STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535033	A. BUILDING _____ B. WING _____	10/07/2021

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MISSION AT CASTLE ROCK REHABILITATION CENTER	1445 UINTA DRIVE GREEN RIVER, WY 82935

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 10/4/21 to 10/7/21. The following common abbreviations are used throughout this document: DON: Director of Nursing RN: Registered Nurse LPN: Licensed Practical Nurse CNA: Certified Nursing Assistant MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care.	F 553		11/5/21

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

Electronically Signed | 10/26/2021

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

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F 553	Continued From page 1 (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on resident representative, staff, and physician interview, and medical record reviews, the facility failed to ensure residents or their representatives were included in care plan development for 1 of 14 sample residents (#40). The findings were: 1. Review of the MDS assessments for resident #40 showed the last comprehensive assessment was an admission assessment completed on 6/3/21. Further review showed a quarterly MDS assessment was completed on 6/16/21 and 9/19/21. The following concerns were identified: a. Interview with the resident representative on 10/5/21 at 10:49 AM revealed the resident's care plan meeting related to the comprehensive assessment was cancelled by the facility following an outbreak of COVID. The care plan was to be rescheduled; however, this did not occur. Further interview revealed a care plan meeting did occur "last Friday or the Friday before." b. Interview with the resident's physician on 10/7/21 at 10 AM revealed a care plan meeting	F 553	F. Tag. 758 Immediate corrective action: IDT held on 10/25/21 to include resident #40. Process change made including letter mailed out to all residents and families informing them of IDT scheduling with MDS reviews. How the facility will identify other residents having the potential to be affected: All residents have the potential to be affected. Measures put in place or system correction in this area include: Monthly audits will be done to ensure IDT meetings are offered timely in accordance with regulation. Who will monitor the new system: Social Services Director and or designee	

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F 553	Continued From page 2 occurred after the resident's representative contacted the physician at his office. The representative requested a care plan meeting as the original care plan meeting was cancelled and had not been rescheduled. c. Interview with the social services director on 10/7/21 at 11:38 AM revealed a care plan meeting with the resident's representative did not occur following the completion of the resident's admission MDS assessment. Further interview revealed a meeting was scheduled on 8/27/21 to discuss the resident's status and possible need for hospice; however, the meeting was cancelled and not completed until 9/24/21.	F 553	How frequently will we monitor: Monthly audits of IDT will be to be completed according to MDS schedule. How will we incorporate the new system into our QAPI system: Identified trends will be reviewed monthly in QA until lesser frequency is deemed necessary by committee.	
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on resident representative and staff interview, and policy and procedure review, the facility failed to ensure quarterly statements were provided to 1 of 1 sample residents (#40) reviewed for personal funds. The findings were:	F 568	F 568 Immediate corrective action: Statement was mailed to the daughter of resident #40 on 10/16/21. Education, policy and procedure was done with	11/19/21

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F 568	Continued From page 3 1. Interview with resident #40's representative on 10/5/21 at 10:48 AM revealed the resident has had an account at the facility since admission on 5/27/21, the representative was in charge of the resident's finances, and the representative had not received a statement for the facility account. 2. Interview with the human resources coordinator on 10/7/21 at 12:46 PM revealed the facility did not a system, for when or to whom statements were sent. Further interview confirmed the resident's representative was listed as the individual who should receive statements for the resident's account and confirmed the representative should have received a statement for the account. 3. Review of the policy titled "Resident Trust Fund Policy" provided by the facility on 10/7/21 showed "...Quarterly Trust Reports...The resident or legal representative must be sent a copy of the resident's trust fund activity for each quarter of the year (F159). Keep a log of these statements on page 8. Logs will be kept in the Resident Trust Binder behind each person's authorization."	F 568	business office manager assistant. All residents with resident trust accounts were mailed statements and log was updated to reflect mailing out of statements. How the facility will identify other residents having the potential to be affected: All residents with resident trust accounts have the potential to be affected. Measures put in place or system correction in this area include: A monthly audit will be conducted to ensure resident trust accounts are reconciled. A quarterly audit will be done to ensure resident statements are delivered to resident and or designee. Who will monitor the new system: Business Office Manager or designee. How frequently will we monitor: Monthly and quarterly audits. How will we incorporate the new system into our QAPI system: Identified trends will be reviewed monthly in QA until lesser frequency is deemed necessary by committee.	
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect,	F 606		11/19/21

