff Development Coordinator/designee. They will also sign off that they have been educated on the Administering Medication Policy. MONITORING Nurse Managers/designee have completed random medication pass evaluation of 7 nurses per month x 1 month then 5 per month x 2 months. DON/designee will present the issues identified from the random observations to the QAPI committee for purpose of process improvement x3 month to ensure compliance is maintained.	

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F 759	Continued From page 18 medication, nurses should obtain the medication from the emergency kit (Stat Safe) and over the counter (OTC) medications were available in the facility's stock of OTC medications. Further interview revealed hold parameters for medications should be indicated on the medication administration record. If there were no parameters and the nurse felt the medication should be held, the nurse should notify the physician prior to holding the medication. g. Review of the policy titled "Administering Medications" last revised April 2019 showed "...8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns...21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose...	F 759		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)	F 801		8/20/21

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F 801	Continued From page 19 This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016,	F 801		

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F 801	Continued From page 20 meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview the facility failed to ensure the dietary manager met qualifications. The census was 95. The findings were: Interview with the dietary manager on 7/12/21 at 9 AM confirmed he was new to the position, and had worked at the facility about 2 weeks. The manager stated he had worked as a private chef and did not have a dietary manager or food service manager certification or a culinary degree. The manager stated he was hired with the understanding that a certification would be required. Interview with the the administrator on 7/12/21 at 11:32 AM confirmed the manager was new and needed to be enrolled in a certification program.	F 801	F 801 Qualified Dietary Staff CORRECTIVE ACTION A Certified Dietary Manager is now in place to mentor the current Dietary Manager 25 hours per week until the current dietary manager is able to take the certification course. The Registered Dietician will provide oversight for an additional 10 hours per week. IDENTIFICATION OF OTHERS	

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F 801	Continued From page 21	F 801	All residents have the potential to be affected by qualified dietary staff. SYSTEMIC CHANGES A Certified Dietary Manager is in place for a total of 35 hours per week. MONITORING The dietary manager reports any changes related to certification to the Quality Assurance Performance Improvement committee as they arise for their review and direction.	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, the facility failed to ensure meals were palatable and at an appetizing temperature for 1 of 1 meals tested. The findings were: Observation on 7/12/21 at 11:52 AM showed residents except those who were in the assisted dining room were awaiting room trays. The meals were put into disposable paper boxes and put into	F 804	F804 Palatability CORRECTIVE ACTION The facility has ordered and has put into use electric Cambro Carts to assist with keeping the room trays warm during meal	8/20/21

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F 804	Continued From page 22 or on top of carts to be distributed to the residents. Interview with the DON on 7/12/21 at 12:03 PM stated due to COVID-19 outbreak precautions meals continued to be served in the resident's rooms. The following concerns were identified: a. Observation of a meal test tray on 7/14/21 showed the meal cart was delivered to the north west hallway at 12:43 PM. The test tray was included with 6 other resident meals on the top of an insulated cart. There were also other meals on trays inside the cart. All of the meals were served in disposable paper clamshell style containers. After the last resident on the hallway was served, the meal was tested at 12:55 PM for taste and temperature. The main item was chicken and dumplings, the taste was somewhat salty but acceptable. The temperature was not acceptable; it was cool, and measured 129.4 degrees Fahrenheit (F). The vegetable was seasoned herbed green beans, which were not at all warm when tasted. They measured 105.6 degrees F. The cake was room temperature and moist with an acceptable flavor. The dinner roll was acceptable. b. Interview with cook #1 on 7/14/21 at 1:09 PM confirmed the paper containers did not hold heat well. They were planning to get a couple of heated carts; currently they had two carts that were not heated but keep meals warmer than if out in the open. c. Interview on 7/14/21 at 10:34 AM with resident #56 revealed the meals were "not hot when they should be, and not edible." "I make myself food because theirs is not edible." The resident further stated they had been eating on disposable containers for over a month, and s/he felt the portions were smaller with the disposable containers.	F 804	service. The number of room trays have significantly been reduced as many residents have returned to the dining room. Education was provided to the Dietary staff by the Dietary Manager/designee prior to 8/20/21 regarding the use of the proper equipment to keep the room tray meals warm and accuracy for plating food to the information provided on the meal ticket. IDENTIFICATION OF OTHERS All residents who are served room trays have the potential to be affected by this practice. SYSTEMIC CHANGES The facility has purchased and put into use 4 electric Cambro Carts to assist in keeping food warm that is being transported to residents for room trays. Education was provided to the nursing staff by the SDC prior to 8/20/21 regarding need to pass room trays as soon as they are received from the kitchen to ensure that the food maintains the correct temperature. The Dietary Manager or designee places a test tray on each cart 3 times per week. The temperature of this test tray is taken after all the other meal trays have been passed to ensure that all meals are holding the correct temperatures at the	

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F 804	Continued From page 23 d. Interview on 7/12/21 at 12:11 PM with resident #191 revealed s/he was having family bring in food because what the facility served was not good. The resident had filed a concern form regarding the food on 7/12/21. e. Interview with resident #1 on 7/13/21 at 12:01 PM revealed the food was "not good," the facility did not provide appropriate options, and the facility did not follow resident preferences. Further interview revealed meal service was frequently an issue and the dietary staff rarely served the posted or requested meals. f. Interview with resident #22 on 7/12/21 at 11:15 AM revealed the food was "not good," usually late, usually cold, and never matched the order or ticket preferences. g. Interview with resident #10 on 7/12/21 at 3:57 PM revealed the food was "not so good sometimes" and residents previously had more options at breakfast which were no longer available. h. Interview with resident #197 on 7/15/21 at 9:53 AM revealed s/he did not feel the diet provided by the facility was conducive to healing and the food was always cold. i. Interview with resident #198 on 7/15/21 at 9:55 AM revealed the food "leaves a lot to be desired."	F 804	time of service. The temperatures are recorded by the Dietary Manager and tracked. Education was provided to the Dietary staff by the Dietary Manager/designee prior to 8/20/21 regarding the use of the proper equipment to keep the room tray meals warm and accuracy for plating food to the information provided on the meal ticket. The Dietary Manager/designee monitors the tray line 3 times per week and observes the accuracy of the meal plated to the information on the meal ticket. MONITORING The Dietary Manager monitors the temperatures for the test trays on the room tray carts and accuracy of meal to identified patterns or trends related to food temperatures and reports his findings to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	
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	F 812		8/20/21

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F 812	Continued From page 24 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, staff interview, and review of Food Code reference, the facility failed to ensure sanitation requirements were met in the kitchen. The census was 95. The findings were: 1. Observations on 7/12/21 at 9 AM showed the following concerns: a. The range top and both convection ovens were in need of cleaning, due to burned-on food debris. b. The hood vents above the range were greasy and dusty and needed to be cleaned. c. The microwave oven had dried-on food stuck to the inside walls. d. The walk-in refrigerator contained a pan with packaged raw ground beef sitting atop two packaged ready-to-eat hams. e. There was dust on the condenser fan cover and surrounding area in the walk-in refrigerator. There was a cart in the area where the chicken pieces for the days meal were laid on pans without any covering.	F 812	F812 Food Procurement, store/Prepare/Serve-Sanitary CORRECTIVE ACTION The range top and both convection ovens were cleaned on 7/28/21. The hood vents above the range were cleaned on 7/28/21. The microwave oven was cleaned on 7/28/21. The raw meat was moved to the bottom shelf on 7/12/21. The dust was cleaned on the condenser fan cover and surrounding area in the walk-in refrigerator and the chicken was	