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F 606	Continued From page 4 exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Based on employee file review, staff interview, and policy and procedure review, the facility failed to ensure CNA abuse registry verification was performed for 1 of 3 sample CNAs (#1) prior to resident contact. The findings were: 1. Review of the employee file for CNA #1 showed the date of hire was 8/16/21. Further review showed there was no evidence the CNA abuse registry was checked prior to the CNA having resident contact. 2. Interview with the human resources coordinator on 10/7/21 at 11:16 AM confirmed there was no evidence the CNA abuse registry was checked prior to resident contact. 3. Review of the Policy titled "Prevention of Resident Abuse, Neglect, and Misappropriation of	F 606	F 606 Immediate corrective action: A copy of the CNA registry for staff member #1 was immediately printed and put into the personnel file. An audit of all CNA's files hired in the past 18 months was completed to ensure CNA registry was current. A CNA registry field was added to the new hire packet to be documented prior hire date. How the facility will identify other residents having the potential to be affected: All new hire CNA's have the potential to be affected. The administrator will sign off on new hire paperwork as completed.	

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F 606	Continued From page 5 Resident Property" provided by the facility on 10/7/21 showed "...Pre-employment processes will include obtaining references from former and current employers, checking the nurse aide registry, obtaining background records and checking with appropriate health professional licensure and registration boards. Employees will be provided with ongoing education about the prevention and intervening in situations that could lead to abuse, neglect or exploitation of a resident..."	F 606	Measures put in place or system correction in this area include: A monthly audit will be conducted to ensure registry is completed using new hire reports in Human Resources system. Who will monitor the new system: Business Office Manager or designee. How frequently will we monitor: Monthly audits. How will we incorporate the new system into our QAPI system: Identified trends will be reviewed monthly in QA until lesser frequency is deemed necessary by committee.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (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	F 656		11/5/21

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F 656	Continued From page 6 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, staff interview, and medical record review, the facility failed to ensure care plans were developed for 1 of 2 sample residents (#3) with indwelling catheter placement. The findings were: 1. Review of the significant change MDS assessment dated 7/10/21 showed resident #3 had diagnoses which included neurogenic bladder and had an indwelling urinary catheter. Review of a physician order with a start date of 2/21/21 showed "Catheter care to be provided Q [every] shift..." Observation on 10/5/21 at 9:41 AM showed the resident was positioned in a wheelchair and the urinary catheter drainage bag	F 656	F 656 Immediate corrective action: Care plan for resident #3 was updated. Reviewed all resident care plans with foley catheters. How the facility will identify other residents having the potential to be affected: All residents with catheters have the potential to be affected. Measures put in place or system correction in this area include: Monthly audits will be done to ensure care	

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F 656	Continued From page 7 was secured under the wheelchair in a privacy bag. The following concerns were identified: a. Review of the care plan last revised on 8/11/21 showed no evidence an indwelling care catheter care plan was developed or implemented for the resident. b. Interview with the MDS coordinator on 10/7/21 at 11:19 AM confirmed the indwelling catheter care plan was not developed for the resident and revealed it should have been completed when the catheter was ordered.	F 656	plans are updated as necessary. Who will monitor the new system: Director of Nursing and or designee How frequently will we monitor: Monthly audits of care plans will be to be completed on all residents with catheters. How will we incorporate the new system into our QAPI system: Identified trends will be reviewed monthly in QA until lesser frequency is deemed necessary by committee.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to prevent the development and worsening of pressure ulcers for 1 of 3 residents (#12) reviewed for pressure ulcers. The findings were:	F 686	F 686 Immediate corrective action: vitamin C and multi-vitamin with minerals along with liquid protein was added to	11/19/21