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F 812	Continued From page 25 f. The supply of clean wiping towels used for surface cleaning in the kitchen and dish room were in poor condition. They were not white but brown and stained. 2. Observations on 7/14/21 beginning at 9:51 AM showed the following concerns: a. The dish machine was being repaired and the 3-compartment sink was needed to sanitize the trays and dishware from the breakfast meal. Interview with dietary aide #1 at that time revealed she was unable to locate the plugs needed for the 3 sinks. She had one plug used in the wash sink, and the rinse and sanitizer sinks were unable to be filled. She stated the trays and dishes that had been cleaned were sprayed with clean water and then the sanitizer solution. She verified the usual process would be to immerse the dishes in the sanitizer solution for the appropriate time. At 10:05 AM the sink plugs were provided by management and the appropriate process was followed. b. The refrigerated unit near the service line was in need of cleaning. The inside and outside was soiled with spilled drinks/food. c. The vent on the wall near the dry storage room was dusty with black dust on and around the vent. The vent inside the dry storage room was also visibly soiled with dark-colored dust. d. The walls behind the food preparation tables were in need of cleaning, they were splattered with dried-on food. 3. Interview with the dietary manager on 7/15/21 at 9:54 AM revealed he was aware of the cleaning needs and the training work that needed to be done. He was attempting to hire staff, and was having to spend much of his time cooking.	F 812	covered on 7/12/21. The wiping towels were replaced on 8/3/21. Plugs for the 3-compartment sink were purchased and put into use on 7/14/21. The refrigerated unit near the service area was cleaned inside and out on 8/3/21. The vent on the wall near the dry storage room and the vent inside the dry storage room were cleaned on 8/6/21 The walls behind the food preparation area were cleaned on 7/28/21. IDENTIFICATION OF OTHERS All residents who are served room trays have the potential to be affected by this practice. SYSTEMIC CHANGES Education was provided to the dietary staff by the dietary manager/designee prior to 8/20/21 regarding cleaning the kitchen, cross contamination, infection control, temperatures, food borne illnesses, and the use of cleaning logs. The dietary manager/designee inspects the kitchen for sanitation, cross contamination, infection risk, temperatures, risk of food borne illness and use of cleaning logs randomly 4 times per week.	

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F 812	Continued From page 26 4. According to Food Code 2017, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 5. According to Food Code 2017, U.S. Public Health Service: 3-302.11 (A) FOOD shall be protected from cross contamination by: "(1) Except as specified in (1)(d) below, separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO-EAT FOOD such as fruits and vegetables, (b) Cooked READY-TO-EAT FOOD, and (c) Fruits and vegetables before they are washed; (d) Frozen, commercially processed and packaged raw animal FOOD may be stored or displayed with or above frozen, commercially processed and packaged, ready-to-eat food." 6. According to Food Code 2017, U.S. Public Health Service: 4-301.12 Manual Warewashing, Sink Compartment Requirements. "(A) Except as specified in (C) of this section, a sink with at least 3 compartments shall be provided for manually washing, rinsing, and SANITIZING EQUIPMENT and UTENSILS. (B) Sink compartments shall be large enough to accommodate immersion of the largest EQUIPMENT and UTENSILS. If EQUIPMENT or	F 812	MONITORING The Dietary Manager monitors the random inspections of the kitchen for sanitation, cross contamination, infection risk, temperatures, risk of food borne illness and use of cleaning logs to identify patterns or trends related to food the findings to the Quality Assurance Performance Improvement Committee monthly or their review and resolution. This tracking will continue for 3 months unless the Quality Assurance Performance Improvement Committee deems it prudent to continue.	