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F 686	Continued From page 8 1. Review of the 8/16/21 significant change MDS assessment showed resident #12 was admitted to the facility on 4/19/21 with diagnoses that included peripheral vascular disease, cerebrovascular accident, dysphagia, degenerative disease of the nervous system, generalized muscle weakness, difficulty walking, and chronic pulmonary edema. Further review showed the resident did not have an ulcer or skin condition present at the time of the assessment, and was identified as being at risk for developing pressure ulcers. Interventions implemented included pressure reducing devices for his/her bed and wheelchair, and application of ointments/medications to areas other than his/her feet. Continued review also showed the resident was suffering from weight loss that was not physician-prescribed. Review of the 9/30/21 Braden Scale assessment showed the resident was at risk for pressure sore development, with a score of 15. The following concerns were identified: a. Review of the resident's weight record showed a 14.23% weight loss between 4/20/21 and 10/6/21. Review of the 9/20/21 weekly Skin and Weight Review showed the resident had a 7.5% weight loss in 90 days. Further review showed a comment stating " ... No concerns noted ...", and the response box for question "New interventions provided?" was marked no. Further review referenced an 8/5/21 Braden Scale assessment showing the resident was at moderate risk for pressure ulcer development with a score of 14. b. Review of the "Weekly Wound Evaluation" dated 9/28/21 showed the resident had an in-house acquired Stage 2 pressure ulcer to his/her coccyx which was identified on 9/25/21.	F 686	resident #12 medication orders. CNA education completed to include care plan location in medical record. All high risk residents reviewed for treatment to prevent or heal pressure ulcers. How the facility will identify other residents having the potential to be affected: All high risk residents have the potential to be affected. Measures put in place or system correction in this area include: Twice monthly audits will be done of high risk residents with use of skin and weight review assessment. Who will monitor the new system: Director of Nursing and or designee How frequently will we monitor: Twice monthly audits will be to be completed on all high risk residents. How will we incorporate the new system into our QAPI system: Identified trends will be reviewed monthly in QA until lesser frequency is deemed necessary by committee.	

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F 686	Continued From page 9	F 686		

c. Review of the "Weekly Skin and Weight Review" signed 10/4/21 showed the resident's had a stage 2 pressure ulcer and no new interventions were implemented.

d. Review of the Visual/Bedside Kardex care reference as of 10/7/21 showed no instructional guidance for positioning, turning, or offloading the resident while in his/her bed or wheelchair.

e. Interview with CNA #2 on 10/7/21 at 1:20 PM revealed the resident was up in his/her chair most of the day, and laid down to rest between meals. She further stated repositioning or offloading wasn't documented by the facility. Further interview revealed CNAs didn't always know if the residents had wounds, so if a wound was identified by the CNAs, they reported the findings to the nurse "so the nurse can look at it and document it."

f. Review of the resident's progress notes showed no nursing or physician documentation related to the skin or wound from 9/25/21 to 10/5/21.

g. Review of the physician orders showed an order dated 10/5/21 to "Cleanse wound to coccyx with normal saline or wound cleanser. Apply skin prep to peri wound. Apply silversorb gel to wound bed and cover with bordered gauze dressing. Change daily. Every shift for Stage 2 pressure wound." Further review showed no current or discontinued orders for interventions or assessment of skin or pressure ulcers since admission.

h. Interview with the DON on 10/7/21 at 11:29 AM revealed the pressure ulcer never presented as a stage 1. She indicated the wound emerged as a stage 2 and she was "Not sure how or why it happened."

i. Review of the facility policy "Pressure Sore Monitoring" provided by the facility on 10/7/21

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F 686	Continued From page 10 showed "...It is the goal of the community to maintain skin integrity... and prevent new sores from developing."	F 686		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		10/29/21

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F 758	Continued From page 11 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure psychotropic medications were necessary for 2 of 5 residents (#41, #45) reviewed for unnecessary medication use. The findings were: 1. Review of the 9/19/21 admission MDS assessment showed resident #41 was admitted to the facility on 9/10/21 with diagnoses which included unspecified dementia without behavioral disturbance. Review of the current physician orders showed an order for Mirtazapine (antidepressant) 7.5 milligrams (mg) by mouth at bedtime related to unspecified dementia without behavioral disturbance dated 9/29/21 and an 9/10/21 order for Anti-Psychotic Monitoring to be performed every shift related to unspecified dementia without behavioral disturbance dated 9/10/21. The following concerns were identified: a. Review of the 9/10/21 physician order for anti-psychotic behavior monitoring showed no specific target behaviors were identified.	F 758	F 758 Immediate corrective action: Targeted behavior was corrected on resident #41 in the eTAR and care plan. PRN anxiety medication was discontinued on resident #45 How the facility will identify other residents having the potential to be affected: Audit completed of target behavior tracking in eTAR for all residents that receive psychotropic medications. Audit of psychosocial care plan completed and targeted behaviors updated. Audit completed on PRN psychotropic medications for justification of use. Justification documentation obtained if needed. Measures put in place or system correction in this area include: Random audits to be completed on	

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F 758	Continued From page 12 b. Review of the care plan last revised on 9/29/21 showed the resident " ...is at risk for behaviors [related to] situational changes and challenges, Dementia." Interventions included "Monitor behavior episodes and attempt to determine underlying cause ... Document behavior and potential causes." Further review showed no specific target behaviors were identified. c. Interview with the DON on 10/7/21 at 1:54 PM confirmed there were no specific target behaviors identified for psychotropic medication use. 2. Review of the 9/25/21 quarterly MDS showed resident #45 was admitted to the facility on 7/10/21 with diagnoses which included depression and insomnia due to medical condition. The following concerns were identified: a. Review of the October 2021 MAR showed an order for "alprazolam (anti-anxiety) 0.25mg Give 0.25mg by mouth every 12 as needed for anxiety" ordered on 7/10/21. Further review showed no stop date or justification for long term use was identified b. Review of the 9/22/21 Pharmacist to Physician Recommendations fax showed the pharmacist recommended "The Alprazolam has not been used in 60 days, consider [discontinue] the Alprazolam." Further review showed the physician agreed to discontinue the medication; however, the medication was not discontinued until 10/6/21. c. Interview with the DON on 10/7/21 at 1:54 PM confirmed the PRN alprazolam order for the resident should not have an open end date and should have been discontinued after 14 days. She revealed PRN medications should be temporary, or the medication should have be	F 758	targeted behaviors for psychotropic medication use. Weekly audits to be completed on new PRN psychotropic medications and stop/review dates. Who will monitor the new system: DON or designee. How frequently will we monitor: Monthly audits of targeted behaviors to be completed on residents that receive psychotropics. How will we incorporate the new system into our QAPI system: Identified trends will be reviewed monthly in QA until lesser frequency is deemed necessary by committee.	

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F 758	Continued From page 13 scheduled. 3. Review of the facility policy titled "Monthly Drug Regimen Review" provided by the facility on 10/7/21 showed "Each resident's drug regimen review must be free from unnecessary drugs... unnecessary drugs will be identified as well as any drug irregularities. In both situations, prompt follow-up will occur." 4. Review of the facility policy titled "Psychoactive Medications" provided by the facility on 10/7/21 showed residents " ... are not given psychoactive drug therapy unless it is necessary to treat a specific condition as diagnosed and documented in the medical record...Psychotropic PRN (as needed) orders are limited to 14 days, if the attending provider or prescribing practitioner believe it is appropriate for the PRN order to be extended beyond 14 days he/she will document rationale in the resident's medical record and indicate the duration of the PRN order..."	F 758		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes:	F 801		11/19/21

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F 801	Continued From page 14 §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, meets the following requirements no later than 5	F 801		

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F 801	Continued From page 15 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 and employee training review, the facility failed to ensure the dietary manager was qualified. The census was 47. The following concerns were identified: 1. Interview with the dietary manager on 10/7/21 at 9:35 AM revealed she had completed the certified dietary manager course through an approved program; however, she had not completed the certification exam at that time. 2. Review of training certificate showed the dietary manager completed the "Nutrition & Foodservice Professional Training Program" on 4/27/21.	F 801	F 801 Immediate corrective action: Certification exam is scheduled for November 8, 2021. How the facility will identify other residents having the potential to be affected: All residents have the potential to be affected by an unqualified dietary manager. Measures put in place or system correction in this area include: The passing of the exam will be audited for completion.	