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F 812	Continued From page 27 UTENSILS are too large for the WAREWASHING sink, a WAREWASHING machine or alternative EQUIPMENT as specified in (C) of this section shall be used."	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		8/13/21

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F 880	Continued From page 28 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure infection prevention protocols were implemented during 2 random observations. The following concerns were identified:	F 880	F880 Infection Prevention CORRECTIVE ACTION	

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F 880	Continued From page 29 1. Observation in the assisted dining room on 7/14/21 at 9:10 AM showed RN #1 was collecting garbage from the tables. She handled the trash from the resident meals and placed the trash into a garbage bag she took from table to table. At that time the RN had one disposable glove on and the other hand was bare. She handled the trash with both hands. Between handling the garbage and assisting residents with taking off clothing protectors she did not perform hand hygiene. At 9:13 AM she took off the one glove, and used hand sanitizer. She then continued to collect the soiled tablecloths and clothing protectors from the tables, and without further hand hygiene she then handled clean folded linens that had not been used and placed them into a covered cart. Interview with RN #1 on 7/14/21 at 9:16 AM verified the linens in the cart were clean and she hadn't used them so she returned them to the cart. She then confirmed she should have sanitized or cleaned her hands each time between handling dirty and clean items. 2. Observation on 7/12/21 at 12:50 PM showed the sit-to-stand mechanical lift outside room 137 was not clean. There was a build-up of debris on the platform, appearing as though it had not been cleaned for some time. 3. Interview with the infection preventionist/SDC on 7/15/21 at 10:42 AM revealed her expectation was for staff to perform hand hygiene when transitioning from a dirty area to a clean area to prevent cross-contamination and staff should clean the entire surface of equipment following use.	F 880	The facility will immediately implement an appropriate infection prevention intervention plan consistent with the requirements of483.80 for the affected unit identified in the deficiency. The infection preventionist (IP) and Director of Nursing (DON), in conjunction with the Medical Director shall complete the following: " Develop and implement hand hygiene procedures for staff during sanitation of the facility during outbreak status. " Develop and implement policy and procedure to ensure equipment cleaning during outbreak status. IDENTIFICATION OF OTHERS The IP and DON, in conjunction with the interdisciplinary team (IDT) will review current COVID nursing facility guidelines from the CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility□s overall compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. Guidelines for COVID-19 can be found at https://www.cdc.gov/coronavirus/2019-ncov/hcp.long-term-care.html. SYSTEMIC CHANGE On or before 8/13/21 the facility shall complete the following actions:	

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F 880	Continued From page 30	F 880	1. DON, IP and applicable IDT members will conduct root-cause analysis to identify and address the reason for non-compliance related to: a. Failure to ensure guidelines for equipment cleaning procedures were not implemented during outbreak status. b. Failure to ensure guidelines were implemented for hand hygiene while performing facility sanitation procedures during outbreak status. 2. The DON and IP will ensure education is provided for the following: a. All staff are educated on hand hygiene while performing facility sanitation procedures during outbreak status. b. All staff are educated on proper equipment cleaning. 3. The facility leadership will contact the Mountain Pacific Quality Improvement Organization (QIO) to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility. The NHA will assign dining room monitors to observe for any cross-contamination issues with infection control within the dining area, the monitors have been educated by the NHA to immediately, rectify the situation as able, educate the staff member involved as needed. Outcomes will be reported at the daily stand-up meetings. The DON/designee will implement a cleaning schedule for all lifts routinely to be completed. This will be monitored during through the nurse managers	

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F 880	Continued From page 31	F 880	walking rounds daily and any issues will be reported on at the daily stand-up meetings. MONITORING Monitoring of approaches to ensure infection control and prevention are effective will include 1. Weekly for no less than 12 weeks, the IP, DON and applicable IDT will conduct on-going monitoring via observation to ensure staff are complying with requirements for: a. Compliance with equipment cleaning during outbreak status. b. Compliance with hand hygiene while performing sanitation procedures during outbreak status. After 12 weeks of monitoring, provided that such monitoring demonstrates expectations are met, monitoring may be reduced to monthly. Monthly monitoring will continue no less than 3 months. All monitoring will be reported to the Quality Assurance Process Improvement (QAPI) Committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes 3 consecutive rounds of monthly monitoring which demonstrates sustained compliance as approved y the QAI Committee and Medical Director.	