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F 801	Continued From page 16	F 801	Who will monitor the new system: Administrator is responsible for monitoring the exam completion. How frequently will we monitor: This will be a one time audit. How will we incorporate the new system into our QAPI system: Exam completion will reviewed in QA.	
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, staff interview, policy and procedure review, and review of food code reference, the facility failed to ensure a sanitary environment was maintained during 1 of 2 meal	F 812	F 812 Immediate corrective action: One on one education done with dietary	11/19/21

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F 812	Continued From page 17 services observed (10/6/21 mid-day meal). The census was 47. The findings were: 1. Observation of meal service on 10/6/21 at 11:38 AM showed dietary aide #1 left the service line with his gloves on, touched the exterior of the walk-in cooler door with both hands, removed a dessert cart from the cooler, used both hands to push the cart near the service line, and returned to the service line. The dietary aide removed lids from pre-poured drink glasses and grabbed the glasses by the rim, then placed the glasses on resident trays. The dietary aide grabbed dessert cups by the rim and placed them on resident trays. Further observation showed the dietary aide opened an individual package of cheese, grabbed the cheese slices in his gloved hand, and placed the cheese on a resident meal tray. No hand hygiene or glove change was performed after leaving the service line or before preparing resident meal trays. 2. Observation on 10/6/21 at 11:51 AM showed dietary aide #1 left the meal service line, grabbed a plastic container, and removed a laminated card from the container. The dietary aide returned to the service line, touched some orange slices, and placed them on a resident's tray. No glove change or hand hygiene was performed after leaving the service line or before preparing resident meal trays. 3. Observation on 10/6/21 at 12:01 PM showed dietary aide #1 rested his gloved left hand on his right forearm. The aide grabbed a glass of milk with his left hand and placed it on a resident tray. No glove change or hand hygiene was performed after touching exposed skin or before preparing resident meal trays.	F 812	aide #1 and review of hand hygiene policy and procedure completed. Dietary staff in-service and education done with all dietary staff to review hand hygiene policy and procedure. Entire staff in-service and education done with all care partners to review hand hygiene and resident assistance in the dining room. How the facility will identify other residents having the potential to be affected: All residents have the potential to be affected. Measures put in place or system correction in this area include: Random audits to be completed in food service and dining room assistance observation. Who will monitor the new system: Dietary manager or designee. How frequently will we monitor: Monthly audits of food service and dining room assistance will be completed. How will we incorporate the new system into our QAPI system: Identified trends will be reviewed monthly in QA until lesser frequency is deemed necessary by committee.	

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F 812	Continued From page 18	F 812		

4. Interview with the dietary manager on 10/7/21 at 9:35 AM revealed she expected dietary staff to change gloves and wash hands every time they left the line and when they contaminated their hands or gloves.

5. Review of a policy titled "Hand Washing" provided by the facility on 10/7/21 showed "...1. When to wash hands: ...b. After touching bare human body parts other than clean hands and clean, exposed portions of arms... g. During food preparation, as often as necessary to remove soil or contamination and to prevent cross contamination when changing tasks..."

6. Review of a policy titled "Bare Hand contact with food and Use of Plastic Gloves" provided by the facility on 10/7/21 showed "...3. Gloved hands are considered a food contact surface that can get contaminated or soiled. If used, single use gloves shall be used for only one task (such as working with ready-to-eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation...6. Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed, and hands must be washed: ...d. After handling anything soiled...l. Any time a contaminated surface is touched...7. Wash hands after removing gloves."

7. According to Food Code 2017, U.S. Public Health Service: 2-301.14 "FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed

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F 812	Continued From page 19 FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLE and: "...(H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands."	F 812		